Care Quality Commission

CAS Care Services Limited

Oakhurst Lodge

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

Oakhurst Lodge is a care home. People in care homes receive accommodation and their care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and both were looked at during this inspection. Oakhurst Lodge provides care for up to eight young adults with autism and severe learning difficulties often accompanied by complex needs, behaviours which might challenge others and self-injurious behaviours. At the time of our inspection there were seven people of both sexes living at the home. The service is located in a residential area close to local amenities. There is a large secure garden and parking on site.

This was the first comprehensive inspection of this service under the provider CAS Care Services Limited. We have rated the service as Good overall. This was because, although we found some areas where the service could improve upon, people overall experienced good care and support.

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

Some improvements were needed to ensure that medicines were managed safely and in line with the provider's policies and procedures. The home was clean and suitable cleaning schedules were in place, however staff were not consistently completing records which demonstrated that they were complying with food hygiene records.

Most parents felt that communication was an area where improvements could be made. Whilst people took part in a range of leisure activities, some relatives felt there was scope to expand on this.

There were sufficient numbers of staff to meet people's needs. Risk assessments were carried out to enable people to receive care with minimum risk to themselves or others.

The provider had appropriate policies and procedures for reporting abuse. This ensured staff had clear guidance about what they must do if they suspected abuse was taking place.

Accidents and incidents were investigated to make sure that any causes were identified and action was taken to minimise any risk of reoccurrence. Lessons learnt were communicated effectively with the staff team and throughout the organisation through a lessons learnt group.

People's dietary needs were met and they were supported to make meal choices.

There were systems in place to support effective joint working with other professionals and agencies and to ensure that people's healthcare needs were met.

In general the environment was suited to people's needs. Further improvements were planned to make the environment more homely. People were being consulted on this.

Staff had built strong relationships with people and knew how best to support them. They knew what was important to people and what they should be mindful of when providing their support. Staff interacted with people in a kind and caring manner.

Staff supported people in a way that maintained their independence and they spoke with, and about, people in a respectful manner. People were supported to maintain relationships with people that mattered to them.

Staff had taken innovative steps to provide information to people in a way in which they could understand allowing them to be as involved as possible in decisions about how their care was provided. People were involved in the running of the service through weekly house meetings.

The registered manager used complaints or concerns to understand how they could improve or where they were doing well.

The registered manager demonstrated a good knowledge of each person living at the home. The registered manager had a clear vision for the service which was underpinned by key values which included dignity, respect and inclusion.

There were systems in place to assess and monitor the quality and safety of the service and these were an integral part of the way in which the registered manager and provider identified shortfalls, learning and innovation to drive improvements in the service.

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.

Some improvements were needed to ensure that medicines were managed safely and in line with the provider's policies and procedures. The home was clean and suitable cleaning schedules were in place, however staff were not consistently completing records which demonstrated that they were complying with food hygiene records.

There were sufficient numbers of staff to meet people's needs. Risk assessments were carried out to enable people to receive care with minimum risk to themselves or others.

The provider had appropriate policies and procedures for reporting abuse. This ensured staff had clear guidance about what they must do if they suspected abuse was taking place.

Accidents and incidents were investigated to make sure that any causes were identified and action was taken to minimise any risk of reoccurrence.

Is the service effective?

Good

The service was effective.

People's rights were protected because the registered manager ensured that the requirements of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) were embedded within the service.

People's dietary needs were met and they were supported to make meal choices.

There were systems in place to support effective joint working with other professionals and agencies and to ensure that people's healthcare needs were met.

In general the environment was suited to people's needs. Further improvements were planned to make the environment more homely. People were being consulted on this.

Is the service caring?

Good

The service was caring.

Staff interacted with people in a kind and caring manner.

Staff supported people in a way that maintained their independence and they spoke with, and about, people in a respectful manner.

Is the service responsive?

Good

The service was responsive.

Most parents felt that communication was an area where further improvements could be made. Whilst people took part in a range of leisure activities, some relatives felt there was scope to expand on this.

Staff had built strong relationships with people and knew how best to support them. They knew what was important to people and what they should be mindful of when providing their support.

Staff had taken innovative steps to provide information to people in a way in which they could understand allowing them to be as involved as possible in decisions about how their care was provided.

The registered manager used complaints or concerns to understand how they could improve or where they were doing well.

Is the service well-led?

Good

The service was well led.

The registered manager demonstrated a good knowledge of each person living at the home and had a clear vision for the service which was underpinned by key values which included dignity, respect and inclusion.

