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Oakmount House

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

This inspection took place on 24 and 25 January 2018.

Oakmount House is a care home which is registered to provide care and accommodation for up to 10 adults with mental ill health. The service does not provide nursing care. People in care homes receive accommodation and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection. It is an older type adapted property situated on a main road on the outskirts of Burnley town centre. At the time of the inspection there were nine people accommodated at the service.

The service was managed by a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Although at the time of this inspection there were two managers registered with the Commission, one was no longer working at the service.

At our last inspection on the 7 and 8 January 2016 the overall rating of the service was 'requires Improvement'. There was a breach of the regulations; this related to the provider not having proper oversight of Oakmont House, including a lack of effective systems for checking, improving and developing the service. We therefore asked the provider to make improvements. We received an action plan from the provider indicating how and when they would meet the relevant legal requirements. At this inspection we found sufficient improvements had been made. At our last inspection, we also made recommendations relating to the assessment and management of risks, infection prevention and control, medicines management and working within the principles of the Mental Capacity Act 2005. We found improvements had also been made on these matters.

During this inspection we found there were no breaches of the regulations of the Health and Social Care Act (Regulated Activities) Regulations 2014. However we found some further progress was needed with medicines management and therefore made a recommendation.

We found there were management and leadership arrangements in place to support the effective day to day running of the service. The new registered manager had made a number of improvements and the provider was monitoring the service to ensure they had proper oversight.

Systems were in place to maintain a safe environment for people who used the service and others. We found some matters were in need of attention and the registered manager took action to make improvements.

Recruitment practices were in place to make sure appropriate checks were carried out before staff started working at the service. There were enough staff available to provide care and support and we were told

staffing arrangements were kept under review.

Staff were aware of the signs and indicators of abuse and they knew what to do if they had any concerns. Staff had received training on safeguarding and protection matters.

Arrangements were in place to gather information on people's backgrounds, their needs, abilities and preferences before they used the service. The registered manager had introduced a way of promoting a smooth admission to the service.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. Policies and processes at the service supported this practice.

We found people were effectively supported with their healthcare needs and medical appointments. Changes in people's health and well-being were monitored and responded to.

People were satisfied with the meals provided at Oakmount House. Arrangements were in place to offer a balanced diet. People were actively involved with devising menus, which meant they could make choices on the meals provided.

People made positive comments about the care and support they received from staff. We observed positive and respectful interactions between people who used the service and staff.

Each person had a care plan, describing their individual needs and choices. This provided guidance for staff on how to provide support. People had been involved with planning and reviewing their care. People's privacy, individuality and dignity was respected.

People had been actively involved with the up-grading of the premises, including choosing furniture, colour schemes and soft furnishings.

People were supported with their hobbies and interests, including activities in the local community and keeping in touch with their relatives and friends. There were opportunities for skill development and confidence building.

There were processes in place for dealing with complaints. There was a formal procedure to manage, investigate and respond to people's complaints and concerns. People could also express concerns or dissatisfaction during their care reviews and during residents meetings.

There were systems in place to consult with people who used the service and staff, to assess and monitor the quality of their experiences.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

We found medicine management practices needed improvement for people's well-being and safety.

Processes were in place to maintain a safe environment for people who used the service. We found some matters required attention and the registered manager took action to make improvements.

Processes for staff recruitment would include the completion of relevant character checks. There were enough staff available to provide people with safe care and support. Staff knew how to report any concerns regarding possible abuse and were aware of the safeguarding procedures.

Requires Improvement ●

Is the service effective?

The service was effective.

Processes were in place to find out about people's individual needs, abilities and preferences. People's health and wellbeing was monitored and they had access healthcare services when necessary. People were supported to eat healthily; their preferred meal choices were known and catered for.

People were encouraged and supported to make their own choices and decisions. The service was meeting the requirements of the Mental Capacity Act 2005.

Arrangements were in place to develop and supervise staff in carrying out their roles and responsibilities.

Good ●

Is the service caring?

The service was caring.

People made positive comments about the supportive and caring attitude of staff. We observed positive and respectful interactions between people using the service and staff.

Good ●

Staff were aware of people's individual needs, backgrounds and personalities, which helped them provide personalised support.

People were supported in a way which promoted their dignity, privacy and independence.

Is the service responsive?

Good ●

The service was responsive.

