Community Homes of Intensive Care and Education Limited

Otterbourne House

Inspection report

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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

This inspection was unannounced and took place on the 8 and 9 November 2016.

Otterbourne House, to be referred to as the home throughout this report, is a care home which provides residential care for up to nine younger and older adults with learning disabilities. People receiving the service also live with complex emotional and behavioural needs including autism. Some people living at the service also had additional health conditions such as epilepsy and cerebral palsy.

The care home comprises of single floor accommodation consisting of seven en-suite bedrooms in the main home which also had a main lounge and a smaller quieter lounge, dining area, laundry room and social area which had facilities including a juke box and pool table. The home was situated with its own communally accessed secure rear garden. Each person living in the main home also had patio doors which led from their bedrooms to a small fenced patio area allowing each individual their own outdoor space. Two annexes were situated in the grounds of the home, both of which comprised of a living room, bathroom, kitchen and a bedroom area. The home was situated on the outskirts of the village of Otterbourne. At the time of the inspection nine people were using the service.

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

Most relatives of those using the service told us they felt their family members were kept safe. Staff understood and followed the provider's guidance to enable them to recognise and address any safeguarding concerns about people.

People's safety was promoted because risks that may cause them harm had been identified and guidance provided to manage these appropriately. People were assisted by staff who encouraged them to remain independent. Appropriate risk assessments were in place to keep people safe.

People were kept safe as the provider ensured sufficient numbers of staff were deployed in order to meet people's needs in a timely fashion. In the event of unplanned staff sickness the provider sought to use existing staff including the registered manager to deliver people's care or used regular agency staff to ensure familiarity for people living in the home.

Contingency plans were in place to ensure the safe delivery of people's care in the event of adverse situations such as large scale staff sickness or accommodation loss due to fire or floods.

People were protected from the unsafe administration of medicines. Staff responsible for administering people's medicines had received additional training to ensure medicines were administered, stored and

disposed of correctly. Staff skills in medicines management were regularly reviewed by other staff including managerial staff to ensure staff remained competent to administer people's medicines safely.

The provider used robust recruitment processes to ensure people were protected from the employment of unsuitable staff.

New staff induction training was followed by a period of time when they worked with experienced colleagues to ensure they had the skills and confidence required to support people safely.

People were supported by staff who had up the most relevant up to date training available which was regularly reviewed to ensure staff had the skills to proactively meet people's individual needs.

People, where possible, were supported by staff to make their own decisions. Staff were able to demonstrate that they complied with the requirements of the Mental Capacity Act 2005 when supporting people during their daily interactions. This involved making decisions on behalf of people who lacked the capacity to make a specific decision for themselves. The home promoted the use of advocates where people were unable to make key decisions in their life. This is a legal right for people who lack mental capacity and who do not have an appropriate family member or friend to represent their views about health issues and where people wish to live.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager showed an understanding of what constituted a deprivation of person's liberty. Appropriate authorisations had been granted by the relevant supervisory body to ensure people were not being unlawfully restricted. Conditions which had been attached to any authorisations had been met appropriately.

People were supported to eat and drink enough to maintain their nutrition and hydration needs. People were involved in developing the home's menus and were able to choose their meal preferences. We saw that people enjoyed what was provided. People were supported to participate in meal times and where it had been identified people were at risk of choking guidance provided by health care professionals was followed. People's food and drink preferences and eating support required were understood and appropriately provided by staff.

People's health needs were met as the staff and the registered manager had detailed knowledge of the people they were supporting. Staff promptly engaged with healthcare agencies and professionals when required. This was to ensure people's identified health care needs were met and to maintain people's safety and welfare.

Staff had taken time to develop close relationships with the people they were assisting. Staff understood people's communication needs and used non-verbal communication methods where required to interact with people. These skills were practically demonstrated both by the registered manager and staff during their interactions with people.

People received personalised and respectful care from staff who understood their care needs. People had care and support which was delivered by staff using the guidance provided in individualised care plans. Care plans contained detailed information to assist staff to provide care in a manner that respected each person's individual requirements. People were encouraged and supported by staff to make choices about their care including how they spent their day within the home or in the community.

Most relatives knew how to complain and told us they would do so if required. Procedures were in place for the registered manager to monitor, investigate and respond to complaints in an effective way. Relatives and staff were encouraged to provide feedback on the quality of the service during regular meetings with staff and the registered manager. Information was made available in alternative formats to allow people receiving the service to provide their feedback or complaints, thereby enabling them to feel valued.