There were systems in place to assess and monitor the quality and safety of the service and these were an integral part of the way in which the registered manager and provider identified shortfalls, learning and innovation to drive improvements in the service.

Care Quality Commission

Oakhurst Lodge

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 unannounced comprehensive inspection took place on 23 and 24 January 2018. One the first day the inspection team consisted of an inspector and an inspection manager. One inspector returned for the second day.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is used by registered managers to tell us about important issues and events which have happened within the 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, such as what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection.

Some of the people using the service were non-verbal or had other communication difficulties and so they were not able to speak with us and so we spent time observing interactions between people and the staff supporting them. We spoke with the registered manager, regional manager, deputy manager, quality director and seven support workers. We also spoke with the maintenance person. We reviewed three people's care records, staff training records, recruitment files for four staff and other records relating to the management of the home such as audits, complaints and meeting minutes. Following our inspection, we spoke with each person's parents and received feedback from four health and social care professionals on the quality of care provided.

This was the first comprehensive inspection of this service under the provider CAS Care Services Limited. When we last inspected this service it was registered under a different provider.

Requires Improvement

Is the service safe?

Our findings

During our inspection, we observed that people seemed relaxed and responded positively when approached or spoken with by staff. We felt this indicated that people felt secure in the presence of staff and with the way in which support was provided. People also appeared to be comfortable with one another and most of the young people had lived together for many years. The majority of parents told us they were confident, their family member was safe at Oakhurst Lodge. Parents told us staff managed incidents of behaviour which might challenge others, well. One parent said, "I am totally in awe of staff, [the person] can display very challenging behaviour, they have dealt with it and supported her very well". A social care professional told us, "Staff working with [person] need a high level of skills and experience, if my client is to be managed safely. I can think of no better service for my client that Oakhurst Lodge at this time".

We looked at how the service managed people's medicines. Medicines were only administered to people by staff who had been trained to do this and who underwent a regular review of their skills, knowledge and competency to administer medicines safely. Medicines were kept in locked cabinets, in a locked treatment room. The temperature of the treatment room was monitored to ensure the medicines were being stored within recommended temperatures. We reviewed each person's medicines administration record (MAR). These contained sufficient information to ensure the safe administration of medicines. Where people required 'as required' or PRN medicines, protocols and treatment escalation plans were in place which described when these should be used. Systems were in place to identify report and investigate medicines related incidents and arrangements were in place for people to have medicines reviews.

We did note some areas for improvement. We found two 'as required' medicines prescribed for one person in August 2016 in the medicines cabinet. Their most recent MAR did not include this medicine. The medicine had not been entered in the disposals book, and we were unable to see records which clarified whether this medicine has been stopped by the prescriber or remained a current medicine. Staff were also unable to clarify this. The registered manager is liaising with the prescriber to address this. The provider's policy stated staff should 'Remember to write the opened date, time and sign on the opened date label, if opening a new bottle'. They were also required to 'check the 'shelf life' of the medicines. We found however, a number of opened medicines with no date of opening recorded and in one case, the medicines shelf life had expired. We identified two recording errors on one person's MAR, when no reason had been entered for the medicine not being given. We were advised that the person often refuses their medicines and that the prescriber is aware of this.

Overall the home was clean and policies and procedures were in place to protect people through effectively preventing and controlling the risk of infections. An annual infection control audit was completed and reviewed how well the service was managing this aspect of people's care. However records used to demonstrate that the service was complying with food standards regulations were not being consistently completed and the temperature of the fridge and freezer was not always being recorded. The registered manager told us they would reinforce the need for all staff to take responsibility for completing these records, particularly in the absence of the chef.

A record was kept of accidents and incidents that occurred within the service. We reviewed these and found that a small number had not been reviewed by the registered manager. This is important to ensure that they have complete oversight of risks within the service. Each month the number and nature of incidents was reviewed to make sure that any causes were identified and action was taken to minimise any risk of reoccurrence. Systems were in place to review safety related incidents and events to ensure lesson were learnt. For example, during the latter part of 2017, two people living at the service had needed crisis interventions to manage their escalating behaviours and to keep them and others safe. Both had needed to be placed elsewhere in an emergency in order that their needs could be met. This had been a challenging time for both people and staff. We talked with some parents about how the service had managed this. The feedback was largely positive. One parent said, "We were aware of the situation, [the person] was frightened but we feel he was well supported, they [staff] are right on top of safeguarding issues". Investigations had been completed by senior staff in relation to these situations. These were open and transparent and identified where there had been failures and also made a number of recommendations such as, ensuring that a nurse assessor was involved in the assessment process for all future new placements within the home. Whilst no new admissions to the service had been made, the registered manager told us about how they were working with their colleagues to undertake a preadmission assessment and consider what transition arrangements might be necessary including robust impact assessments for the people already using the service. We were confident that lessons had been learnt from the previous placement breakdowns. The provider had also implemented a lessons learnt group to share learning from safeguarding investigations or incidents across the organisation and the registered manager also told us learning was also shared with staff at team meetings to improve the quality of care provided at the home.