People received personalised care and support. Processes were in place to monitor, review and respond to people's changing needs and preferences.

People had opportunity to maintain and develop their skills. They had access to community resources, to pursue their chosen interests and lifestyle choices.

There were processes in place to manage and respond to complaints, concerns and any general dissatisfaction with the service.

Is the service well-led?

Good ●

The service was well-led.

There was a management team providing effective leadership and direction. The provider had improved their quality monitoring arrangements to ensure they had proper oversight of the service.

Staff were knowledgeable and positive about their work. They indicated team work was good and the manager was supportive and approachable.

There were processes in place to monitor and check the quality of people's experience of the service.

Oakmount House

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 24 and 25 January 2018 the first day was unannounced. The inspection team consisted of one adult social care inspector, an inspection manager and 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.

Before the inspection, we reviewed the information we held about the service, including notifications and previous inspection reports. A notification is information about important events which the service is required to send us by law. We contacted the local authority contract monitoring team and had discussions with the local authority safeguarding team. We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to decide which areas to focus on during the inspection

We used a number of different methods to help us understand the experiences of people who used the service. During the inspection visit, we spent some time with people, observing the care and support being delivered. We talked with six people who used the service about their experiences of their care and support. We talked with a support worker, senior support worker, deputy manager and the registered manager.

We looked at a sample of records, including three care plans and other related care documentation, staff recruitment procedures, training records, menus, complaints records, meeting records, policies and procedures, quality assurance records and audits.

Is the service safe?

Our findings

We checked how the service protected people from abuse, neglect and discrimination. All the people we spoke with indicated they felt safe at the service. Their comments included, "I do feel safe here," "I am comfortable with all the staff" and "The staff are very approachable." We observed examples where staff positively and considerately responded to people's specific needs and behaviours.

Prior to the inspection, we reviewed the information we held about the service relating to safeguarding incidents and allegations of abuse. We discussed and reviewed some of the concerns with the registered manager. We found the registered manager had appropriately liaised with local authority in relation to all allegations and incidents. We discussed with the registered manager their responsibilities to monitor any safeguarding incidents and accidents at the service, to ensure there is a proactive 'lessons learned' approach. Systems had been introduced to record and manage safeguarding matters, including the actions taken to reduce the risks of re-occurrence.

Staff spoken with expressed an understanding of safeguarding and protection matters. They were aware of the various signs and indicators of abuse, including physical abuse, psychological harm and potential discrimination. They were clear about what action they would take if they witnessed or suspected any abusive practice. Staff said they had received training and guidance on safeguarding and protecting adults. The service had policies and procedures to support an appropriate approach to safeguarding and protecting people. We looked at the processes for supporting people with managing their monies and found there were safe and accountable systems in place. Staff spoken with were aware of the service's 'whistle blowing' (reporting poor practice) policy and expressed confidence in reporting any concerns.

We looked at the way people were supported with the proper and safe use of medicines. All the people spoken with said they received their medicines on time and got pain relief if needed it. At our last inspection we found people's ability to manage their medicines was not routinely risk assessed and reviewed, there was no overall audit of the medicines processes and staff competence in administering medicines had not been assessed. At this inspection we found improvements had been made and processes were in place to provide people with safe support. Records and discussion showed, people's preferences and abilities to manage their medicines had been assessed and kept under review. There were electronic systems in place to check aspects of medicine management practices on an ongoing basis. We also noted a comprehensive medicines audit system had been introduced to identify shortfalls and make improvements. Staff had received medicines management training and their competencies in undertaking this task had been assessed.

The medicines administration records (MAR) we reviewed were appropriately kept, complete and accurate. We found there were individual protocols for the administration of medicines prescribed "as necessary" and "variable dose" medicines. The protocols were important to ensure staff were aware of the individual circumstances when this type of medicine needed to be administered or offered.

We found people's medicines were stored safely and securely. There was a monitored dosage system (MDS)

for medicines. This is a storage device provided and packed by the pharmacy, which places tablets in separate compartments according to the time of day. Although there were no controlled drugs (medicines which may be at risk of misuse), safe storage facilities for such medicines were not available. This meant should controlled drugs be prescribed the storage facilities would not meet the requirements of the Misuse of Drugs Act 1971. We discussed this shortfall with the registered manager and following the inspection we received confirmation that a suitable storage cabinet had been ordered.

