St Anne's Community Services

St Anne's Community Services - Oxfield Court

Inspection report

Oxfield Court
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection of Oxfield Court took place on 19 April 2016 and was unannounced. The service had previously been inspected in November 2013 and was found to be in breach of regulations relating to the environment, poor record keeping and staffing. We checked during this inspection whether improvements had been made.

Oxfield Court supports adults with learning disabilities with additional complex health needs. Accommodation is provided in four separate bungalows, each of which has a manager who oversees the provision of care for people. On the day of the inspection there were 22 people living at Oxfield Court. Three of the bungalows were at full occupancy with six people and one had four people with two vacancies.

There was a registered manager present on the day we inspected. 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.

People were safe as staff demonstrated an in-depth understanding of people's individual needs based on their experience and knowledge gained through care records. Staff knew what constituted a safeguarding concern and were aware of how to report such issues. The service had robust and rigorous risk assessments in place to minimise the likelihood of harm whether through the use of equipment or people's behaviour. These were regularly reviewed and updated.

Staffing were appropriate on the day we inspected and ensured that people had their needs met in a timely manner. Medicines were administered, recorded and stored safely.

We saw in records and by speaking to staff there was an ongoing supervision and training schedule which supported staff to develop and progress in their own development. Staff were encouraged to challenge and offer new ideas if they could see areas for improvement.

The service was acting in accordance with the requirements of the Mental Capacity Act 2005 by ensuring that people who lacked capacity to make specific decisions had appropriate assessments in place to support staff to make decisions in their best interests. Where people were not able to assess risk to themselves or did not have the freedom to leave, Deprivation of Liberty Safeguards were in place.

People were supported with their nutrition and hydration needs, whether by being encouraged to prepare their own food as far as possible or through specific nursing input. We found that people had regular access to external agencies as required and regular meetings and information was shared when needed between such services to maintain people's optimum care.

Staff were patient, caring and kind and people responded well to attention. There was evidence of a good

rapport between staff and people using the service and we saw that people were encouraged to make as many decisions for themselves as possible during the day. The service demonstrated a consistent culture of respecting people's privacy and promoting their dignity.

People had access to a wide range of activities both within and outside of the service. We saw care records were clear and detailed, emphasising key attributes and information about how best to support someone. Records were easy to navigate and it was evident from staff discussions that they were used regularly as staff knowledge was current.

The service had a complaints policy, although had not received any complaints. However, they had received many compliments and positive feedback.

People and staff were content and enjoyed being at the service. Staff felt supported and encouraged to offer new ideas and develop new ways of working if this resulted in better outcomes for people in the service. The registered manager provided consistent and transparent leadership which was reflected in the approaches between each of the bungalows on site.

Quality assurance measures were effective and sought to drive forward improvement with people at the heart of 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?

Good

The service was safe.

People were safe as staff had a sound understanding of how to identify and report any concerns.

Risk assessments were detailed and based on individual need with clear direction for staff.

Medicines were administered, recorded and stored in line with guidelines and the service had an appropriate level of staffing to meet people's needs in a timely manner.

Is the service effective?

Good

The service was effective.

Staff were supported with regular supervision and training, and all had received a comprehensive induction.

The service was acting in accordance with the requirements of the Mental Capacity Act 2005 and people's consent sought wherever possible.

People were supported with their nutritional needs which varied in complexity across the service and had access to health and social care support as required.

Is the service caring?

Good

The service was caring.

Staff were consistently patient, caring and kind and engaged with people while respecting their right for privacy.

We saw excellent examples of dignity being respected and people being encouraged to make as many decisions as possible themselves.

Is the service responsive?

Good

The service was responsive.

People were supported to undertake activities of their own choosing and care records were very person-centred and detailed.

The service had not received any complaints but had a clear complaints policy and recorded all compliments it received.

Is the service well-led?

Good

The service was well led.