Support plans included risk assessments covering a range of areas such as travelling in cars, eating and drinking and the risks associated with conditions such as pica which means the person may be at risk of placing objects into their mouth and choking on these. The risk assessments were developed where necessary with the input of the provider's multi-disciplinary team which included a speech and language therapist, psychologist and a registered nurse. Each shift had staff trained in caring for people with epilepsy and in safely supporting those at risk of choking due to having swallowing problems. Staff had a good understanding of the risks associated with people's care and how to support them to maintain good health and to stay as safe as possible both within the home and when out in the community. We did note that in the case of one person, their care plan stated that they should be weighed on a monthly basis, but there was no record of this taking place. The registered manager told us that this was because the person refused to be weighed. We have asked that the registered manager to ensure this is reflected in the person's support plan and associated records. Staff tried to maximise people's freedom where possible and action was taken, where able, to reduce the amount of support being provided if it was safe to do so and alongside a suitable contingency plan.

Some of the people within the service could at times express themselves through displaying behaviours which could challenge others which included physical aggression towards staff or towards objects. Where this was the case people had positive behavioural support plans which had been developed with the input of the person, if able, and the provider's psychology team. Plans included a description of the potential behaviours, the possible triggers, justification for intervention, and the agreed techniques to be used. There was clear guidance on the proactive and preventive strategies which needed to be tried before any physical intervention was considered. Where physical interventions or restraints were required, staff used a nationally accredited approach. The support plans viewed were clear and stressed the importance of taking the least restrictive actions first and of applying the restrictive interventions for the shortest length of time necessary to reduce risk and bring the situation under control. Staff told us they felt confident in the use of these techniques and this was confirmed by the health and social care professionals we spoke with, with one saying, "I have attended one activity with [the person] and staff support with him interacted with him

positively and was able to de-escalate positively, a situation that had caused [the person] to become agitated". Following the use of physical interventions, debriefing sessions were held. These sessions are a supportive tool for staff and contribute to reflection which can help lead to the reduction in the use of physical interventions. We did note that these debriefing sessions were not always being recorded. We recommend that moving forward these debriefing sessions are recorded in line with the provider's policies and best practice guidance.

Environmental risks were managed. Fire and legionella risk assessments had been completed and a ligature risk assessment was also in place. Regular checks were undertaken of the fire safety within the service and fire drills took place periodically. People had personal emergency evacuation plans (PEEPS) which detailed the assistance they would require for safe evacuation of their home. A business continuity plan was in place which set out how the needs of people would be met in the event of the building becoming uninhabitable or an emergency such as a fire or flood or loss of power. Checks were made to ensure that gas and electrical appliances were safe to use and of the water temperatures to ensure that people were not at risk of scalding. Window restrictors were also checked to ensure they were in good working order. The perimeter fencing was checked to ensure it was free from damage.

Staff told us there were usually sufficient staff deployed to keep people safe and to support them with activities and other daily living tasks. Rotas showed that there were usually five or six support workers and a team leader on duty during day shifts and four staff and a team leader at night which was in keeping with planned staffing levels and helped to ensure that each person had a dedicated staff member. In addition, on weekdays there was a full time activities co-ordinator and a chef. Additional staff were rostered should they be needed to assist with supporting people to visit their families for example. One parent told us, "We only give a days' notice, but they always have enough staff for someone to come with us when we want to go out with [the person]". The service had a team of bank staff to cover gaps in the rota. Our observations during the inspection indicated that there were sufficient numbers of staff available to meet people's needs and to provide meaningful interaction and engagement.

Relevant checks were completed before staff were employed. Each staff member had provided an application form, a full employment history and proof of identity and attended a competency based interview to check their suitability and competency for the role. Satisfactory references from previous employers had also been obtained. Disclosure and Barring Service (DBS) checks had been completed. DBS checks alert the provider to any previous convictions or criminal record a potential staff member may have which helps them to make safer recruitment decisions.