People were supported to participate in activities to enable them to live meaningful lives and prevent them experiencing social isolation. A range of activities were available to people to enrich their daily lives which included attending school to progress their academic potential. Staff were motivated to ensure that people were able to participate in a wide range of external activities and encouraged them to participate in external day trips they knew people would enjoy.

The registered manager fulfilled their legal requirements by informing the Care Quality Commission (CQC) of notifiable incidents which occurred at the service. Notifiable incidents are those where significant events happened. This allowed the CQC to monitor that appropriate action was taken to keep people safe.

Most relatives told us and we saw that the home had a confident registered manager and staff told us they felt supported by the registered manager. The registered manager provided strong positive leadership and promoted the providers values which included providing person-centred care to people within a homely environment whilst promoting their independence with the aim to allow people to live semi independently. These values were known by staff and evidenced in their working practice.

Quality assurance processes were in place to ensure that people, staff and relatives could provide feedback on the quality of the service provided. People were assisted by staff that encouraged them to raise concerns with them and the registered manager. The provider routinely and regularly monitored the quality of the service being provided in order to drive continuous improvement.

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 safeguarded from the risk of abuse. Staff were trained and understood how to protect people from abuse and knew how to report any concerns.

Risks to people had been identified, recorded and detailed guidance provided for staff to manage these safely for people.

People were supported by sufficient numbers of staff who had been subject to a robust recruitment procedure ensuring their suitability to deliver care.

Medicines were administered safely by staff whose competence was assessed by appropriately trained senior staff.

Is the service effective?

Good

The service was effective.

The provider ensured that staff had the relevant induction, on-going training and support to be able to proactively meet people's needs and wishes.

People were assisted by staff who demonstrated they offered them choices in ways that could be understood and responded to. Staff evidenced that they understood how to support people effectively so their needs were met.

People were supported to eat and drink enough to maintain their nutritional and hydration needs. People who had specific needs in relation to eating and drinking were provided with the additional support required to protect them from any associated risks.

Staff understood and recognised people's changing health needs and promptly sought healthcare advice and support for people whenever required.

Is the service caring?

Good

The service was caring.

Staff were compassionate and caring in their approach with people supporting them in a kind and sensitive manner. Staff had developed companionable and friendly relationships with people.

Where possible people were involved in creating and reviewing their own personal care plans to ensure they met their individual needs and preferences. Advocates were sought to support people with their decision making processes where they were not always able to do so independently.

People received care which was respectful of their right to privacy and maintained their dignity at all times. People receiving one to one support were cared for by staff who understood and evidenced the need for people's independence and respected their need for privacy.

Is the service responsive?

Good

The service was responsive.

People received care that was based on their needs and preferences. They were involved in all aspects of their care and were supported to lead their lives in the way they wished to. The service responded quickly to people's changing needs or wishes.

People were assisted by staff who actively encouraged people to participate in activities to allow them to lead full, active and meaningful lives.

People's views and opinions were sought and listened to. Appropriate communication methods were used to ensure people could express their wishes and these views were respected. Processes were in place to ensure complaints were documented, investigated and responded to appropriately.

Is the service well-led?

Good

The service was well led.

The registered manager promoted a culture which was based on the provider's values of creating a homely environment and the promotion of people's independence. Staff knew these values and this was evidenced in their working practices.

The registered manager provided strong leadership fulfilling the legal requirements of their role. Staff were aware of their role and

felt supported by the registered manager. They told us they were able to raise concerns and felt the registered manager provided good leadership.

The registered manager and provider sought feedback from people and their relatives and acted upon this. They regularly monitored the quality of the service provided in order to drive continuous improvement.

Otterbourne House

Detailed findings

Background to this inspection

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

This inspection took place on the 8 and 9 November 2016 and was unannounced. The inspection was conducted by one Inspector.

Before our inspection we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law. We did not request a Provider Information Return (PIR) from this provider prior to the inspection. A PIR is a form which asks the provider to give some key information about the service, what the service does well, and what improvements they plan to make. We obtained this information during the inspection.

During the inspection we spoke with the registered manager, the deputy manager and three members of staff. We viewed nine people's care plans, seven of these people's daily care records and six medicine administration records. We reviewed six staff recruitment files, staff training records and staff rotas for the dates 16 October to 12 November 2016, quality assurance audits, policies and procedures relating to the running of the service, accident and incident forms and maintenance records. After the inspection we spoke with the relatives of four people.

Not all the people who lived at the home were able to communicate their views and opinions regarding the care they received. As a result we completed a number of observations throughout the course of the inspection. These involved observing staff interaction with people as well as a lunchtime observation.

This was the first inspection of the home since it was registered to deliver care on 21 August 2015.

