Oakdown House Limited

Oakdown House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Oakdown House on the 13 April 2017 and the inspection was unannounced. Oakdown House provides care and support for people living with profound physical and learning disabilities and complex communication needs. The service is registered to accommodate up to 45 people, and is split across three separate residential units. At the time of our inspection, there were 38 people living at the service.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Some people were not able to communicate with us using speech, we therefore spent time observing how staff and people interacted and gained feedback from people's relatives. One relative told us, "It is a lovely place to live and the carers are all kind." People also told us how they enjoyed living at Oakdown House. One person told us how they enjoyed tapestry and had recently been out for fish and chips and was looking forward to the morning activity of seeing the farmer and making things.

People were encouraged and supported to eat and drink well. Care plans included clear guidance on people's nutritional needs and the level of support required. People's weight was monitored, however, it was not consistently clear how it was decided how often people should be weighed. We have made a recommendation for improvement.

The provider was not consistently working within the principles of the Mental Capacity Act 2005. It was not consistently clear if people had consented to their care plans, taking of photographs and sharing of information. Where restrictive practice was in place, appropriate applications had been under the Deprivation of Liberty Safeguards (DoLS). For those applications which had not yet been authorised, the provider was unable to demonstrate whether the person had consented to the use of restrictive practice or not. We have made a recommendation for improvement.

The management of risk was safe. Risk assessments were in place and actions were in place to address specific risks such as the risk of choking. We identified concerns in relation to the easy accessibility of latex gloves, but the registered manager took appropriate action to address this concern.

Peoples' health was monitored and they were referred to health services in an appropriate and timely manner. Any recommendations made by health care professionals were acted upon and incorporated into people's care plans. Care plans were person centred and provided clear guidance for staff to follow on how to provide person centred care.

Staff treated people as individuals with dignity and respect. Staff were knowledgeable about people's likes, dislikes, preferences and care needs. They approached people in a calm, friendly manner which people

responded to positively. Staff also spoke with people in a dignified way and knew how people liked to receive care.

People told us they liked the staff and were always treated with respect and dignity. We observed good care, a gentle manner and what looked like genuine friendship between people and carers and among people themselves.

People received a personalised service as staff knew people well enough to care for them in a way that met their needs and preferences. People's preferences and social needs were respected. Activities were many, stimulating and varied and people were supported to maintain links with the community and their relatives.

Staff had received essential training and there were opportunities for additional training specific to the needs of the service, including autism, behaviour that may challenge, and the care of people living with dementia.

There was an open, transparent culture and good communication within the staff team. Staff spoke highly of the registered manager and their leadership style. There were sufficient numbers of staff to meet people's needs and to keep them safe. The provider had effective recruitment and selection procedures in place.

There were suitable arrangements in place for the safe storage, receipt and management of people's medicines. Medicine profiles were in place which provided an overview of the individual's prescribed medicine, the reason for administration, dosage and any side effects.

There was a complaints process in place and all complaints had been responded to appropriately and within a reasonable time frame. There were regular resident and staff meetings and an annual service user satisfaction survey. People said they felt listened to and that their opinions counted.

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

Oakdown House was safe.

Medicines were managed safely. People received their medicines as prescribed and when needed. The provider was actively recruiting more staff and staff felt staffing levels were sufficient. Staff were subject to rigorous pre-employment checks to ensure they were suitable to work at the service.

Staff had received adult safeguarding training and following any safeguarding concerns and enquiries, improvements had been made to ensure people remained safe.

Is the service effective?

Requires Improvement

Oakdown House was not consistently effective.

The requirements of the Mental Capacity Act 2005 were not always followed.

Staff received training that was appropriate to their role and responsibilities. Staff had a good understanding of people's complex support and health needs. People had good access to healthcare professionals for routine check-ups, or if they felt unwell. People's health was seen to improve as a result of the care and support they received.

Is the service caring?

Good

Oakdown House was caring.

People were supported by staff that were kind and caring. Positive relationships had been developed between people and staff. Staff appeared to know people well.

Visiting was not restricted and people were supported to maintain relationships with people that mattered to them.

Support was focused on people's preferences where it could be established and respect of their dignity.

Is the service responsive?

Good

Oakdown House was responsive.

People received support that was person centred and tailored to their individual needs and preferences.

There were individual and group activity plans in place to support people to lead active, purposeful lives and to be involved in the wider community.

There was a complaints procedure in place and any complaints had been dealt with appropriately.