The provider had appropriate policies and procedures for reporting abuse. This ensured staff had clear guidance about what they must do if they suspected abuse was taking place. Safeguarding people from harm was discussed at staff supervision and staff meetings and the provider maintained oversight of all safeguarding concerns through the use of a tracking tool. Staff had a positive attitude to reporting concerns and to taking action to ensure people's safety. People were supported to understand how to stay safe. For example, the local police visited to talk with people about this and about stranger danger and information had been made available in a range of formats to ensure that people knew how and with whom they should raise any concerns about their safety. Whistleblowing procedures were in place, although staff were confident that the leadership team would act on any concerns they might have about a person's safety.

Good

Is the service effective?

Our findings

There was evidence that staff worked collaboratively with other professionals to understand and meet people's needs. For example, the registered manager was working with one person's family and a range of health and social care professionals to plan and assess a move to supported housing. As already described in this report, the registered manager was taking action to ensure that all assessments of people referred to the service for a placement would involve a robust multi-disciplinary assessment. Should people need to be admitted to hospital for example, information about the person, such as how they communicated, their support needs and likes and dislikes was shared with other professionals in the format of a 'Communication Passport'.

Care plans provided information to ensure staff knew how to meet people's individual needs. Each person had a support plan, a positive behaviour support plan and risk assessments. Each person had a health action plan, which provided information about past and current medical conditions as well as records of all healthcare appointments and information about how their physical health needs were being met. People's support plans were person centred and contained information about the support they needed with areas such as personal care, eating and drinking and with domestic tasks or leisure opportunities. The staff we spoke with had a good understanding of people's needs and how to support them effectively. We did note that not all staff had signed to confirm that they had read people's support plans.

In general the environment was suited to people's needs. The home was secure. The front garden was kept secure through the use of key electronic gates and the front door to the home could only be opened by entering a code into a key pad which we observed that staff were very careful to keep private. These restrictions were in place to keep people safe rather than to restrict people's movements. To the rear people had access to a large secure garden where there were areas for growing vegetables and other outdoor equipment such as a swing and basketball hoop. Inside, each person had a single ensuite room which had been personalised and decorated according to their individual tastes and choices. During the inspection, one person's room was being repainted in a colour of their choice. There were a variety of different areas where people could spend time, including a reading room, an activities room and a lounge. We noted that these rooms were not very homely and were sparsely furnished. The registered manager told us that some of the homes furnishings had been damaged or had needed to be removed to prevent these being broken or causing harm to people whilst they had been caring for the two people experiencing a crisis. They assured us that this furniture would now be reintroduced. New furniture had also been ordered including sofas. The service had a sensory room, on the day of the inspection, this room was cold and not very inviting. We also noted that the ball pit was only padded on one side. We were concerned that this could present a risk to people with self-injurious behaviours. We brought this to the attention of the deputy manager. We also raised some concerns that some items of furniture, including a coffee table, a chair and sofa might not be suitable for environments supporting people who might display challenging behaviours which might include damaging or throwing items of furniture. We recommend therefore that the provider review the furniture provided to ensure that it is all of a suitable design and safe and secure for both people and staff, whilst also providing a homely environment.

People's rights were protected because the registered manager ensured that the requirements of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) were embedded within the service. The MCA 2005 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. Where people were able to express their wishes and choices it was evident that staff respected these and had involved them in planning their care.

To check whether people were able to make more complex decisions about their care, staff had completed mental capacity assessments. For example, we saw mental capacity assessments in relation to whether people could consent to living at Oakhurst Lodge or to staff managing their finances. Support plans noted which decisions had been made in a person's best interests and who had been involved in the consultation. Staff had received training in the MCA 2005 and were able to tell us about the key aspects of the legislation and how it impacted upon their day to day support of people, for example, one support worker told us, "Mental capacity is whether people can make decisions for themselves, whether they can process, retain and understand information".

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA 2005. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Five people had an authorised DoLS in place due to the level of supervision they required to ensure their safety both within and outside of the home. The registered manager was knowledgeable about which people had conditions applied to their DoLS. We did note however, that in the case of one person, their DoLS authorisation had expired. The request for a new authorisation had not been made until a month later. We discussed with the registered manager the need for a there to be a more robust system in place to alert them that DoLS authorisations might be lapsing so that these can be reapplied for in a timely manner and therefore avoid people being deprived of their liberty illegally.