Good

Is the service safe?

Our findings

Most relatives told us their family members were safe because staff were present to support the people who lived there and the home was secure owing to the security measures in place. One relative told us, "Yes (my family member is safe), there's always one person with him and he's not left on his own to wonder about". Another relative said, "Yes I believe so (family member is safe), it doesn't look like he can get our or anyone can get in without being authorised."

People were protected from the risks of abuse because staff understood the signs and the actions they should take if they suspected a person had been abused. This included identifying the signs they would recognise in people who communicated using non-verbal methods and who were unable to verbally express their concerns. The provider had safeguarding policies in place. These provided information about preventing abuse, recognising signs of abuse and how to report it. Guidance was available in people's daily care files, which contained the local safeguarding authorities contact telephone numbers staff could call in the event they were concerned about a person's safety. Staff were able to describe the physical and emotional symptoms people suffering from abuse could exhibit and knew their responsibilities when reporting a safeguarding situation. People knew how to identify the signs of abuse and to report these appropriately to keep people safe.

Risks to people's health and wellbeing had been identified and guidance provided to mitigate the risk of harm to them and other people. All people's care plans included their assessed areas of risk and provided guidelines for staff on the support people required to remain safe. These included risks and information associated with people's behaviours which may challenge staff and others. Risk assessments included information about action to be taken by staff to minimise the possibility of harm occurring to people, for example one person living at the home was at risk of choking as a result of their medical condition. Another person was at risk of falling. Information in people's care plans provided guidance for staff about how to assist them to eat and move around the home safely to minimise the risk of them experiencing an adverse incident. We observed staff assisting people in a manner which ensured their safety. Records showed people had received the appropriate treatment in accordance with their risk management plans. Staff knew how to meet people's needs safely.

Accident and incident forms were completed when people and staff were involved in adverse situations in the home. Where people had been involved in incidents with others living at the home these were documented, investigated and measures put in place to minimise the risk of reoccurrence. These incidents were then reviewed by the registered manager and appropriate referrals made to external health and social care professionals to identify if any additional action could be taken to prevent a reoccurrence for people.

Some people living at the home could exhibit certain behaviours which could challenge others. Appropriate guidance was provided to staff regarding the actions required to manage these incidents to ensure the person and other people living at the home were kept safe. This information provided clear information for staff of potential triggers which could lead to such behaviours being displayed. It also included detailed signs and changes in people's vocal projections and body posture changes which could indicate a person

was becoming distressed. This guidance enabled staff to recognise when people were becoming distressed and allowed them to take early intervening action. This was important to ensure the behaviours did not escalate which could place the person at risk of harm to themselves or others. When people began displaying behaviour during the inspection which could have escalated leading to harm being caused we saw staff were aware of the risks and took appropriate action and followed the guidance provided for people's safety.

People were assisted by sufficient numbers of staff to be able to meet their needs safely. In the event of any staff being unavailable for their shift due to last minute sickness people would be assisted by staff who adapted their shifts to provide the additional cover required. The registered manager, deputy manager and the chef were also appropriately trained and could deliver people's care if required. The home was using agency staff to ensure appropriate support was available to people. This was, in main, due to an emergency admission before the inspection which required a marked increase in staffing levels. Where agency staff were used the home used the same agency and requested the same staff attended. The home was able to quickly adapt to changes in people's needs to ensure that sufficient numbers of staff were available to support them. For example, when one person was admitted to hospital due to illness, the home was able to arrange additional support for them in hospital from the existing staff. This enabled the person to have a familiar face with them whilst they were away from their familiar supportive environment. Recruitment of new staff had been completed by the time of the inspection which meant the home would have sufficient numbers of consistent permanent and bank staff who would be able to support people which would minimise the future use of agency staff. Staffing levels were regularly monitored to ensure that sufficient numbers of staff were deployed in order to meet people's needs.

Robust recruitment procedures were completed to ensure people were assisted by staff who were of suitable character. The provider requested full application forms with details of past employment history. Where gaps were identified in this employment the provider ensured that suitable reasons for this were sought. Staff had undergone other detailed recruitment checks as part of their application process and these were documented. These records included evidence of good conduct from previous employers and included a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care services. People living in the home were actively involved in the interview process of new staff recruitment. During interview stages people would be encouraged to participate by meeting with potential new staff. This allowed potential new staff to meet the people they would be supporting and allowed the registered and deputy managers to observe how potential new staff were able to interact with people with learning disabilities. This process enabled managerial staff to identify whether or not potential new staff were comfortable and able to respond in a calm and appropriate manner to behaviours displayed. People were kept safe as they were assisted by staff who had been assessed as suitable for the role.