We reviewed the policies and procedures for medicines management and found they were lacking in detail on providing clear step by step instructions on medicines administration. There was also a lack of guidance on key aspects of safe medicines management. For example, there was no policy to direct an appropriate response to 'covert' administration or 'over the counter' remedies.

We recommend that the provider considers the current National Institute for Health and Care Excellence (NICE) guidance on medicines management and take action to review and update their policies and procedures accordingly.

We looked at the processes in place to maintain a safe environment for people who used the service, visitors and staff. At our last inspection the registered manager had introduced daily checks of radiators for safe surface temperatures. However, we found radiators were not guarded and did not have low surface temperature heat emitters and the risks to individuals had not been assessed. At this inspection we found each person had risk assessments on the potential for people's prolonged contact with hot surfaces. But we noted radiators had not been fitted with guards to ensure safe temperatures. We discussed the potential risks and impact associated with this shortfall with the registered manager who acknowledged our concerns. Following the inspection visit, we received confirmation that radiator covers were to be fitted in the two bedrooms with the highest identified risks. We will continue to monitor the providers 'rolling programme' of installing radiator covers at our next inspection.

We found health and safety risk assessments had been carried out and kept under review. There were accident and fire safety procedures available. Records showed arrangements were in place to check, maintain and service fittings and equipment, including electrical and gas safety, water temperatures and fire extinguishers. New lockable cabinets had been obtained for the safe storage of confidential records. We found fire safety risk assessments were in place. Fire drills and fire equipment tests were being carried out. Each person who used the service had a PEEP (Personal Emergency Evacuation Plan). Records showed fire procedures were discussed individually with people each month. There were separate contingency plans to be followed in the event of emergencies and failures of utility services and equipment. We advised this information be collated in one policy for ease of reference in an emergency.

We reviewed how people were protected by the prevention and control of infection. At our last inspection we found some improvements were needed with the laundry area. At this inspection we noted improvements had been made. A wash basin, liquid soap and paper towels had been supplied in the laundry area. Paper towels and liquid soap dispensers had also been fitted in bathrooms and toilets. There were cleaning schedules and associated recording systems to maintain hygiene standards. Records and discussion indicated staff had completed training on infection control. There were processes to check, monitor and respond to infection prevention and control measures at the service.

We reviewed how risks to people's individual safety and well-being were assessed and managed. At our last inspection we found there was a lack of routine screening/assessing of risks associated with age including: skin integrity, malnutrition and falls. At this inspection we found improvements had been made. Individual risk assessments and risk management strategies were in place to guide staff on minimising risks to people's

wellbeing and safety. The risks assessed included, malnutrition, falls, compliance with medicines, aggressive behaviours and accessing the community. There were also individual skin integrity screening assessments and plans in place to monitor people's skin condition. However we suggested a nationally recognised assessment tool would provide a more effective response. The registered manager agreed to pursue this matter. We noted processes were in place to appropriately review and update individual risk assessments. Staff spoken with were aware of people's risk assessments and said they had access to them.

The staff recruitment procedures aimed to protect people who used the service. At our last inspection we found some aspects of staff recruitment could be better. However, as there had not been any new recruits since our last inspection, we could not fully assess staff recruitment in practice. We therefore reviewed the systems in place to support a safe recruitment process. We found the registered manager had revised and updated the application form to obtain relevant details and had introduced a recruitment monitoring checklist. The staff recruitment policies and procedures had also been updated to support and direct the process.

The service managed staffing levels and the deployment of staff to support people to stay safe and meet their needs. People spoken with did not express any concerns about the availability of staff at the service. Staff spoken with considered there were enough staff available to provide safe support. They confirmed action was taken to cover staff absences and there was on call management support in the evenings and at night. We looked at the staff rotas, which indicated processes were in place which aimed to maintain consistent staffing numbers. The registered manager said staffing levels were kept under review and were flexible in response to people's needs, lifestyles, appointments and activities. The expectation to work flexibly to meet the needs of the service was included in staff contracts of employment. There was a 'lone worker' policy to offer guidance and protection to staff. During the inspection we found there were sufficient staff on duty to support people.

Is the service effective?

Our findings

We reviewed how people's needs and choices were assessed and their care and support delivered to achieve effective outcomes. The people we spoke with indicated they were satisfied with the care and support they experienced. One person told us, "This service is good for me and could happily stay here for the rest of my life."