Procedures were in place to ensure that new staff received an induction into the service and to the needs of the people they would be supporting. For example, new staff completed a detailed workbook on caring for people with autism. New staff also completed the Care Certificate. The Care Certificate sets out the competencies and standards of care that support workers are expected to demonstrate. A support worker told us their induction had been helpful. They had been able to read each person's support plans and had had weekly meetings with their supervisor, during which they had been set targets such as the completion of Care Certificate standards.

Staff were positive about the training available and told us it helped them to perform their role effectively. Face to face training was provided in a number of subjects such as; safeguarding, administering medicines, emergency first aid, and in recognised and accredited strategies for managing behaviour that challenges, including the use of physical interventions. Online training was undertaken in additional subjects such as responding to emergencies, equality and diversity, food safety, health and safety, Mental Capacity Act 2005 (MCA 2005) and infection control. Ongoing support for staff was achieved through individual supervision sessions and an annual appraisal. Staff told us, and records confirmed, they received three supervision sessions a year and found these useful in measuring their own development and identifying additional training needs.

People's care plans included information about their dietary needs and where appropriate there was evidence that other professionals had been involved in informing plans or assessing dietary risks such as

speech and language therapists. Information about people's specialist diets were also displayed in the kitchen. There was evidence that people were encouraged to eat healthily and to have a varied diet. We observed people being offered a choice of what they would like for lunch and accessible widgets were available to support people with no verbal communication to indicate their meal choices. Widgets are symbols or pictures which can be used to help people communicate or to understand information. Meals were usually prepared by the chef and we observed that drinks, fruit and snacks were available if requested. We observed part of the lunch time meal on the first day of our inspection. Staff ate alongside people promoting an inclusive atmosphere and the lunchtime experience appeared to be a positive one. Adapted cutlery was used to support people to be as independent as possible. One of the dessert options was cup cakes with one of the people using the service had made.

Most of the people who lived at Oakhurst Lodge lived with complex health and social care needs and there was evidence that staff worked closely with their internal multi-disciplinary team which included psychiatrists, psychologists, nurses and speech and language therapists (SALTs) who visited the service weekly. However, the local community learning disability services felt that they had not always been consulted in a timely manner when people were crisis. They felt this was beginning to improve and they were currently working with three people using the service. There was evidence that staff supported people to have healthier lives. For example, people had annual health checks and medicines reviews and routine screening. Where required, people were being supported to follow healthy eating plans and to lose weight, for example, we observed staff suggesting to one person, that they not have sugar on their cereal or a second bowl, which they readily agreed do, instead choosing a slice of toast. Most of the parents were happy with the way in which the service supported their family member's health care needs, for example, one parent told us, "They work hard to manage [the person's] health needs, try to ensure he gets some exercise". A social care professional told us, "Based on the care plans I reviewed for [the person] it appears that his health needs are being met and staff ensure that he accesses health services when required".

Good

Is the service caring?

Our findings

People told us that staff were kind and caring and this was confirmed by their parents with one parent saying, "I am absolutely confident that all the staff I have met are kind and caring" and another telling us how their child only wanted to come home for a couple of night at a time as they were so happy at the service. They said, "We count ourselves lucky". A social care professional told us, "In my opinion the residents at Oakhurst Lodge are treated with dignity and respect. There are good efforts made to ensure that people's individual strengths are encouraged and understood". A staff member told us, "Yes [the staff] are all kind and caring, or I would have a lot to say about it". Our observations indicated that staff interacted with people in a caring and good natured manner and we observed some appropriate banter between people and staff. People seemed comfortable in the presence of staff and at times clearly looked to them for comfort, reassurance and support, but also for interaction and engagement. We observed that where necessary staff maintained clear boundaries in an attempt to avert behaviours which might challenge or to try and promote a harmonious living environment. This was done in a kind but firm manner.

Staff told us they enjoyed their role and spoke positively about supporting people and helping them to achieve goals or to try new things. One staff member said, "Every day, I feel I've made a difference….helped them get the best out of life". Another staff member said, "You build a rapport with them [people using the service], [person] was baking with me the other day, using the whisk, it was going everywhere, when we have arts and crafts classes, there is glitter and paint everywhere, but we are sat together interacting". The registered manager praised the staff for often going the extra mile to help ensure people had the best quality of life possible. We were told about examples which demonstrated this such as staff willingly travelling abroad to support one person whose travel plans to return to Oakhurst Lodge had been delayed. Staff were familiar with the content of people's support plans and how best to support them and were able to tell us about what was important to people and what they should be mindful of when providing their support. One support worker said, "The staff here take the time to get to know them [people using the service] as individuals".