Is the service well-led?

Good

Oakdown House was well-led.

Relatives and staff expressed confidence in the management of the service.

They commented that the management was approachable and listened to their views.

Systems were in place to assess and monitor the quality of the service and the day-to-day running of the service.

Oakdown 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 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 the 13 April 2017 and was unannounced. The inspection was carried out by three inspectors 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.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection we checked the information that we held about the home and the provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

During the inspection we spent time with people who lived at the service. We spent time in the lounge, dining room and day centre. We took time to observe how people and staff interacted. Some people were unable to use structured language to communicate verbally with us, so we took time to observe how people and staff interacted at lunch time and during activities. We spoke with two visiting relatives, nine people, the registered manager, six members of staff, the activity coordinator and the nominated individual.

We looked at seven care plans and associated risk assessments, three staff files, medication administration record (MAR) sheets, incidents and accidents, policies and procedures other records relating to the management of the service. We also 'pathway tracked' people living at the home. This is when we followed the care and support a person's received and obtained their views. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

We lasted inspected Oakdown House on the 29 May 2015 when it was rated as 'Good.'

Good

Is the service safe?

Our findings

People's safety at Oakdown House was important. Risk assessments were in place which explored how to mitigate any risks in the least restrictive manner. Although some people could not tell us if they felt safe, those who could communicate verbally said they did and we observed that when people needed support there was always a staff presence to provide reassurance and guidance where appropriate. A visiting relative also confirmed they felt confident leaving their loved one in the care of Oakdown House. They told us, "I know they are safe here and they like it here."

The management of risk was safe. Care and support was provided to a number of people who were at risk of choking. We found clear guidelines were in place to reduce the risk of choking. For example, some people required a soft diet and one to one assistance with eating and drinking. Guidance was in place which included information on how to position the person. For example, one person's risk assessment noted, 'when staff are supporting me they need to have my chair slightly back to allow my head to face forward.' Where people were at risk of digesting or inhaling products, appropriate action had been taken. For example, one person's care plan identified they had previously tried to eat soap and bubble bath. Their care plan identified for these products to be locked away and we found they were. Some people at had been identified at risk of choking through digesting latex gloves. As part of their Deprivation of Liberty Safeguard, conditions were in place for latex gloves to be kept out of their bedroom and we saw measures were in place to ensure gloves were not stored in people's bedrooms. However, we identified that some boxes of gloves had been left in easy reach of people in communal areas. We brought this to the attention of the registered manager who agreed to take action and address our concerns.

Guidance produced by the epilepsy society advises that epilepsy is more common in people living with a learning disability. Where people had a diagnosis of epilepsy, clear guidance and risk assessments were in place. Guidance included on when medical care should be sought. For example, the risk assessment for one person identified that 999 should be called if the person hadn't recovered after 10 minutes of administering their emergency epilepsy medicine. Epileptic seizure plans were in place which included information on possible triggers, warning signs, how seizures manifested and the requirements for staff support when one is triggered. This demonstrated that the overall management of epilepsy and seizures was safe.

Risks associated with moving and handling were addressed and risk assessments were in place. For example, where people required the assistance of two staff members to move and transfer along with a mobility aid (hoist), risk assessments considered the equipment required, handling constraints and other factors which may prevent a safe transfer. Picture guidelines were in place for staff to follow which included pictorial guidelines on how to position the person and the guidelines for the use of slings and hoists. Good moving and handling practice was observed throughout the inspection. Where people were living with reduced mobility, staff told us of the actions they took to reduce the risk of skin breakdown. One staff member told us, "We support one person to change position regularly and apply cream." Pressure relieving equipment was also in situ as a preventative tool for people with reduced mobility. For people receiving care on a pressure relieving mattress it is important that the setting of the mattress is set to the individual's weight to ensure the mattress provided the correct therapeutic support. This minimised the risk of a person

sustaining skin breakdown. On the day of the inspection, we were unable to locate any guidance on what the individual's mattress relieving mattress setting should be and documentation was also not available to confirm that the setting of the mattress was checked daily. We brought this to the attention of the registered manager who took action and this was addressed during the inspection.