People were protected from harm because there were contingency plans in place in the event of an untoward event such as large scale staff sickness, severe weather events or practical risks associated with fire or flood. To ensure people's safety their care plans included hospital assessments. These provided detailed and easily read information for staff and emergency services when dealing with an emergency situation. These included how people communicated, their current medication, people's mobility needs and any risks associated with peoples eating.

People received their medicines safely as arrangements were in place for the safe storage, administration and disposal of medicines. Staff received specific training in medicines management and were subject to annual competency assessments to ensure they could manage and administer people's medicines safely. There were clear arrangements in place to ensure that people were protected from receiving the wrong

medicines. Medicines were mostly administered using a monitored dosage system from a blister pack prepared by the providing pharmacy. The home ensured that when medicines were administered this was witnessed by a second member of trained staff. This ensured that the risk of any medicines errors were reduced as two members of staff would be responsible for ensuring the correct medicines were administered. We could see that medicines were ordered, stored, reviewed, documented and disposed of correctly.

For people receiving time critical medicines such as those to be administered for people experiencing an epileptic seizure specific guidance had been created to allow staff to easily recognise when and how much medicine should be given. Staff recognised and understood this guidance and people were provided with medicines appropriately to meet their needs. People were supported to receive their medicines by staff who had received the appropriate, training, guidance and support in order to be able to safely manage medicines.

Good

Is the service effective?

Our findings

Most relatives we spoke with were positive about the ability of staff to meet their family members' care needs. They told us staff respected their family members decisions and choices and took steps to promote people's independence wherever possible.

People were assisted by staff who received a thorough and effective induction into their role. New staff were required to complete an induction which followed the Care Certificate induction standards. These are nationally recognised standards of care which care staff need to meet before they can safely work unsupervised within the first 12 weeks of their employment. This induction covered a number of areas including staff understanding their new role, working with people in a person centred way, communication, awareness of mental health, dementia and learning disabilities and basic life support. Alongside this training new staff completed the provider's own induction training which included new staff being aware of how and when to contact other social care professionals involved in people's care, the home's aims and objectives, the correct handover procedure and the use of personal protective equipment.

Staffs induction was followed by a period of shadowing to ensure they were competent and confident before supporting people. Shadowing is where new staff are partnered with an experienced member of staff as they perform their role. This allows new staff to see what is expected of them. Staff had undergone or were in the process of training in specific key areas such as epilepsy, autism, positive behavioural support, activities and nutrition. The home also identified members of staff who displayed the potential to complete senior roles and encouraged these staff to participate in the providers management development programme. Staff were provided with sufficient training to enable them to conduct their role with confidence.

People were assisted by staff who received guidance and support in their role. There were documented processes in place to supervise and appraise all staff to ensure they were meeting the requirements of their role. Supervisions and appraisals are processes which offer support, assurance and learning to help staff develop in their role. The registered manager said that supervisions were due to occur every eight weeks which was in line with the provider's policy of six supervisions a year. All staff we spoke with said they could and were happy to seek additional guidance and support from their senior members of staff including the registered manager at any time. This process was in place so that staff received regular and consistent support to enable them to conduct their role confidentially and effectively.

The Mental Capacity Act (MCA) 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff were able to discuss the principles of the MCA and how they used this in their everyday interactions with people when supporting them.

Records showed that people had been when people had been assessed as lacking capacity to make specific

decisions about their care, the provider had always complied with the requirements of the MCA. Records showed that where required decision specific best interest meetings had been held with people, family members and social care professionals when people were unable to consent to receiving care for example. The registered manager had ensured decision making processes were documented to ensure that any actions taken on people's behalf had been discussed and agreed as appropriate and necessary.

For example, people living at the home were not involved in self-administering their medicines or managing their own finances. In these instances the service was responsible for assisting people to take their medication as prescribed and managing their money on their behalf. When people required money staff would assist them to take out the money they would need from their bank accounts. The registered manager and senior staff would then review and retain bank statements and receipts to ensure people were not being subjected to financial abuse. The service demonstrated they had assessed people's capacity to make specific decisions regarding managing their finances and medicines. Best interest decisions had been completed to ensure that the home was demonstrably operating in people's best interests and relatives and significant persons in people's care had been involved in those decisions.

People can only be deprived of their liberty to 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). The registered manager and staff showed an understanding of DoLS which was evidenced through the appropriately granted authorities from the local authority. Staff were able to discuss the reasons for people being subject to a DoLS and the actions they would take to ensure they were able to support people in the least restrictive way.