We looked at the way people's needs were assessed and planned for, prior to them using the service. Although there had not been any new people at the service since our last visit, the registered manager described the processes to be followed. This would involve meeting with the person and completing a needs assessment, by gathering information from them, their families and any relevant health and social care professionals. The assessment tool introduced to support the process indicated a wide range of needs and abilities would be considered. People were to be encouraged to visit the service, for meals and short stays. This would support the ongoing assessment process and provide people with opportunity to experience the service before accepting a place. The registered manager said the admission process would take into consideration the person's compatibility with people already using the service. A structured way of recording this important part of the assessment process had been introduced. The service had policies to support the principles of equality and diversity. This meant consideration would be given to protected characteristics including: race, sexual orientation and religion or belief.

We looked at how consent to care and treatment was sought in line with legislation and guidance. Most people spoken with expressed an awareness of their care records and confirmed they had signed in agreement with them. During the inspection we observed staff consulting with people on their individual needs and choices. We noted instances where staff involved people in routine decisions and sought their agreement on the support given. Staff spoken told us they routinely consulted with people about their support and their lifestyle choices. One staff member said, "Everyone here can make their own decisions. We always ask them and give them choices." The care records we reviewed included signed and dated agreements on various consent matters. People had signed individual contracts which outlined the terms and conditions of residence. They had also signed in agreement with their care plan records.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions or authorisations to deprive a person of their liberty were being met. The 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. 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.

At our last inspection we found some shortfalls in how the service worked within the principles of the MCA. At this inspection we found improvements had been made. We saw there were processes in place to screen and monitor people's capacity to make specific decisions. There was information to demonstrate

appropriate action had been taken to apply for DoLS authorisations by local authorities in accordance with the MCA code of practice. Records had been kept to monitor and review the progress of pending applications. Policies and procedures had been devised and introduced to provide guidance and direction on meeting the requirements of the MCA and the registered manager had obtained a copy of the MCA code of practice for reference. Staff spoken with indicated an awareness of the MCA and DoLS, including their role to uphold people's rights and monitor their capacity to make their own decisions. We discussed with the registered manager ways of proactively highlighting people's capacity to make their own decisions in the care plan process.

We looked at how people were supported to live healthier lives, the access they had to healthcare services and ongoing healthcare support. All the people we spoke with indicated they had access to health care professionals when needed and told us staff supported them with appointments. One person said, "I have regular checks with the doctors and dentists." People's medical histories and conditions were included in the care planning process. This included an assessment of their mental health needs. Healthcare needs were monitored and considered as part of ongoing reviews. One person explained, "The staff understand my illness and help me in the best way they can." People had 'hospital passports' to share important and personalised information when people accessed health care services. The service was signed up to a system whereby they could access remote clinical consultations; this meant staff could access prompt professional healthcare advice at any time.

The registered manager and staff described some of the incentives introduced to promote healthy lifestyle choices. Included were changes to menus/food supplies and obtaining information for people on various health conditions and local support groups. People were offered the opportunity for physical exercise, including walks and exercise classes. We discussed with the register manager the value of including 'physical fitness' as a specific area of need in the care plan process.

We checked how people were supported to eat and drink enough to maintain a balanced diet. We asked people for their opinion of the meals provided at the service, their comments included, "I am happy with the food," "The meals are pretty good," "Some of the meals we have are not that good" and "The food is alright."

People's individual dietary needs, likes and dislikes were known and recorded in their care plans. The menus were regularly discussed and agreed with people during the residents meetings. The day's menu was on display in the kitchen. Various options were offered at each mealtime, including three main meals in the evening.

Some people were involved with food shopping, which meant they could make further choices. People could also request specific items to be included on the weekly shopping list. We noted people could make drinks and snacks for themselves whenever they wished. The registered manager introduced nutritional screening assessments and dietary needs care plans for each person. People's weight was checked at regular intervals. This helped staff to monitor risks of weight loss/gain and support people with their diet and food intake. GP's and dieticians had been liaised with as necessary. Staff expressed an awareness of nutrition and healthy eating. They described the support they provided people with in relation to food, diet meal preparation and cooking.