Medicines were managed safely. Storage arrangements were appropriate and included suitable storage facilities in an area where the temperature was monitored to ensure medicines were stored at a temperature that would not have a detrimental effect on how they worked. Staff supported people to take their medicines and completed the Medication Administration Record (MAR) chart once the medicine had been administered. Staff ensured people had taken their medicines safely. We spent time with one member of staff who was supporting people to have their lunchtime medicines. They explained to the person what their medicine was for and what drink they would like to have. One person had their tablets placed on top of jam. The staff member clearly explained they had strawberry jam along with their tablets which made the person smile. Once each person had been supported to their take medicines, another staff member checked the MAR charts and medicine trolley to ensure documentation was accurate and the medicine had been administered as prescribed. A staff member told us, "We implemented this practice following a number of medication errors and it has greatly improved. We hardly have medication errors now."

Medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of safely. The date liquid medicines were opened was recorded and where people had been prescribed medicines to be taken when required (PRN) clear guidance was available to staff about how and when these should be administered. People had regular medicine reviews with relevant professionals to promote good health. Staff had completed training in the safe handling of medicines and the registered manager completed observations of staff practice to ensure they were competent in medicines administration. One member of staff told us, "I really enjoy medication training. I find it really interesting as it's so important. I have enjoyed learning about the different types of medication and the difference they make."

Each person had an individual medicine profile which included information on how they liked to take their medicines along with the details of any side effect. Information was also recorded on the quantity of the medicine and the prescribing instructions.

Systems were in place to ensure people's rights were protected and people were kept safe from potential harm. These included clear systems for protecting people from abuse. Training records confirmed staff had received adult safeguarding training. Staff talked to us about their responsibility to recognise and report any abuse. They were able to give examples of what they considered to be abuse and neglect and told us they would always report any incidents to their line manager or raise concerns directly with the local authority. Where safeguarding concerns had been identified, appropriate action had been taken to ensure the person was safeguarded and their rights protected and upheld. The registered manager and staff told us of learning that had been derived from previous safeguarding concerns. One staff member spoke to us about a safeguarding incident which involved them contacting external agencies alongside the police. They told us how they provided support to both the person and staff.

The provider had effective systems in place for the safe recruitment of staff. Records showed that recruitment checks were in place to ensure staff were suitable to work at the service. Disclosure and Barring Service (DBS) checks were carried out for all the staff. The DBS is a national agency that keeps records of criminal convictions. They requested and checked the references provided for staff and their suitability to work with people.

A management risk assessment was in place to determine staffing levels. This considered potential risks, such as sickness and the core staff levels and skill mix required to ensure people's safety. The registered manager told us, "From this risk assessment we determine the maximum and minimum number of staff required." Where people required one to one care, we saw this was provided. Staff felt staffing levels were sufficient but acknowledged there could be ups and down. One staff member told us, "Sometimes there can be staff shortages, particularly in recent weeks where some staff have started in post but it wasn't for them so they left. However, everyone mucks in." Staff told us that the impact of this meant that at times people could not go off site to do planned activities such as hydrotherapy the week before. Staff however felt things were improving and the registered manager confirmed they were actively recruiting. During the inspection, we observed staff spending time with people and responding to people's needs in a timely manner.

Requires Improvement

Is the service effective?

Our findings

Staff had the skills and knowledge to meet the needs of the people living at Oakdown House. Relatives spoke highly of the service and staff's abilities to meet their loved one's care needs. One relative told us, "The staff are ever so good." Staff members told us they felt supported and had received training that was tailored to the needs of people they supported.

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. Training records demonstrated that staff received training on the MCA and staff members told us how they worked within the principles of the act. During the inspection, we observed staff gaining consent from people and providing options as to what people wanted to do, where they wanted to sit and what they wanted to eat. A range of decision specific mental capacity assessments were in place. For example, one had been completed to determine whether an individual had capacity to consent to a safeguarding process. However, the provider was not consistently following the principles of the MCA 2005 Code of Practice. For example, a range of restrictive practice was in use. Such as the use of bed rails, lap belts, helmets, door sensors, door guards and leg belts. The registered manager had recognised that people's liberty was restricted and subsequently applied for Deprivation of Liberty Safeguards (DoLS). However, not everybody's DoLS application had been authorised by the appropriate local authority. Where applications had been authorised, mental capacity assessments had been completed by a staff member from that local authority. However, for those whose application had not been authorised, the provider was unable to demonstrate if the person consented to the use of restrictive practice, or whether the restrictive practice was in their best interest and the least restrictive option.