People living at the home were not always able to move around all areas of the home freely. There were a number of certain areas of the home where people could not enter without staff support such as the laundry room where chemicals used in the completion of washing tasks were stored and the kitchen where knives were stored. Where restrictions had been placed upon people's free movement these had been appropriately assessed via the MCA and best interest processes. Guidance was then provided to staff on how to support people to ensure any such restriction on their movement was as limited as possible. For example, it was documented that people could enter the locked laundry room whenever wanted they would just require a member of staff present to ensure they were not taking any action which placed them at risk of harm. This ensured that where restrictions were applied to people's movement they were not excessive and action taken was the least restrictive option available for people. Where conditions had been applied to DoLS authorisations for example, requesting occupational therapy referrals were made to discuss people's care, we could see these conditions had been acted upon in a timely manner.

The registered manager promoted the use of advocates and Independent Mental Capacity Advocates (IMCAs) for people who were unable to make key decisions in their life. Access to IMCAs are a legal right for people over 16 who lack mental capacity and who do not have an appropriate family member or friend to represent their views in relation to major healthcare decisions or decisions about where to live. This ensured any large decisions were made in a person's best interests.

People were supported to have sufficient to eat and drink to maintain their nutrition and hydration needs. We saw people had a choice of menus and enjoyed the food provided. The home's chef (and staff when the chef was unavailable) prepared people's meals and people were involved in discussions regarding their menu choices. People were offered a wide range of food including nutritionally balanced and visually appealing meals. Staff supported people to maintain a healthy, balanced diet.

People ate well and were provided with sufficient time to eat their meals at their own pace. For those who

required additional support during their meal times staff knew people's individual risks and ensured these were managed. One person's support plan had identified that they required individualised support to manage their risk of choking. The guidance for staff included how they needed to have their meals presented to them in order to ensure this risk was managed effectively. Staff were aware of this risk and ensured this person's risk was managed safely. Where people did not like the main meal which was on offer people were able to choose alternatives they would prefer. People received the food and drink they required, and requested, in order to meet their nutritional and hydration needs and food preferences.

People were supported to maintain good health and could access health care services when needed. Records showed that when required additional healthcare support for people was requested by staff. We saw that people were referred to speech and language therapists when appropriate, such as when they were at risk of choking. Psychological reviews were also sought when required due to an increase or change in people's behaviours. When issues or concerns had been raised about people's health, immediate suitable healthcare professional advice was sought, documented and communicated to staff. This enabled health plans to be followed and for people to receive the care they required to maintain good health. One relative told us, "Yes oh yes they're (staff) are very good with that he had a problem…one of the girls spotted it and referred it to the doctor…in that respect it's very good."

Specific and clear guidance was provided to support staff on how to support people living with certain conditions, such as epilepsy. Care plans provided guidance for staff on the actions to take in order to maintain people's health and wellbeing. For those living with epilepsy clear guidance was provided to staff on how to manage their health conditional effectively. Guidance included indicators that a person may be about to suffer a seizure such as increasing their food and fluid intake for example and the actions required to be completed by staff to keep them safe if a seizure were to occur within the home and the local community. This guidance also included details regarding how frequently the person needed to be monitored throughout the day and night to ensure their wellbeing needs were met when they were not in the company of staff. Staff knew the actions to take and were confident in discussion how they would manage people's epilepsy and other health care needs effectively. People were also involved in annual health checks with their GP which included annual medication reviews to make sure their health needs were being met. People were supported by staff who knew how to manage specific health care conditions and ensured people received regular healthcare professional support to ensure their on-going health and well-being.

Good

Is the service caring?

Our findings

People displayed behaviours which indicated they enjoyed living at the home and we could see they experienced friendly and companionable relationships with staff. People indicated that they were happy by displaying relaxed body language, happy facial expressions whilst interacting with staff, moving around the home and participating in activities. Relatives told us that their family members' support was delivered by caring staff. One relative told us, "They (staff) speak to him (family member) nicely and they get him to do stuff, he's not very affectionate but they're always trying to get him up and seeing how he is, that side of things is brilliant." Another relative said, "Yes, yes, yes, there's one guy he really cares about (family member), he takes him out, cuts his hair and everything".