People appeared happy and contented and staff expressed how much they liked working at Oxfield Court as they felt supported and valued.

The service had a pro-active registered manager who constantly sought to improve the service and had systems measuring progress, consistency and quality which showed how this was achieved.

St Anne's Community Services - Oxfield Court

Detailed findings

Background to this inspection

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

This inspection took place on 19 April 2016 and was unannounced. The inspection team consisted of two adult social care inspectors and one specialist advisor who was a learning disability nurse and registered manager.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information was also used to assist with the planning of our inspection and to inform our judgements about the service.

We spoke with one person using the service and observed seven other people using the service who had limited verbal communication skills. We spoke with six staff including four support workers, one nurse, and the registered manager.

We looked at five care records including risk assessments, five staff records, minutes of staff meetings, complaints, safeguarding records, accident logs, medicine administration records and quality assurance documentation.

Good

Is the service safe?

Our findings

We spoke with a member of staff and asked them how they ensured people are safe. They replied "I make sure that staff follow the care plans and risk assessments. If I suspected or saw a staff member abusing a resident I would inform my manager, safeguarding, the Care Quality Commission (CQC), and the family. I will refer to the doctor if needed and follow any advice given. I would record and document all events." Another member of staff told us "Abuse can be one service user attacking another, intimidation or an injury. I would always refer anything to the nurse or manager, and the number for the safeguarding team is in the file." This member of staff told us they had had to report concerns about an agency member of staff but this was dealt with swiftly and the person was removed from the service. This demonstrated the service had staff who were able to recognise and respond to concerns in a timely manner.

The registered manager told us, and we saw evidence, that all staff had received safeguarding training and updates were offered regularly in team meetings. This was usually by a case study where staff could discuss their learning and understanding. We saw examples of this in the minutes of these meetings. The area manager also conducted monthly visits and during these randomly sampled staff's knowledge by asking them questions. The service promoted people speaking out if they had any concerns and had posters and leaflets in easy read format so that people could access support.

We looked at risk assessments for the service and found these to be person-centred. They ensured a person was enabled to complete tasks as much as possible for themselves with support only where needed. The service had recently reviewed all its moving and handling documentation and was keen to ensure they accurately reflected how a person should be supported safely. This was enabled through the advice of external health professionals such as an occupational therapist and physiotherapist who provided pictorial and written guidance as to the most appropriate methods to be used. This was supported by photographic detail showing how a hoisting sling should be used for example.

In one care record we saw person-specific risk assessments for choking, health and safety while in bed, injuries incurred as a result of agitation, bathing, fire and cross infection. This person had involuntary movement and the service had considered measures to reduce the risk of injuries occurring during such times. Each risk assessment identified the action, the likely consequence, the benefits of undertaking the specific activity as well as a person's level of understanding around the risk posed. The assessment considered the factors which would increase and decrease the risk of harm, and how to minimise the risk. In one scenario the person was unable to have a shower as they were awaiting the provision of some new equipment and the bathing risk assessment was very detailed outlining each stage of the procedure that should be followed to ensure the person was bathed safely and felt supported.

The service had generic building risk assessments for each bungalow which considered fire safety and evacuation procedures alongside procedures for staff when supporting people on trips such as to the swimming pool, therapy sessions or when there was adverse weather. Each bungalow manager conducted their own fire risk assessment every six months for the premises. We saw that each person had their own personal emergency evacuation plan which was reviewed every six months. There was also a record of each

staff member having signed to say they had seen and understood the policy on their first day of working. This was also evident for all bank and agency staff who were given a premises tour. All staff had received full fire training and there was evidence of regular fire drills and alarm tests. This meant that the service took the safety of the people using the service seriously.