We brought these concerns to the attention of the registered manager who was open and responsive to our concerns. For example, during the inspection, they started to undertake mental capacity assessments for the use of bed rails. We have judged these concerns not to be a breach of regulation, as the impact on people was minimal and the registered manager took action immediately. However, we have identified this as an area of practice that needs improvement.

We recommend that the provider seeks guidance on the implementation and embedment of the MCA 2005.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. DoLS referrals had been made for most people living at Oakdown House. The registered manager was awaiting further contact regarding the outcome and had been in touch with the Local Authority DoLS team to seek an update.

People received effective support from staff that were skilled in helping them to maximise their independence and increase their quality of life. Staff had completed training in supporting people to meet their individual health needs. All staff members were trained in epilepsy and the administration of emergency medicine. Training also included autism awareness, dysphagia and dementia. The registered manager told us how they had recognised that people were living longer and they were now supporting people with a dual diagnosis of dementia and learning disability. Consequently the registered manager had organised for a 16 week dementia training programme provided by the Care Home in Reach Team. Training was provided on communication skills and dementia awareness and staff felt the training was insightful and useful.

Staff spoke highly of the training provided and also confirmed that their competency was assessed through observations. Staff competency checks considered whether staff used personal protective equipment, how the risk of infection was minimised and how they supported the person to eat and drink.

Guidance produced by Skills for Care advises of the importance on a strong, skilled and competent workforce. This was recognised by the provider and registered manager. The registered manager told us, "One of our strengths is how we develop staff. For example, a lot of staff have worked up from care assistants to team leaders." Support was in place for staff to access additional qualifications such as health and social care diploma's. One staff member told us how they were working towards their NVQ (national vocational qualification) level 5. Staff spoke highly of the training opportunities and one staff member told us, "We are really supported here."

Mechanisms were in place to support staff to develop their skills and improve the way they cared for people. Staff received regular supervision. Supervision is a formal meeting where training needs, objectives and progress for the year are discussed. Staff told us they felt supported within their roles and felt able to approach the registered manager with any queries, concerns or questions. One staff member told us, "The manager is very good and gives us the freedom and opportunity for development."

People required careful support around their nutritional and hydration needs. There was clear individual guidance about how to support people safely and effectively with eating and drink. For example, one person's eating and drinking care plan identified that they required support from staff to cut up their food into bite size pieces. Their care plan also identified that if their food was not cut up, they would tend not to eat and would not ask for help. Adapted cutlery and plate guards had been sourced and were in place to promote people's independence with eating and drinking. A large number of people required one to one support with eating and drinking at lunchtime. Staff sat down next to people and supported people at their own pace. Some people needed specialist support with complex healthcare needs, including PEG feeding. This was required when people could not maintain adequate nutrition with oral intake. Guidance and information was readily available on the person's PEG regime which included advice on when staff should administer water flushes and at what time should an individual PEG regime commence. Although guidance was in place which included information of the person's feed regime, we found information was not available on how to effectively maintain the PEG site. For example, when the PEG should be rotated, how often it should be cleaned and how it should be cleaned. We brought these concerns to the attention of the registered manager who took action immediately and during the inspection process implemented a PEG care plan.

Care plans included information on people's weight and how often people should be weighed. For example, one person's care plan identified, 'because my weight is stable, I can be weighed every three months.' However, it was not clear how that decision was made. We identified one person who was a very low weight, yet their care plan identified they should be weighed every three months. Staff told us how they were

managing this person's weight by offering fortified drinks. However, documentation failed to reflect how the decision was made on how often people should be weighed. We have identified this as an area of practice that needs improvement.

We recommend that the provider seeks guidance from a national source on the oversight of people's weight.

Staff worked in partnership with external health care professionals to promote good outcomes for people. Each person's care plan included a section called, 'my medical information.' This provided clear information on people's medical needs and the healthcare professionals involved in their care. People had regular access to GPs, chiropodists, dieticians and Speech and Language Therapists (SALT). The district nursing team provided regular support to one person who had dressings in place and staff told us how they worked in partnership with external professionals. The registered manager told us how they were creating a story book with one person in partnership with the local community learning disability team and phlebotomist. They told us, "This person is terrified of needles and causes them a lot of distress and previously we have had to use low level distraction techniques. However, we now creating a story book and working with professionals on how we can safely support them to have a blood test."

Good

Is the service caring?