Staff were knowledgeable about people, their preferences, specific behaviours and their support needs. They were able to tell us about people's favourite activities, their personal care needs and any particular diet they required. All staff in the home took time to engage and listen to people. Conversations were friendly, relaxed and mutually engaging. Each person's sense of humour was known by staff and conversations held were fun and personalised. People were treated with dignity as staff spoke to and communicated with them at a pace which was appropriate to their level and needs. Staff allowed people time to process what was being discussed and gave them time to respond appropriately to ensure people were engaged. Some people living at the home required one to one care or two to one support whilst living in the home whilst being supported in the community. This meant their support and care needs were such that they were a risk to themselves and others if they were not accompanied by suitable numbers of staff. We could see that this one to one support was provided in a non-intrusive and respectful way. People were allowed to move freely around the home and were not restricted by the staff who supported them.

Staff spoke fondly of the people they supported which had allowed personal but professional relationships to develop. The development of these relationships had been assisted by people's care plans which had been written in a person centred way. Person centred is a way of ensuring that care is focused on the needs and wishes of the individual. Care plans were written in a way which showed affection for the people they were discussing. Care plans had personal information people wanted staff to know about them which allowed staff to have a greater understanding of people's needs and the care they required. Care plans detailed people's non-verbal communication methods which they would use when happy or distressed. One person liked to make a particular sound with their tongue when they were happy, this person's care plan detailed that staff should respond with the same noise as this person found this comforting. Staff knew people's individual needs and the methods to use to reassure and support people in a way that brought them reassurance.

People were included, as far as possible, in the planning of their care and support. Care plans contained detailed information about people's personal histories, any medical conditions they had, and what impact changes in their health had on their mood and wellbeing. They also included information about people's activities they enjoyed and the routine that they preferred with the delivery of their personal care.

Staff were able to discuss people's individual needs and we could see that they reflected people's

preferences in the way they provided their support. Staff told us how they assisted people to express their views and to make decisions about their day to day support. This included enabling people to have choices about what they would like to eat, wear and what activities they wished to participate in. We saw that people were being offered choices on a daily basis about how and where they wished to spend their time which was respected.

When people were distressed or upset staff knew how to comfort them and offer reassurance. During the inspection one person began exhibiting signs that they were becoming anxious. All staff spoke to this person with kindness trying to find the reasons as to why they were displaying this behaviour. This person was then diverted to participate in an activity in their room and their behaviours ceased as the person was happily enjoying having their hair styled by staff. Staff were also aware of people's triggers which could lead to them becoming upset and we could see they took appropriate action to minimise the distress people were feeling. People were cared for by staff who genuinely cared for their emotional wellbeing and took steps to ensure people were happy.

People were encouraged by staff to personalise their rooms and living spaces. People's bedrooms were individually personalised and decorated to reflect people's interests. One person had a particular fondness for a TV entertainment show. We could see that almost life size cardboard cut-outs of the key people in this show were in this person's room. Staff had also made contact with the TV channel which made this show to see if they would be able to accommodate this person visiting. Whilst this was still awaiting a response memorabilia was in the process of being supplied for this person. This showed staff displayed genuine thought and care into making this person feel valued and be surrounded by items that were important to them.

Throughout, the home was decorated in neutral colours with bold soft furnishings such as chairs and sofas with large pictures and some ornaments on cupboards and shelving units. The home was also decorated with pictures people had painted and drawn and displayed photographs of people taking part in external activities. This provided a homely environment for people living at Otterbourne. The registered manager wanted people to feel like they were living in their own home. By involving people in decisions regarding decoration of rooms and the display of drawings, painting and photos within the home this feeling was promoted.

During the inspection staff were responsive and sensitive to people's individual needs, whilst promoting their independence and dignity. Staff were able to provide examples of how they respected people's dignity and treated people with compassion during all interactions. This included allowing people additional time with the tasks they could complete independently whilst remaining vigilant to their needs. People were provided with personal care with the doors shut and staff knocked on people's doors and waited for a positive response before entering to support them. When people wanted to have time away from staff and other people living in the home, this was respected. Checks to ensure people were safe and not experiencing a health related concern were respectful of people's right to privacy and not obtrusive.

Staff told us it was part of their role to encourage people who used the service to be as independent as possible. People had guidance included within their care plans which were agreed actions that people wanted to be able to achieve independently. For example, one person's care plan stated that staff were to encourage them to prepare their meals, take laundry to the laundry room and be involved in house choirs. This care plan provided instructions on how they were to be supported to best assist this person so they retained their sense of independence. Staff knew the importance of supporting people to remain independent and we saw people were encouraged to do things for themselves continually during the inspection. A relative told us that as a result of the support provided by staff their family member had

become more skilled and independent at contacting them by telephone. They were now able to do this independently which allowed them to communicate freely and easily whenever they wanted. The staff were committed to maintaining and enhancing the skills of the people they were supporting.

Good

Is the service responsive?