The importance of supporting people to use and maintain their existing skills was referenced throughout their support plans. For example, support plans described, 'The things I can do on own' and the 'Things I need help with'. The staff we spoke with demonstrated a good understanding of people's needs and told us how they supported people to be as independent as possible, for example, we observed staff encouraging people to take their own plates and cups to the kitchen, where the person was reluctant to do this, staff compromised and offered to that the bowl and spoon if the person took their placemat and plate.

Staff were mindful of people's dignity, for example, staff were seen to be discreetly suggesting to one person that they be supported to change their clothing as this had become stained with food. Staff spoke with, and about, people in a respectful manner and people's support plans were written in a manner that was respectful of people's individuality. For example, one person's support plan asked that staff remind the person to close the bathroom door when using the toilet as they could often forget this. Although most people were supported on a one to one basis for most of the day, we saw that this was delivered in a manner that was mindful of the person's need for privacy and for some personal space.

People were supported to stay in contact with those that were important to them. Most people saw their family members regularly and were supported by staff, where necessary, to visit their family homes or join their families on trips out. Where family lived further away, people were supported to stay in touch through the use of video calls. Relatives told us they were always made to feel welcome at Oakhurst Lodge with one telling us they felt part of an 'extended family'.

Special occasions were celebrated such as people's birthdays. The service had held a Halloween party where people and staff had dressed up. During the previous year the service had celebrated their ten year anniversary with a party and staff were planning a family fun day for the summer to which people's relatives would be invited.

The registered manager understood how the planning and delivery of care should be underpinned by the requirements set out in The Equality Act and staff had received training in equality and diversity. The Equality Act is the legal framework that protects people from discrimination on the grounds of nine protected characteristics. These are, age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity. People were not discouraged from expressing their sexuality and were supported to have personal time in the privacy of their own room. Where people had expressed a desire to attend church, this had been supported, although no-one was currently doing so.

Good

Is the service responsive?

Our findings

Most of the health and social care professionals we spoke with told us the service provided care that was person centred and responsive to people's needs. For example, one professional told us, "[People] have individualised care plans, individualised activities that are planned and based on individual preferences". Another told us, "Those staff that I observed interacting with the resident I went to visit, were knowledgeable about how to respond to his repetitive questioning, which if not responded to appropriately could invoke anxiety". A third professional said, "I have nothing but praise for Oakhurst Lodge…. They have worked very flexibly with our service; including in the most challenging of circumstances…I would personally….unhesitantly rate this service as excellent". One healthcare professional did tell us that further functional analysis of people's behaviours might assist staff with intervening and managing challenging behaviours.

Our observations during the inspection indicated that staff knew people well, they spoke knowledgeably about how people liked to be supported and of the things that were important to them. It was clear that staff knew people's communication methods whether this was through words, signing or behaviours that staff had become familiar with. Support plans detailed the support people needed and this was personal to them. The plans were informative and contained information such as people's preferred daily routines, 'What people like about me' and 'Relationships important to me'. Information was provided about the 'Things I am still learning' and the 'Things that can cause me to be anxious'. A social care professional told us, "The care plan that I viewed had good and clear information about the individual's needs, behaviours support plans and interventions that may be required". People's needs and support plans had been reviewed regularly and people, their families and health and social care professionals were involved in reviews.

Staff knew people well enough to recognise that they were becoming anxious and know the strategies they could use to support them at these times. Staff told us of how with their support and interventions, people were achieving new milestones and achievements. For example, one person had enjoyed a four day break away where they had gone swimming for the first time in a number of years. The registered manager told us how one person had started to speak just a few words and had responded well to the intensive support being provided. A relative said the service provided was "Amazing" and had "Given [family member] a life". They told us that staff knew their family member well and "Knew how to manage him". Another relative said, "I think they are brilliant, I can't fault the way they look after [family member]". A third said, "I am really impressed with his key worker, she is very good, she knows him pretty well….he is very relaxed, very happy, he used to be more nervous".

Staff maintained journals which noted how each person had been, what they had eaten and what activities they had been involved in. These journals were written in a person centred manner and captured how people were feeling, for example, staff had recorded that they had read a story with one person who was very happy and smiley and that on another day, the person had done really well shopping in the supermarket, enjoyed a long forest drive and helped prepare a cup of tea. A communication book was used to share information effectively, such as whether people had healthcare appointments they needed to keep

and daily handover took place which helped to ensure staff all remained informed about any changes in people's needs.