We reviewed how people's individual needs were met by the adaptation, design and decoration of premises. People were satisfied with the accommodation and facilities available at Oakmount House. One person explained how they had been involved with upgrading their bedroom, including choosing new furniture and colour schemes. They said, "I really like my room. It's made a big difference. It has been worth it." At the time

of our visit a lounge and dining room were in the process of being redecorated and it was apparent people had been fully involved and consulted on the changes. We noted the lounge chairs remained unsuitable, however the registered manager was able to confirm that new more comfortable chairs had been ordered. We also questioned the suitability and configuration of one bedroom with an adjacent bathroom area. The registered manager assured us the suitability of this room was under review. We reviewed how the service used technology and equipment to enhance the delivery of effective care and support. The service had internet access to enhance communication and provide access to relevant information.

We looked at how the service made sure that staff had the skills, knowledge and experience to deliver effective care and support. Staff spoken with described the training they had received and said that learning and development was ongoing at the service. Although no new staff had been recruited since our last inspection, processes were in place to support an initial induction training programme which included the completion of the Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers adhere to in their daily working life.

Is the service caring?

Our findings

We reviewed how the service ensured that people were treated with kindness, respect and compassion and that they were given emotional support when needed. People spoken with made some positive comments about the staff team and the care and support they received. They said:

"The staff are fantastic," "All the staff are good people," "They are really good and down to earth" and "The staff are always caring." We observed meaningful and positive interactions between people using the service and staff. Staff showed sensitivity and consideration when responding to people's needs. Staff had been provided with equality and diversity training. Equality is about championing the human rights of individuals or groups of individuals, by embracing their specific protected characteristics and diversity relates to accepting, respecting and valuing people's individual differences.

People told us they were happy with the approach and attitude of staff at the service. They made the following comments about the way they were treated: "The staff are always polite," "Staff always treat me with respect" and "The staff go out of their way to help us as much as they can." We noted examples where staff were respectful and kind when supporting and encouraging people with their daily living activities and individual lifestyles. The service had a 'keyworker system.' This linked people using the service to a named staff member who they worked more closely with. The main aim of the 'keyworker system' was to develop more trusting and beneficial relationships. Staff spoken with knew people well and understood their role in providing people with person centred care and support. They indicated they had time to provide care and support, also to listen to people and involve them with decisions. Staff were aware of people's individual needs, specific routines, backgrounds and personalities. They gave examples of how they supported and promoted people's individuality and choices.

We checked how the service supported people to express their views and be actively involved in making decisions about their care and support. Everyone had a support plan which identified their individual needs and preferences and how they wished to be supported. There were 'things to know about me' profiles and 'person centred lifestyle passports' which provided an overview of people's routines and expectations and how they wished to be supported. The information was written in a respectful and person centred way and included: background histories, personal relationships, family contact, cultural heritage and spiritual needs. Most people indicated they had been actively involved in compiling their care plans. Processes were also in place for people to review their individual circumstances, care and support during a monthly one to one 'feedback' discussion with their keyworker. We noted from records, that people had been encouraged to share their views on a variety of relevant topics.

We asked people if the support they received promoted their independence. They described how they had been enabled to develop independence skills, by accessing the community resources and doing things for themselves and others. During the inspection, we observed people doing things independently and making their own decisions, some with staff support. Promoting choice and encouraging independence was reflected in the care plan process, for example sharing responsibilities for domestic tasks and using public transport. Staff spoken with explained how they encouraged independence, in response to people's individual abilities, needs and choices. For some this had included trying new experiences, confidence

building and motivating people to do things. One staff member explained, "Some people need a little pushing, but we don't force them," another said, "Most people do a lot for themselves and we encourage them."

Regular residents meetings had been held. This had provided the opportunity for people to make suggestions, be consulted and make shared decisions. We noted from the records of meetings that various matters had been raised, discussed and followed up, including menus, activities and changes to the accommodation. The meetings had also been used to enlighten people on relevant topics. There was a notice board which provided details of proposed activity plans, the staff rota and 'what to do if you are not happy' guidance. We noted the service's CQC rating and the previous inspection report were also on display. This was to inform people of the outcome of the last inspection. The registered manager had introduced a 'read me file' of information. This included the guide to the service, resident's 'rules' and a summary of the service's key policies and procedures. There were 'self-help' leaflets from various agencies and details of local community resources. This had helped to increase people's awareness of matters which could affect them and services available to them. This had helped to promote their rights and choices.