Our findings

Interaction between staff and people using the service was warm, caring and friendly. Throughout the inspection we saw staff attentively and respectfully assisting people in a reassuring manner. We saw that where a person was becoming unsettled or needing reassurance, members of staff responded to them in a clear and respectful manner. Visiting relatives spoke highly of the caring nature of staff. One visiting relative told us, "It is a lovely place to live and the carers are all kind".

For people living with a learning disability, good communication ensures that people can express themselves and make sense of the world around them. Staff demonstrated a good knowledge of how best to communicate with people. During the inspection, we asked for a tour of Oakdown House. Before the tour, the registered manager and staff told us how people would communicate with us and what questions they might like to ask us. Throughout the inspection, we observed staff communicate with people in a forum that suited and met their needs. For example, some people communicated using makaton. Staff told us how they had received training and one staff member was a makaton tutor. During the inspection, staff signed using makaton which enabled them to communicate with people. We also observed that staff were skilled in using different approaches and ways of communicating with people. For example, staff communicated with two people who were unable to communicate verbally via picture boards. They told us how they used colour charts to help them pick what colour they wanted their bedroom wall painted. It was clear staff had spent considering time learning how to engage and communicate with people to ensure their voice was heard. One staff member talked to us about how they have used mirrors to engage one person who finds direct eye contact threatening but is better if the eye contact is via a mirror as this is less invasive.

People's bedrooms were spacious, in good decorative order and had been personalised, for example with photographs, sensory items and art. This helped to create a familiar, safe space for people. The registered manager told us how people were involved in choosing the colour scheme for their bedroom and how their bedroom reflected their personality. For example, one person was a keen Thomas the Tank Engine fan and this was clearly reflected within their bedroom. Guidance produced by the National Institute for Health and Social Care Excellence (NICE) advises that sensory stimulation for those living with a learning disability can promote quality of life. Staff understood the importance of sensory stimulation. One member of staff told us, "Some people really enjoy the stimulation of various lights and music."

Guidance produced by the Social Care Institute for Excellence (SCIE) advises on the importance of choice and control for people within care homes and empowering people to retain their identify. Staff recognised the importance of supporting people to maintain their individuality and identity. For example, staff supported people to do their hair and make-up. People's individual care plans included information on how people liked to dress and what was important to them. For example, one person's care plan noted, 'I enjoy having my make-up and hair done and looking in the mirror at the end result.'

The atmosphere in the service was appropriate to the people living at the service. It was fun and lively and close friendships had formed between people. People were able to maintain relationships with those who mattered to them. For example, we saw in diaries that there was a reminder for staff to support people to

make Mother's Day cards for relatives. Visiting was not restricted and guests were welcome at any time. Relatives told us they could visit at any time and they were always made to feel welcome. During the inspection, we observed relatives spending time with their loved one in the lounge enjoying a hot drink.

Staff demonstrated a strong commitment to providing compassionate care. It was clear that they knew people well and had a good understanding of how best to support them. We spoke with staff who gave us examples of people's individual personalities and character traits. They were able to talk about the people they cared for, what they liked to do, the activities they took part in and their preferences, for example, in respect of food. Staff knew about peoples' families and some of their interests. One staff member told us how one person enjoyed cuddles and throughout the inspection, we observed this individual go up to staff members for cuddles which they happily returned.

People's wishes at the end of their life were in the process of being explored and sensitive end of life care plans were being implemented. The registered manager told us, "We recently supported someone who remained here during the end of their life. We worked in partnership with the local hospice team and overall we felt we did it right. We then reflected on that and agreed we needed to roll out end of life training and support people and their families to consider their end of life wishes. The service also had a memorial garden to remember those who had previously lived at Oakdown House.

Staff supported people and encouraged them, where they were able, to be as independent as possible. The registered manager and staff told us how they encouraged people to make daily choices. One staff member told us, "People chose what they want to do, what they want to wear and what they want to eat. Every Sunday we all make a meal together and people get involved by deciding what they want and we then cook the meal together." The registered manager and provide told us about how some people were supported to undertake various jobs around the home which promoted their independence and self-esteem. One person did various filing and shredding in the office, another person told us how they did gardening and tiding up around the home. One person had set up their own car washing business. Upon arrival to the inspection, this individual approached the inspection team, introduced themselves and asked if we would like our car washed. During the inspection, we spent time with this person and they told us about their business and how they enjoyed it. They seemed happy and excited when we asked them about their job.

People's diversity and spiritual needs were upheld. Staff recognised the importance of supporting people to maintain their religious beliefs. For example, staff supported one person to access their local church and two people went to the local church next to Oakdown House every Sunday.