Most parents felt that communication was an area where some improvements could be made. For example, one parent said, "Communication is my small complaint; [the registered manager] doesn't always get my messages". Another relative told us they sometimes got conflicting information from staff about how their family had been or had enjoyed an activity or trip which they found frustrating. A social care professional told us, "There has also been some signs that staff on the ground are at times not feeding back to the relevant health teams or management about issues raised by the individual's mother regarding health observations". A health care professional said, "At times, calls have been not returned when I leave messages". Most of the parents we spoke with expressed regret that they no longer received weekly 'home contact' letters telling them how the week had been for their family member, what activities they had been involved in and progress made with goals or objectives. Parents told us they valued these and that they served as a talking point during webcam chats. We spoke with the registered manager about this, who told us, they would speak with parents about how they might try and improve the quality and consistency of these letters.

The service had an activity co-ordinator who worked weekdays and oversaw the delivery of activities both within and outside the home. Each person had an 'Active Support Timetable' which provided an overview of the planned activities for the coming week. The timetable also included some suggestions for activities that staff could try in the event of the person declining the planned activities. Within the home people engaged in activities such as crafts and puzzles. We observed people spending time on their tablet and playing games with staff such as hide and seek which they were clearly enjoying. We observed a staff member doing a puzzle with one person. They were encouraging and interacted with the person throughout the activity which for a period of time, they were fully engaged with. We also saw a staff member paying hand clapping games with one person who was making loud vocalisations which we were told was the person's way of expressing their happiness. Movie nights were now taking place and included popcorn and takeaway. Outside of the home, people were supported to go for drives, to local beaches and shopping. People had visited the theatre and other key attractions in London. Some people went swimming, trampolining and fitsteps sessions. People had the opportunity to try new activities such as donutting accessed via a national charity whose aim was to increase participation in sport and exercise to stay healthy. Alongside these leisure activities, people were encouraged to focus on attaining certain targets which might include things such as using the communication board more or cleaning their room. When targets were achieved, this was celebrated and the accomplishment displayed on the achievements board and celebrated at the weekly house meeting.

Most people were not able to give us feedback about the activities provided. One person did tell us that they would like more one to one time and would like more variety. Most of the parents we spoke with felt that their family member was being supported to follow their interests and take part in a suitable range of activities. However, two people's parents were less positive. They felt more could be done to support their family member to undertake a greater range of person centred activities. One parent told us, "[The person] gets bored easily if not active and I don't think he is doing as much as he should be, they [staff] are full of good intentions, but they [the person] are spending hours on end watching [a streaming service]. Both of these parents were clear that staff tried to be supportive and did care about their family members wellbeing, but they felt there was not always sufficient action taken to provide proactive support that was really focused on the individual's needs. The families told us they were working with the registered manager and other health and social care professionals to try and resolve these concerns. We found that improvements could be made to ensure that records demonstrated more clearly that staff have tried to offer a range of alternatives when activities were declined and to tailor activities to people's goals. The registered manager

acknowledged that the records could be more detailed in terms of evidencing this.

A range of tools had been used to meet the information and communication needs of people and support them to express their emotions or views and to be involved in decisions about their care. For example, we saw staff using signing to ask one person, what they would like to do next. Staff had created an accessible widget-based document designed to help one person understand information as part of a mental capacity assessment. Staff had also used widget icons to create a story supporting another person to understand and come to terms with a recent family bereavement. There were boards displaying pictures of a range of foods or activities from which people could choose. People who were unable to verbally tell staff that they were in pain could use a pain board to visually point to areas on a picture of a body which may be causing them discomfort or pain. We did note that this board was not ideally located along a corridor and would recommend that a more suitable location be found for this.

In addition to the examples given above, there was other evidence that the service had taken innovative steps to provide information to people in a way in which they could understand allowing them to be as involved as possible in decisions about how their care was provided. For example, one person with visual impairment had a button outside their room. When pressed it sounded a message telling them this was their room. The message had been recorded in their own voice. This person was also being supported to use a device that read audio labels for a wide range of items in and around the home. A social care professional told us, "I saw examples of how the service has tried to develop ways of enabling residents to communicate their needs as best as possible".

An easy read service user guide was available as were easy read posters describing who people could speak with if they were unhappy or had a concern or a complaint. Similar posters were also available about how people could report bullying or abuse. This meant that the service was complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

The registered manager used complaints or concerns to understand how they could improve or where they were doing well. There had been four complaints since our last inspection. These had been investigated and responded to appropriately. A comments box was located near the front door for people, their relatives, staff or visiting professionals to use. This helped to ensure that people and staff had the opportunity to give feedback about the service.