We found in people's care records that accidents and incidents were recorded in detail with scrutiny by both the immediate manager and the area manager. Details of any injury were recorded and the circumstances around the incident where known. In most instances we saw an investigation had taken place where it was necessary. Specific instructions were then given to staff by the area manager if they had identified any other possible actions to be taken. These were then evidenced in a person's care records whether through a revised risk assessment or further care plans to support a person's specific needs. In one record following a fall that identified the equipment was faulty it was noted 'checked the lap belt and found it opened itself. Chair and belt removed from service and awaiting re-assessment.' This showed the service had responded to a serious situation quickly and taken remedial action to ensure the safety of the individual. As with any safeguarding concerns, any learning from incidents was shared with staff through their supervision and we saw this in meeting records.

We observed the nursing staff administering medicines to people. This was done in pairs across the whole site. Prior to administration the Medication Administration Record (MAR) was checked. Each MAR had the person's photo displayed and details of any allergies. There were no recording gaps in the charts which showed medicines had been relevantly coded and signed for. We checked the storage of medicines including controlled drugs which were stored and recorded in line with requirements. The controlled drug record was completed with two signatures and balance amounts and medication was not overstocked.

The service had a medication policy and procedure which included reference to homely remedies such as painkillers and there were also PRN (as required) protocols in place. For people in receipt of Midazolam, a drug used to calm agitation, there were appropriate protocols in place which were mirrored in their medication record. We also saw a policy for the use of anticipatory drugs prescribed when a person was nearing the end of their life which advised staff when to give such medication, the descriptions of symptoms and actions advised. As most people in the service were not able to give verbal consent to receiving medication we saw the service had mental capacity assessments and best interest decisions in regards to staff administering medication on their behalf which provided the necessary authorisation.

We asked the nursing staff what action they would take if they incorrectly administered someone's medication or found that another member of staff had and they were able to explain the appropriate action they would take in depth. The service conducted regular medication audits which showed they were keen to ensure the process and systems were as safe as possible.

We spoke with staff as to whether they felt the service could meet people's needs safely with the number of staff on duty. One staff member said "Yes, for the number of people we currently have but if we have any more people this would need to be increased." Another staff member said "Yes, most of the time." A further staff member told us "Recently it has improved and we are able to support people if they become anxious as there are more staff."

The service was holding a series of interviews on the day of our inspection to recruit more support staff, although they had a full complement of nursing staff. The registered manager advised us there was a minimum staffing ratio of three support staff per bungalow and this was increased to four in one bungalow where people presented with more complex behaviour. Each bungalow was supported by a qualified nurse. The use of agency staff was kept to a minimum. The registered manager told us agency nurses were only

used in the service when permanent staff were on training and they always used their own staff to support at night. If agency support was needed it would be during the day so disruption to people using the service was kept to a minimum and there were always familiar faces around. This meant that people's needs for consistency and routine were considered a high priority.

We checked staff recruitment files and found that appropriate pre-employment checks had been carried out including identity and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. All agency staff were subject to the same checks prior to the commencement of their employment.

Infection control policies and procedures were in place and these were up-to-date and had been audited. Staff had received necessary training including the Control of Substances Hazardous to Health (COSHH). We observed the laundry room had the correct colour coded laundry bags, mops and buckets as well as a cupboard with colour coded cloths. Staff attended to cleaning duties in the bungalows and there were clinical, domestic and hazardous waste bins available. All bathroom and shower rooms had aprons and gloves available to use and we observed staff using protective personal equipment where necessary. We saw posters relating to infection control and management on display. This helped to control the risk of infection and minimise the likelihood of harm for people.

Good

Is the service effective?

Our findings

We asked staff what induction they had received. One member of staff said "I was supernumerary and shadowed for two weeks. My practice was reviewed and I was asked if I felt comfortable taking on care tasks. Staff are happy to admit here if they feel they need more support and we get it." Staff we spoke with told us they had received training in manual handling, health and safety, infection control and COSHH and safeguarding. They had also worked through a booklet which had questions and answers and led to discussions in meetings with their manager.