Our findings

Most relatives told us the service supported their family members to lead interesting and full lives. We saw people enjoyed the activities they were provided with and were encouraged by staff to make decisions about how they would like to spend their time on a daily basis. One relative told us, "They (staff) go cover and above what's required of them in terms of giving (family member) stimulation and what he likes and they make sure they deliver on that and they've come up with some innovative things".

People received consistent personalised care and support. People's care and support they required was set out in a written plan that described what staff needed to do to make sure that personalised care was provided. When initially planning care the care plans took into account people's history as well as the activities that were important to them. Records showed relatives and health care professionals such as assistant psychologists were involved in the creation of these care plans to ensure all the person's needs, wishes and wants were taken into consideration. Most relatives confirmed they were invited to be involved in the planning and reviews of people's care as requested and required.

People were supported by staff to express their views and formally discuss their care. Care plans were reviewed at least yearly and risk assessments were updated monthly to ensure they remained current and provided the most up to date guidance available. These reviews also took place if there was a change in a person's personal circumstances such as a health difficulty or change in their support needs. For example, during the inspection we saw professional health care advice had been sought regarding how to maximise one person's ability to communicate with staff. It had been identified that their communication needs meant they did not always understand when there was going to be a change in the activity they were participating in which could lead to anxiety. The recommendations made were immediately updated in this person's care plan providing the advice to staff on the techniques to use to improve communicating with this person. This included using visual images and prompt cards to show when an activity would shortly be coming to an end and when it had concluded. This provided immediate visual recognition for the person so they were aware of what action would be occurring, thus minimising their levels of distress and anxiety. Staff were aware of the changes in this person's communication needs and it was clearly documented for all new staff entering the home what actions were required to support this person appropriately. Relatives were also involved in this process. One relative told us, "Yes, completely, (involved), it (care) is regularly reviewed."

The registered manager and staff were keen to fulfil people's lives by seeking ways to allow people to experience different social and leisure opportunities. All the people in the home were supported to take part in activities in the local community and attend social groups. The registered manager was also seeking external financial and practical support to enable people to access the community with greater ease. For example, one person in the home had particular mobility needs which meant to easily and regularly access the community they would need a specifically adapted mobility vehicle. The registered manager had identified this need and was taken action to address so this was made available to them.

During one person's initial care planning process it was identified they had always been involved in their schools faith based assembles. As a result the staff and registered manager ensured this person's spiritual

needs were met. This included taking this person to the local cathedral to participate in church services and inviting a vicar into the home who read bible stories with them. This allowed them to retain their link to their faith which had been an important part of their life before moving to the home. Some people living in the home were supported to attend a local college five days a week and where people had left the school system staff sought additional educational placements for people. Staff spoke enthusiastically about seeking alternative educational placements for one particular person where they would learn skills which would further support their ability to live more independently and allow them to gain experience of working within the community.

People had weekly activity planners which detailed what activities were available to them. However, whilst people had structured routines available this was subject to change on a daily basis. People were provided with opportunities to change their mind and participate in alternative activities. Staff knew people's preferences and provided people with choice asking people daily what they would like to do.

We saw during the inspection a variety of activities were available to people. These included attending local social groups and events, visiting Marwell Zoo, swimming, cooking and attending areas of outstanding natural beauty for walks. People were also encouraged to attend go into town for coffee, to attend the local cinema, visit the beach and to participate in their own personal shopping. People were asked during their monthly house meetings as a standing agenda item whether or not there were any indoor or outdoor activities they would like to see available to them and these were accommodated where possible. People were also encouraged to participate in the provider's talent show which was open to all people living in the provider's homes. We could see staff supported people to create music and dance routines which had resulted in people living in the home coming first. This was an achievement that was celebrated and photos showing this accomplishment were displayed within the home. People were supported by staff who recognised the importance people becoming and remaining socially active and took positive steps to encourage this social interaction and participation.

People and relatives were encouraged to give their views and raise any concerns or complaints. The provider's complaints policy provided information for people, relatives and staff about how a complaint could be made, the timescales for any response and how to complain to the Care Quality Commission and the Local Government Ombudsman (LGO). The LGO is the final stage for complaints about social care provides. It is a free and independent service that ensures that a fair approach is taken to complaints made. People were reminded at monthly residents meetings what actions they could take if they had any concerns and wished to complain. To support this easy to read information with pictures explaining how people could raise concerns if they were unhappy were openly displayed within the main foyer to the home. Information was also available to people in a number of different formats if required to increase the numbers of way in which people could raise a concern including the use of Makaton signs, sign language, braille and by the use of audio tapes.