Good

Is the service responsive?

Our findings

Oakdown House was responsive to people's changing needs and people's preferences were taken into account so that they received personalised care. People's relatives told us that the service was responsive and the registered manager and staff kept others well informed about any changes in the support people needed, for example, if someone became unwell. As well as being kept informed, those in the person's life also felt fully involved in the support provided. They told us they were updated with any changes or issues that affected care.

At the last inspection we identified areas of improvement in relation to care plans not always reflecting people's current care needs. Recommendations were made and at this inspection, we found improvements had been made.

People's needs were assessed before they came to live at the service to ensure that their care and support needs could be met there. This assisted staff to deliver responsive care and support. Following the preadmission assessment, individualised care plans were devised. The aims of the care plan included for the team to work consistently in their approach, to provide a safe environment and to work towards improving the quality of life for the individual. Care plans included a 'My Care Passport.' This provided an overview of the person's needs and how best to support the individual in a person centred manner. Information was available on how the person communicated, their likes, dislikes and things that may upset them or worry them. For example, one person's care passport noted, 'I dislike noisy crowds and I am not keen on showers although I have recently chosen to accept support from certain staff.'

The history of each person made up an important part of each person's care plan. The information painted a portrait of the person and the service made use of the details to record the support they provided for that individual. The information was used as an aid to help staff to get to know the person they were caring for even better, so that support effectively met their needs. We spent time talking with one person who told us about their likes, dislikes and what activities they enjoyed doing. They told us they enjoyed tapestry and they had recently been out for fish and chips and was going to see the farmer that day to make some things. We found that their care plan clearly reflected this. People's individual, hobbies, likes and dislikes were clearly reflected within their care plans which enabled staff to provide person centred care. For example, one person's care plan noted that what makes them happy was dancing and listening to music. Within people's individual care plans were goals which had been set. For example, one person's goal had been noted as, 'to support me to continue to make myself understood and my needs known.' However, there was no review of this goal. Therefore it was not clear if they had met that goal or if they were still working towards it. We brought this to the attention of the registered manager who identified this was something they were working on and would be continually reviewing as part of people's care plan reviews.

Guidance produced by Skills for Care advises that behaviours which challenge can arise for different reasons, often personal to the individual. Positive behavioural support (PBS) is the best way of supporting people who display, or are at risk of displaying, behaviour which challenges. Staff told us how they had received PBS training and how they used that training to respond to people's needs. Positive behaviour

support plans were plan which identified triggers and how best to respond. For example, one person's positive behaviour support plan identified that pain or boredom could be a trigger for them and that they would often initiate hugs. The support plan identified that they enjoyed being hugged back.

People were supported to pursue social interests and activities that were important to them. The service had a dedicated day centre on site and was in the process of building a second day centre. The registered manager told us, "We fund the day centre ourselves and it is a great asset. We employ about 11 members of staff who work specifically in the day centre." During the inspection, we spent some time in the day centre. A range of posters and pictures were on display proudly showing what activities people had engaged in and enjoyed. The registered manager pointed out pictures of when visiting animals had visited the service, including a snake. The day centre also had a reminiscence room which had been created so people could sit and look at old videos and photographs. On the day of the inspection, people were enjoying making Easter eggs and the activity coordinator told us how sensory cooking really encouraged independence and promoted people's self-esteem. They also added, "When we first started the sensory cooking, people weren't really interested but then once people tasted the food, they became much more interested."

People had individual activity plans in place. For example, one person was supported to access a college course once a week. Another person was supported to access a music therapy session. The activity coordinator told us, "Each month, we try and have a theme for activities and based on that theme we try to achieve outcomes." For example, in January 2017, the theme was personal safety. Activity ideas included road safety sessions, safety stories, safety in the day centre and a visit from the police. Outcomes for the month were noted as 'for residents to have a greater understanding of personal safety.' People spoke highly of the activities and throughout the inspection, we observed people engaged in a wide range of activities.