The staff member also told us "I got everyone's files to read and worked with other colleagues first so that people got to know me and I them." We saw evidence in other staff records of this comprehensive induction programme which demonstrated staff's understanding of particular areas. Where staff were new it was clear that performance objectives were set and these were closely monitored with new targets set where necessary. All records were signed by employee and manager, and dated showing the discussion was shared and agreed.

We looked at staff supervision and training records. One staff member told us "I have supervision every three months. Initially I had it every month for my first year. We discuss any absence, how I'm getting on with different people in the service, anything that I can help with and any issues that the registered manager wants me to know. If I had any issues outside of this time I would raise it." We saw in supervision records that an overview of the person's performance was recorded and their strengths assessed. In one file we saw "[Name] is a competent member of staff and meets the needs of people with excellent care." This staff member's performance was then assessed against the quality of their practice, timekeeping, attitude and working relationships amongst other areas.

In another file a member of staff had identified their best achievement as working with people at the end of their life. The member of staff had stressed the importance of working with both the person and their family at such a key time. Areas for development had also been noted and training arranged to support this. This showed the service was keen to ensure staff had a balanced assessment of their skills and identified areas which needed further development. Individual records also contained key points of information the registered manager wished to share and the use of this format enabled all staff to receive the same information and discuss it.

Each staff file had a detailed list of all training that each member was required to complete. This also included dates of forthcoming training to ensure that none was missed. We saw that some staff were due moving and handling refresher training and this had been scheduled for completion by the end of the month. Staff had received training in moving and handling, emergency aid, infection control, fire, safeguarding vulnerable adults, mental capacity and health and safety. There was also nurse specific training for managing epilepsy, positive behaviour support (PBS) and using a syringe pump. Certificates evidencing that staff had completed these areas were also in the files.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw the registered manager had appropriately applied for DoLS authorisations for people who lacked capacity to make decisions around their willingness to remain in the service and that others had been authorised. We did not identify any that had specific conditions attached.

We asked a member of staff their understanding of DoLS and they told us "It's providing the least restrictive option for someone. We let people do as much as they can but keep them safe." The staff member was able to explain about a person using the service who kept sliding off their seat due to involuntary movement and so a restriction of their liberty was considered by use of a lap belt in a specialised chair. This person had had respiratory issues as a result of poor posture and so, even though the service had tried alternative seating options, the use of the straps in the chair were beneficial as the person had much better respiratory health and less injuries as a result of falling on the floor. This person had an authorised DoLS in place.

We saw people had mental capacity assessments in place for specific decisions such as finance management, the use of locks on bedroom doors, administration of medication and observations during the night. In each instance the decision was recorded such as the use of money for staff meals when out with a person on social outings. This decision had been discussed with the person's deputy as appointed under the Court of Protection who had agreed it was in this person's best interests to go out and socialise as the person enjoyed this. If they were unable to purchase meals then they would have to return home or take a packed lunch which was not an option due to their special dietary needs.

One staff member we spoke with said "Someone has capacity unless proven otherwise. Capacity can be based on every day decisions and much larger ones. So a person can choose what to wear or eat but may not understand how to manage their finances. We assess on a needs basis. Someone's frame of mind can make a difference. If they're calm they can make decisions." Another staff member told us "We support people to make choices in any way they can by using pictures or showing them the options and using information in the support plan." A further staff member said "By looking a person's body language, using signs and symbols to help them make the choice." This showed staff understood the differing levels of assessing capacity and the importance of being decision-specific.

People were supported with their nutrition and hydration needs throughout the day. One person said "I enjoy the food." We heard staff ask people what they would like to eat and in one instance we observed staff support the person to make their lunch. We observed two people being fed through their PEG (percutaneous endoscopic gastrostomy). This is a device which enables someone with swallowing difficulties to receive nutrition directly into their stomach. This was done discreetly and the staff interacted with the people throughout the procedure, ensuring they were happy and comfortable. We observed staff wearing appropriate protective clothing to minimise the risk of infection.