We looked at how people's privacy was respected and promoted. All bedrooms were for single occupancy and some had en-suite facilities. Some people preferred to spend time alone in the privacy of their rooms and this choice was respected by staff. People's bedroom doors were fitted with suitable locks to help promote privacy of personal space and people had been offered keys. We observed staff knocking and waiting for a reply before entering people's rooms. One person told us, "They respect my privacy." Staff were aware of the importance of maintaining people's privacy and confidentiality. They gave examples of how they applied these principles in practice. We observed staff being respectful of people's privacy and confidentiality, by knocking on bedroom doors, seeking people's permission before entering bedrooms and being discreet when sharing information.

Is the service responsive?

Our findings

We looked at how people received personalised care that was responsive to their needs. People spoken with said, "The staff go out of their way to help us as much as they can" and "Staff are always there when I need them."

People had individual care and support plans, which had been developed in response to their needs and preferences. The care and support plans and other related records we reviewed, included people's needs and choices. Consideration was given to people's preferred methods of communication, engagement and interaction. One person explained, "They know how to talk to us in a way we understand" The plans contained details on how people's care and support was to be delivered by staff. They identified specific areas of support such as; social integration, physical needs, domestic skills, relationships and rehabilitation. There were action plans and agreed objectives in response to identified needs and preferences.

The care plans were underpinned by a series of risk assessments, which aimed to promote people's rights, independence and choices, whilst keeping them safe. There was evidence to show that the care plans were regularly reviewed and updated with the involvement of people who used the service. One person told us, "I go through my care plan every few months." Staff spoken with indicated the care plans were informative, they said they had access to them during the course of their work. They described how they delivered support in response to people's individual needs, routines and aspirations. We were given examples of the progress people had made, resulting from the service being responsive and developing ways of sensitively working with them.

Records were kept of people's daily living activities, their general well-being and the care and support provided to them. There were also additional monitoring records as appropriate, for example relating to behaviours, accidents and incidents. There were 'hand over' discussion meetings between staff to communicate and share relevant information. These processes enabled staff to monitor and respond to any changes in a person's needs and well-being.

People told us how they were supported to engage in activities within the local community and pursue their hobbies and interests. They indicated they were satisfied with the range of activities offered and supported by the service. We found positive and meaningful relationships were encouraged. People were actively supported as appropriate, to have contact their family and friends. There were individual planned schedules of proposed activities. People had been supported to attend community based resources and chosen leisure activities. These included, visits to nearby towns, shopping, walks out, attending community centres and clubs and holidays.

There were some in – house activities such as crafts, bingo and videogames. The residents had recently hosted a coffee morning for their chosen charity at the service. Two people had also attended training sessions alongside the staff team. This inclusive approach to learning and development had provided people with the opportunity to increase their skills and knowledge, enhance their self-esteem and build their confidence.

We checked if the provider was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. The care plans were presented in a way to help make them accessible to people. The information in care plan records was in plain language and included large type, there were some pictorial references to help explain the content. An album of photographs of the actual meals served, was being compiled to complement the menus, this was to help people make decisions and choices. We discussed with the registered manager, ways of producing the service's written material in a more 'user friendly' format which would help with meeting the expectations of the Accessible Information Standard.

We reviewed how people's concerns and complaints were listened and responded to and used to improve the quality of care. People we talked with had awareness of the complaints processes and expressed confidence in sharing their concerns. One person commented, "If I had something I wasn't happy about, I would approach a staff member." People we found people were actively encouraged to voice their opinions in residents meetings, where the topic of 'complaints' was routinely included on the agenda. Similarly people were invited to raise concerns and dissatisfaction during their one to one reviews.

The complaints procedure was assessable to people who used the service. The information provided guidance on making a complaint and how it would be dealt with. It included reassurances that people raising concerns would not be treated differently or discriminated against. Included were the names and contact details of people who complaints could be raised with, such as the registered manager and owner. The procedure also included information on other agencies that may provide support with complaints, including the local advocacy service and social care government ombudsman.

The registered manager had introduced complaints forms for people to complete if wished. The forms proactively guided people through the process of raising a concern. Reference was made to the support available to help people with the process. There were processes in place to record, investigate and respond to complaints and concerns. The service had policies and procedures for dealing with any complaints or concerns. The registered manager described the systems in place to monitor complaints, to identify and proactively respond to any patterns and trends. Staff spoken with expressed an understanding of their role in responding to concerns and complaints.