Good

Is the service well-led?

Our findings

The service had a registered manager who was registered with the Care Quality Commission. They were supported by a deputy manager and team leaders. The registered manager demonstrated a thorough knowledge of each person living at the home and of the staff team and understood her responsibilities and followed procedures for reporting any significant events which occurred within the service to CQC and to other organisations such as the local authority safeguarding team.

Staff and parents were overall complimentary about the leadership team. One parent said, [The registered manager] is very good and the deputy is really lovely too". A staff member told us the registered manager was "Very strong, assertive, every time I have asked for advice, they have helped me, they are very proactive, a great boss". A staff member told us the deputy was "Brilliant with [person], I am kind of proud of him stepping up to be deputy". Whilst all staff told us the registered manager was very supportive during an incident or crisis, some felt that they would value the registered manager spending more time outside of the office when things were going well. One staff member said, "It means they miss the good things and staff don't get the recognition for it".

House meetings with people were held and were an opportunity for people to be involved in decisions about how their care was provided such as what activities they would like to do. For example, people had been encouraged to think about what new evening activities they would like to do. Their suggestion for a movie night had been acted upon. Accessible surveys had been used to seek people's feedback about their care. One person's response had indicated that they wished for their bedroom to be painted. This was being done during our inspection. Surveys had also indicated that the food was too bland and so the menu had been refreshed in response. People's views were also shared as part of the formal reviews which took place and through the use of advocacy services. For example, people were visited by both the provider's advocate and where appropriate by independent advocates or formal representatives, which helped to ensure that people's rights were protected and their views and wishes heard. Parent's views were sought through the use of annual surveys. The feedback was largely positive and where suggestions had been made for how the service could improve, these had mostly been acted upon, although we did note that the lack of weekly contact letters had been raised and parents were still telling us that this was still problematic.

Regular staff meetings were held to keep staff informed about changes but also to discuss issues affecting people using the service. One staff member told us, "We had a meeting this week, we spoke and each and every resident, if there is anything lacking, we come up with a solution, other options, they [the leadership team] listen". We observed a good working relationship between the registered manager and staff. Staff told us that morale and team work was good following a difficult period when they had been caring for two people in crisis. A staff member told us the leadership team had been supportive saying, "They knew what we were going through and how difficult the situation was for us". Another staff member said, "The managers are more than happy to help, if you ring the on call, they call straight back or come in". The registered manager told us they too were well supported by the provider and additional support had been provided whilst they were managing the difficult period in 2017 referenced elsewhere in this report.

There were systems in place to assess and monitor the quality and safety of the service and these were an integral part of the way in which the registered manager and provider identified shortfalls and promoted learning and innovation within the service. The provider employed a head of quality and compliance whose team of auditors made regular announced and unannounced visits to Oakhurst Lodge and reported on their findings. The registered manager undertook a range of audits throughout the year which included health and safety, medicines and infection control audits. Quarterly audits were performed by other local managers allowing an assessment of the quality of care to be made from a fresh perspective.

Each week the registered manager reported to their regional manager on the number of significant events which might have occurred such as levels of disciplinary action, accidents and incidents, complaints and any use of physical intervention. If there was an unexpected increase in any of these areas, then the registered manager would be asked to complete a detailed report for the provider explaining the reasons for this. These quality and safety indicators were compared with the findings in previous weeks to help the provider identify emerging risks within the service. The findings were also shared with the provider's senior management team through clinical and operational governance meetings which helped to ensure that they too had an oversight of risks or concerns within the service

The registered manager and provider had a service improvement plan based upon their vision for the service. Aims included, the leadership team obtaining a diploma in autism awareness and developing links within the local community that would offer people opportunities to develop their independence and life skills. They also wanted to continue to invest in the staff team and involve the seniors more in the running of the home and develop their skills. The registered manager told us they also wanted to develop the garden and support people to have more holidays of their choice. The vision was underpinned by key values which included dignity, respect and inclusion and it was evident that people, and their right to make choices and decisions about their care was delivered, were at the heart of the service. From our observations during the inspection, both the leadership team and the staff group appeared to care for people in a manner that was in keeping with these values. The registered manager had a good understanding of their own strengths and weaknesses and areas for development. They kept up to date with current good practice and attended regular meetings with managers from the provider's other homes and the senior leadership team and board to share learning and information. They were throughout the inspection open and transparent, being frank about areas where improvements could be made. They told us, "I wouldn't hide anything, we can make mistakes, but it's important to learn from it".