In one bungalow a person was reluctant to come to the dining table but was encouraged and supported by staff to do so. They were promptly served their meal and offered a drink. We observed some people who were unable to verbally communicate being supported with nutrition and it was evident through their body

language they were enjoying their meals. We asked staff if people had any special dietary needs and one told us that "[name] needs to have blended food and thickened fluid due to their swallowing difficulties, and [name] needs support to maintain a healthy diet due to their diabetes." The registered manager was able to discuss people's specific needs and how they dealt with some issues such as weight loss to the extent that no one was nutritionally at risk due to the close monitoring taking place.

We also noted in each bungalow kitchen photos of people and their specific dietary requirements within the cupboards so that any member of staff could access this information. This showed their preferred method of eating, cutlery and other utensils, and also the consistency required for food and fluids. This was summarised information to that in people's care records which had more detailed descriptions. This meant that all staff were able to access key information quickly and ensure people were supported in the best manner for them.

We saw in records that people had access to health and social care support as needed and the service drew on the advice of external agencies when looking at people's needs. People had access to the correct pressure relieving equipment and this was used appropriately. We saw people regularly saw the GP, dentist, occupational therapist, psychiatrist, optician and other services as needed. These visits were logged in detail in the care records providing a chronological account of a person's healthcare journey.

One staff member told us "There is a separate handover for nursing and care staff. Carers are given all the key information when they arrive on shift so they know what has happened and is happening for people. This is verbal but the nurse handover is written."

The environment had been improved since the last inspection although there were still some communal corridors and doorways in need of repainting. This was an ongoing programme and we could see where changes had been made. Bedrooms were clean and all had been personalised by people's own effects. In one bungalow we saw the person had chosen their own wallpaper to help them settle as they had only recently moved. The grounds of the care home were well attended, lawns were cut and tidy and the home appeared looked after. Living areas were clean and homely, with ornaments and reading lamps giving it a cosy feel. Each bungalow had a sensory room with calming lighting and the opportunity for some quiet time. There were small kitchens leading off the lounge areas which were also clean with posters of health and hygiene information on display. The fridge was stocked with fresh vegetables and there was fresh fruit available in a bowl.

Good

Is the service caring?

Our findings

We asked one person how they were treated by staff and they said "People are nice to me and look after me well."

We observed interaction in the bungalows throughout the day. Most people had limited verbal communication skills and so we observed through their body language and sounds how they were feeling. One staff member spoke gently to someone in the lounge and smiled saying "Good morning [name]. You've woken up now" and a further member of staff discreetly wiped some saliva from someone's face. In another bungalow we heard someone say "I'm wet" and the staff member quietly directed them to their room and said "I'll come and help you get changed."

We observed one person being spoken to in a kindly manner and encouraged to stack some play bricks they had. They were encouraged to sort them into different colours. Later we observed the person throw one across the room as they became frustrated. They were asked considerately to pick it up by a staff member so that people did not fall over it. They obliged and the member of staff and individual shared a conspiratorial smile which showed the depth of rapport.

A member of staff asked one person if they would like fresh nail polish as theirs had become chipped. They were shown a range of colours and chose one. The member of staff duly sat and painted this person's nails, clearly showing an interest in the individual as they discussed what they had been doing the previous day. There was a positive level of engagement. Later in the afternoon we heard staff asking people their preference for a TV show and this led to a discussion about the merits of one over another between a number of people and staff.

One staff member advised us "If I heard someone being spoken to in a derogatory manner I would use disciplinary action for bad practice. Raised voices and derogatory comments are not acceptable at all."

Staff members were aware of the importance of maintaining privacy and promoting someone's dignity. One staff member told us "I always ensure the door is shut during personal care assistance, the 'do not disturb' sign is on and maintain privacy by keeping personal areas covered. I follow the support plan so I know how the person receives their care." We observed these signs in use throughout the bungalows. In one bungalow we observed a dignity board which showed the service's ten point charter as to how someone should be supported with dignity. This was a pictorial guide to the ten expected standards of behaviour such as being respectful, offering choice and listening to people.