Support was sourced from external resources to promote people's quality of life. For example, an aromatherapist visited the service twice a week to provide relaxing massages. The provider also employed a counsellor who visited people to provide emotional and psychological support. Once a week, a local farmer visited the service and ran a morning farming session where people would pot plants and engage in gardening activities. One person told us, "I'm looking forward today, we are doing gardening." The registered manager told us that most people were funded for one to one support to access the local community and where possible they would take people on holiday. For example, one person had expressed a wish to go to Australia, however, due to health complications; staff were working with the person to overcome those complications and were currently looking at flights to Guernsey. The registered manager also told us, "Some families like for our staff to go away with them and recently one member of staff supported a person to go on a family holiday which they enjoyed." A wide range of trips out were organised for people and we saw that people had recently been to Dungeness for the day. Staff and people also told us how they enjoyed going out for BBQs, trips to Drusilla's and were planning on going to Bewl water soon to watch the dragon racing.

The use of technology was integrated and used to promote interaction and engagement between staff, people and relatives. The registered manager told us, "We have a range of computers, ipads and tablets for people to use. One person has a selfie stick which we attach to their wheelchair so they can facetime their parents. Technology is a great way for us to keep relatives updated and informed." During the inspection, we spent time with one person who was watching a YouTube video on how to make pop up Easter cards. They told us, "I really want to make one."

There were arrangements to listen to and respond to any complaints. One person told us, "If I was worried or not happy, I would email the big boss (provider)." Accessible complaints information had been provided for those people able to understand the easy read formats. The provider had received one formal complaint

since the last inspection. Documentation confirmed that feedback was given to the complainant, a letter of apology was sent and learning had been derived from the complaint.

Good

Is the service well-led?

Our findings

Everyone we spoke with shared the same determination to provide quality support to people. It was important to the registered manager and staff that this was done while maintaining a relaxed homely atmosphere. Staff, people and relatives spoke highly of the registered manager and the management team. One staff member told us, "The manager is very supportive and adopts an open door policy. He is very visible and will always help out if we are short staffed. He even helps with personal care if needed. He often takes people out on trips and knows them well. People often approach him to ask him when they are going out again."

The culture and values of the provider were embedded into everyday practice. The provider had a value statement which stated their aims and objective as an organisation. These included, 'to provide high quality person centred support. To be an employee of choice and to provide a safe and homely environment.' We found these aims; objectives and values were embedded into practice. Relatives spoke highly of the service and its homely atmosphere. The registered manager told us how the organisation was a family run service that was established in the 1980s when many learning disabilities institutions were closing down. The registered manager commented, "They wanted to create a homely and supportive environment that was a home for life."

The provider used a range of ways to seek the views of people, staff and relatives. Satisfaction surveys were sent out to relatives which covered a range of areas from catering, food, personal care, premises and management. Feedback from the latest satisfaction survey in 2016 found that all respondents felt the management's efforts to create a good atmosphere was very good. Staff meetings were held on a regular basis and provided a forum for the registered manager to communicate with staff and for staff to share ideas. Documentation confirmed that staff meetings were held monthly and the latest staff meeting in March 2017 reflected that the registered manager had raised concerns with staff about the lack of communication between them and people during lunchtime meals. The registered manager told us that staff were upset about this and action had been taken to address this.

The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The registered manager confirmed that no incidents had met the threshold for Duty of Candour.

There were systems in place to review the quality of all aspects of the service. The registered manager told us, "We have revised all of our audits to be based around the CQC's key lines of enquiry for residential services. Each month the care coordinators complete a monthly checklist which considers the individual domains, such as safe and they are linked to the key lines of enquiry." For example, the monthly checklist covered areas such as accident forms, health and safety, fire, medication, risk assessments, food and fluids and a range of other areas. The registered manager also utilised resources from Skill for Care and had

completed a CQC evidence and action plan. This considered each key line of enquiry and what action or changes they could make. The action plan identified the following changes that would be made to help improve and develop practice. These included, 'electronic care plans to be implemented and electronic staff management system to be used more effectively to oversee all employment checks. The provider also completed monthly audits which focused on regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. As part of these audits they spoke with staff and people. They also considered incidents and accidents, risk assessments, supervisions, the number of hospital admissions, the number of complaints and staffing levels. Following each audit, a range of recommendations were made. For example, the last audit in January 2017 identified some issues with care plans and risk assessments. An action was implemented and would be reviewed at the next audit.

The quality of care delivered was also assessed through the forum of observations. The registered manager regularly observed practice, such as observed lunchtime meals and also completed positive behavioural support observation checklist. This considered the person being supported, what staff were doing, examples of what was said and observations noted. This enabled the registered manager to identify areas of good practice and areas for improvement. It was clear that the registered manager was committed to the continual improvement of Oakdown House. Throughout the inspection, they were open and responsive to our concerns, taking action immediately.