The service did not usually provide end of life care. However we discussed with the registered manager ways of sensitively planning for people's needs and preferences and the processes in place to support people who may experience bereavement.

Is the service well-led?

Our findings

We reviewed how the service promoted a clear vision and approach, to deliver high-quality care and support which achieved positive outcomes for people. People spoken with had an awareness of the overall management arrangements at the service. They expressed an appreciation of how the service was run. They told us "It's a good service with great staff" and "The manager is very approachable and easy to talk to." Staff told us, "The management is really good. Things have been put in place. The service has improved," "Things are really good at present" and "There's good teamwork. We all work together and support each other."

At our last inspection we found the provider did not have proper oversight of Oakmont House and there was a lack of effective systems for checking, improving and developing the service. At this inspection we found improvements had been made. The provider was visiting the service unannounced at least once per week, to check matters and to speak with people who used the service and staff. One staff member commented, "The provider calls regularly. He asks how things are going. He is approachable and his phone number is available." The provider also attended for monthly quality review meetings with the registered manager. The registered manager indicated the provider was supportive, appropriately involved in the running of the service and approachable. There were records of the regular quality meetings which demonstrated the provider had oversight of the service, including all matters arising and plans for ongoing development. However, we suggested the provider should complete a report of their findings on the unannounced visits, to constructively demonstrate their oversight.

We found there were action plans available to inform and direct the proposed developments to the premises. There had been some progress in developing the service in response to people's changing needs. Medicines management processes had been audited in accordance with current guidance and action had been taken to make improvements. People's capacity to make decisions and choices had been assessed and action taken to apply as appropriate for DoLS authorisation. The service's policies and procedures had been reviewed and updated and they were readily available for staff to refer to. Arrangements were in place for audits to be carried out on processes and systems. These included: care plans, room audits, staff training, financial records and care plans.

Since our last inspection there had been some changes in the leadership and management of the service. The acting manager had been promoted to manager and had achieved registration with the Commission, and a new deputy manager had been appointed. The registered manager had attained recognised qualifications in health and social care. She had updated her skills and knowledge by completing the provider's mandatory training programme and through attending relevant seminars and networking with other registered managers. Throughout the inspection, the registered manager expressed commitment to the ongoing developments at the service and demonstrated a proactive response to the inspection processes. We found there good administrative processes in place. The registered manager had introduced a staff 'champions' approach whereby key staff had been given lead roles on specific work themes, such as, health and safety, infection prevention and control and medicines. Staff spoken with made positive comments about the registered manager. They said, "The new manager is brilliant," "very approachable" and "She is very helpful towards the residents. They are getting what they need." Processes were in place for

staff to provide ongoing feedback on the manager's leadership and conduct. However we suggested the registered manager should also receive a structured appraisal of her work from the provider.

We looked at how are people who used the service, staff and others were consulted on their experiences and shaping future improvements. People were encouraged to express their opinions in their individual reviews. The registered manager had introduced a monthly feedback process, which proactively enabled people to reflect on and share their experiences. Their responses were monitored and responded to accordingly. People had been given the opportunity to complete a satisfaction survey and a staff consultation survey had been undertaken. The responses had been reviewed and outcomes shared in various meetings. We discussed with the registered manager ways of proactively sharing the outcomes surveys and ensuring the results were embedded into the quality monitoring processes. Information in the PIR showed us the registered manager had identified some matters for ongoing development over the next 12 months.

The service's vision and philosophy of care was reflected within the written material including, the statement of purpose, job descriptions, staff handbook and policies and procedures. A six monthly newsletter had been introduced to help convey the ethos of the service and share information. Staff expressed a good working knowledge of their role and responsibilities. They were aware of the management structure and lines of accountability at the service. Staff had been provided with job contracts of employment and staff handbook, which outlined their roles, responsibilities and duty of care. They had access to the service's policies, procedures and any updates. Staff meetings were held on a regular basis. We looked at the records of the most recent staff meetings and noted various work practice topics had been raised and discussed. Staff spoken with told us they were actively encouraged to make suggestions and voice their opinions during meetings.

We evaluated how the service worked in partnership with other agencies. We found arrangements were in place to liaise with other stakeholders including: local authorities, the health authorities, and commissioners of services. There were procedures in place for reporting any adverse events to the CQC and other organisations, such as the local authority safeguarding and deprivation of liberty teams. Our records showed that notifications had been appropriately submitted to the CQC.