One person was using the toilet but disliked the toilet door being shut completely so a stable door had been installed and the top half had been left open, meeting both their need and preserving their dignity. When this person left the bathroom of their own volition staff quickly responded by covering them with a towel and escorting them back to their room gently. We later observed in the communal lounge that someone had been incontinent but this was sensitively handled by a quiet word in the person's ear to advise them they should go and get changed to feel fresher.

The service had dignity champions throughout the home whose role was to promote positive practice and challenge any disrespectful behaviour. One staff member told us "We have meetings once a month and people are given the opportunity to raise any issues. Protecting someone's dignity is not just about covering them with a towel; it's about the use of appropriate language for their age and understanding to aid choice and decision making." The same staff member also advised us of the importance of adhering to people's religious and cultural beliefs. They had recently supported people with decorating Easter eggs and bunting for those that wished to celebrate this festival.

The service had developed a particular strength in supporting people at the end of their life. The registered manager told us the service had been awarded the Gold Standard Framework and developed an audit tool which was on social media discussing 'doing it my way'. This showed the journey for both individual and their family and the service acknowledged how close these two were intertwined.

Good

Is the service responsive?

Our findings

One person we spoke with said "I get to go out a lot. I like to go to the cinema, theatre and see music." We spoke with a visiting health professional who had been visiting the service for over ten years. They told us "The service is consistent across each of the four bungalows and homely. People are supported well." We asked staff if they felt people had enough to do. One staff member replied "Yes, they are supported to join in if they want to and in going for walks." Another staff member said "We always try offer people what we know they like. One person likes going out for drives and listening to musicals. Another person likes puzzles and music. We follow their lead and react to their mood."

People were supported throughout the day to engage in activities. During mid-morning we observed someone receiving an aromatherapy massage from a visiting professional and another person asked for a milkshake. This was duly provided. One person had finished their hot drink and was encouraged by staff to return their empty mug to the kitchen thus promoting their independence. We heard staff ask people if they would like to sit in the garden as the weather was so nice and chairs were taken outside. Staff sat talking with people. One staff member told us "We let people do as much as possible for themselves. Even though one person is unable to eat food due to their swallowing problems, they like to help with cooking and will help us weigh the food. Another person is encouraged to butter their own bread for sandwiches." We observed this later in the day.

The registered manager told us that someone had recently celebrated their fiftieth birthday and had enjoyed time with a visiting owl sanctuary which had been arranged by the service. One person, who had limited physical agility, spent much of their time looking up and so staff had taken them out kite flying. The registered manager also told us that plans were in place to consider wheelchair ice-skating as one staff member had suggested this.

People had also attended scarecrow festivals and other activities in the nearby community such as canal trips. Another person who spent much of their time in bed had had a bird feeder placed outside their room to provide visual stimulation. We saw from recent staff meeting minutes that one person had recently enjoyed a day trip to Blackpool on the train and that a holiday caravan had been booked for a week in the summer for all people to go and enjoy time away.

It was evident from the discussions we had with staff that they knew people and their needs well. One staff member told us "We have someone who is not currently safe using cars as they take off the seatbelt so they are only allowed in taxis with a staff member each side to support. This is recorded in their care plan." Another staff member said "One person is on the autistic spectrum and goes in to a vehicle before getting into their wheelchair. We know they won't go straight into their wheelchair from the house." This was repeated later to us by a different member of staff showing the depth of knowledge staff had as to how best support people.

We looked at people's support files and found them to be person-centred and detailed. Each file had the person's photograph, date of birth, and key contact details. People's preferences and choices were

recorded, their usual routines noted in depth and details of significant events such as best interest meetings were kept in the file for when someone was not able to make a specific decision. They also contained evidence of other agency involvement such as physiotherapy input. Each record also contained daily notes which were written twice daily highlighting key events and the person's presentation for that day. In one record it was noted "[Name] has been very chatty this afternoon talking to everyone."

The support plans gave clear directions and information to staff to meet the individual's needs in detail which followed relevant policy and guidelines. Areas included morning and evening routines, personal care support, specialist nursing care such as stoma care, diet, cultural needs, medication and communication. Each file was unique to that person and had the relevant information to reflect their specific needs. We saw evidence that all staff had signed to indicate they had read and understood the plans. This record was in each person's file and was replaced each time the file was changed so regular monitoring took place. The changed areas were identified to assist staff in locating key information. This meant that staff were supported to access key information quickly and efficiently.

Each person's file had an activity log which referred to activities over and above usual routine such as 'going out for tea' or 'shopping'. Reference was also made when a person attended day care including activities undertaken there. People had individual objectives set annually and these were reviewed regularly. In the care records we saw correspondence with other providers such as day care and evidence of discussions as to how relevant a person's objectives still were, and whether any adjustments were necessary. Each objective had a corresponding action plan which considered the benefits of achieving this, the person's need to do it and what was required to facilitate this.

The care records included key personal information such as 'what makes me happy' and 'how to tell when I'm happy'. The former referred to things such as getting out and about and wearing perfume. There was also a section about 'things I must have in my life' and we could see for this person these were offered during the day of our inspection. This showed that the service was responding to people's specific needs.

Support plans were in easy read format to help people who struggled with written communication. Support plans were evaluated monthly, with a more in depth review every six months. If needs changed in the interim the plans would be amended accordingly. The registered manager held regular meetings with the managers of each bungalow to facilitate this.

The registered manager spoke with us about their recent support of some occupational therapy students who had supported people with completion of their life story books. This work had been extended to include people's support plans being recorded on a camcorder to show them engaged in activities. This was played back to people who enjoyed watching themselves on the film and people received individual DVDs so they could play them in their own room whenever they wished. We also saw people were supported to grow tomatoes and other produce in the gardens and greenhouses.

The service had not received any complaints since 2011. We saw evidence of many compliments received in the way of thank you cards and also one from an external staff member who complimented the service on being friendly and welcoming.

Good

Is the service well-led?

Our findings

One person we spoke with told us "I like living here." Another said "It's nice." One relative said in their annual survey feedback "I appreciate how I've been kept informed as to [name's] health and happiness. Never, on any visit, have we found [name] not well groomed and dressed. I've never been anything but completely satisfied with the level of care received. Thank you for all your dedication." Another relative had recorded "[Name] gets lots of attention and is given exceptional care and understanding. They are always very clean and well turned out. They get taken out a lot and the home is clean and tidy."

We asked staff how they felt working at Oxfield Court. One staff member told us "Most of the time it is enjoyable. We get support from each other. We are given the freedom to do things." Another said "I have asked for more training and been encouraged to progress." We asked staff if they felt supported in their roles and one replied "Yes, definitely." Another staff member said "Yes, I absolutely love it. I have been encouraged to do roles I have put myself forward for and been supported by other team members." The registered manager also said "I feel very supported by the area manager and all the managers of the service here. It's a team effort."

We saw evidence of an annual customer survey which was in picture form to encourage people to complete it. One person had written they had been unhappy to move into the home but we saw in their care record this was because their previous home had closed down. We saw the person settled and laughing.

The home held six monthly resident meetings in each bungalow. These meetings were recorded in pictorial format with a photograph next to each person's comments. The last meeting had discussed holidays, any changes people wanted, what they wanted more of and people's likes about the service. In one note it said "[Name] had a drink then left the room. They enjoy drives and aromatherapy." For another person it said "Enjoyed Shrek at the cinema – [name] would like to go again….[name] enjoys shopping and has been recently." We saw this in their care record. One person with verbal communication said "I like all the staff very much and think they all do a good job. I like everything about living here."

Regular staff meetings were also held. In the most recent minutes we saw there was a review of each person in the home with significant information that needed to be shared. This information was also recorded in a person's care plan but the staff meeting allowed the opportunity for wider discussion such as how to best manage someone's behaviour. There was also evidence of discussion around policies and procedures. In the latest minutes safeguarding had been discussed as to what it is and is not and also a detailed discussion about dignity in practice. Staff were reminded of people's objectives and to ensure they were trying as far as possible to meet them.

We found all relevant and current policies and procedures and staff had signed and dated when they had read and understood the documents. These were also available online with the registered provider responsible for reviewing and evaluating accordingly. There was a robust auditing system which reviewed information monthly in relation to infection control, accidents and incidents, health and safety, pressure care, medication, safeguarding, complaints, fire safety and DoLS. This was in addition to the regular support

plan reviews evidenced in each person's file. The area manager also conducted monthly audits of the service checking staff's knowledge as part of this and identifying areas for development.

The service had necessary safety checks in place including gas, legionella, LOLER (Lifting Operations and Lifting Equipment Regulations) for the use of equipment, emergency lighting and fire safety. We saw a wheelchair, sling and mattress audit with checks completed weekly depending on the equipment. These were stored for each individual using such equipment and copies of the labels of slings for hoist were in these notes which showed the size and instructions for use. Where issues had been found such as a dip in a mattress this had been replaced promptly.

We asked staff what they felt the values of the service were and one told us "active participation and to support individuality. This is done by promoting people's dignity, offering choice and encouraging independence." Staff were aware of initiatives in other bungalows and were keen to implement in their part of the service. The registered manager told us "Valuing people is our key value. Communication and inclusion are important with the people using the service at the centre. We are always looking at ways to improve."

We spoke with staff about the challenges facing the service. One said "The lack of funding sometimes limits opportunities but we try and be as creative as we can." The registered manager said that recruiting the right staff was an ongoing concern but checks were in place to minimise the risk of the wrong people being appointed. They felt the service had improved recently following some intense recruitment drives. Another risk the registered manager felt was staff not adhering to guidelines hence the requirement for all staff to sign to say they had read and understood any changes to people's care records. The service showed it was aware of potential risks and had plans in place to address these.

When we asked about achievements staff focused on the progress of individuals within the service. One staff member referred to a person having more stable blood sugars due to a balanced diet and for another it was supporting the person to become less anxious. The registered manager was proud of the Linda McEnhill Award 2015 the service had received for their end of life support. This had generated a positive reputation for their commitment in this area which had been recognised by local commissioners. The registered manager was also keen to promote staff 'thinking out of the box' and being creative. This included the use of assistive technology to further develop people's independence such as using thumbprint technology for someone to open a door rather than having to rely on a staff member.

We asked staff how they knew they were providing a quality service. One member of staff said "We ask people if they are happy. If they rock and hum, then we can believe they are. Also family feedback is positive and other professionals who come in to the home are complimentary." Another staff member said, when asked how they knew people were happy "I think they are they are settled and smile often. They are content."

The registered manager was keen to ensure consistency of approach in how people were supported while reflecting their individual need. They told us "Staff receive supervision at the same time with the same core information shared. We are currently looking at report writing." One member of staff told us "We have regular supervision and we are encouraged by our manager to put ideas across and to challenge." Other quality measures the registered manager had in place were regular observations of staff in their day to day role. They were also aware through the care plan audits and review meetings that staff were facilitating the achievement of people's objectives and trying to consider alternatives if circumstances changed. These audits evidenced detailed recording and best practice. Staff were supported to access additional training wherever it was felt appropriate over and above the minimum requirements and utilised knowledge from

the student nurses who worked at the service, again sharing best practice.