Most relatives were confident they could speak to the registered manager to address any concerns. Systems were in place so if complaints were received they could be documented, raised to the registered manager, investigated and a suitable response provided. No formal complaints had been made since the service was registered to deliver care in August 2015. Relatives told us they knew how to make a complaint and felt able to do so if required. One relative said, "I'd go to the manager and say if I'm not happy." Another relative told us, "I am regularly in contact with them (the home) about niggly things if I'm unhappy so no reason to raise a formal complaint".

Good

Is the service well-led?

Our findings

The registered manager promoted a service which was open and supportive to both staff and people living at the home. They sought feedback from people living at the home and relatives to identify ways to improve the service provided. Most relatives said they were happy with the quality of the service provided and thought the home was well led. One relative told us, " Well so far we haven't had anything bad, so I would say on the whole yes (good quality of care provided)." Another relative said, "We've got the deputy who is absolutely fantastic, he's been a brilliant link with us".

The registered manager was keen to encourage a culture which placed an emphasis on people being supported to achieve independence. This was with the aim of preparing and helping people to move on from the home to more independent living accommodation. The home was described by the registered manager and staff as people's home and everything that staff did was to meet and support people's needs as well as promoting their independence, emotional and physical wellbeing. They wanted the home to have a happy, fun and relaxed atmosphere to promote this homely environment. This culture was known and evidenced by staff and most relatives we spoke with. One relative told us, "On the whole there's a positive atmosphere…it (the home) has a relaxed and happy environment". Another relative said, "It's been quite nice when I've been there they've made me feel welcome, got me a cup of coffee and explained what (family member) has been up and what they've got planned for him."

The registered manager was available to people and staff to offer guidance and support whenever they were required. Staff felt consistent support was given by senior staff and the registered manager. One member of staff told us, "Yes I think with the senior team and the management team often we'll go in the office and we'll have a conversation which is quite honest and we'll come up with a solution." Another member of staff said, "They're (management staff) always there and you can knock the door and talk to them and then you have the deputy manager and seniors so yeah, it's good (support received)".

Staff were able to clearly and accurately discuss the provider's core values which included being committed and passionate to providing a person centred service, staff acting with integrity at all times and treating people with dignity and respect. These values were included in staff training, displayed openly within the home and discussed during staff supervisions. These values were not only exhibited by the staff but by the registered manager and other senior staff. A member of staff told us, "(registered manager) is brilliant, she's always there for you, in or out of work she can speak to you about things and support you in a way that not many mangers would…she looks out for the service users and the staff…she's just a really, really good manager and I love working under her". Our observations showed that all staff followed these core values in their interactions with people and responded quickly to people's individual needs. Staff were aware and ensured that people were given every opportunity to fulfil their needs and wishes to live an independent life as possible.

Staff were clear about what was expected of them and their roles and responsibilities. The provider had a range of policies and procedures in place that gave guidance to staff about how to carry out their role safely and effectively. Staff knew where to access the information they needed to enable them to deal with new

situations and could seek advice and guidance from other staff and managers.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. We use this information to monitor the service and ensure they responded appropriately to keep people safe. The registered manager had ensured notifications about significant events had been reported to the CQC in an appropriate and timely manner in line with CQC guidance. These are required for the CQC to monitor incidents as they occur and to identify and confirm that appropriate action had been, and would, be taken in the future in order to keep people safe and minimise the risk of a reoccurrence or the original incident.

The registered manager sought feedback from people, relatives and staff to identify how the service they received could be improved. People, relatives and staff were asked for their feedback by a variety of methods which included participation in care plan reviews and through residents' monthly meetings. The provider also ensured that there were systems in place to monitor the quality of the service people received though the use of regular provider and registered manager audits. The results of these audits were then used to create an action plan. This action plan covered all areas of care delivery and included timescales for completion and who was responsible for ensuring these actions were completed.

The provider also used people living in their homes to take part in 'Expert Audits'. During these people living at a provider's home would visit another home in the area and conduct an audit on the home. As part of these inspections these people looked at areas such as; if the home was welcoming, if staff answered the door to their visit quick enough and if staff were polite. The expert auditors would also meet with people and staff at the home asking them about their experiences living and working at the home. These were a useful way for the provider to obtain the objective views of people who lived in other homes, identifying issues which would be important to them if they were living at that particular home. Where people were not always able to verbally communicate their thoughts the use of the expert auditor was an important way to obtain people's perspective on what they felt was important to them.

The last Expert Audit had been completed in November 2015 and it was identified they had not been informed of the emergency procedure upon their arrival at the home. As such in the event of an emergency occurring such as a fire for example, they would not have known where the safe place to wait for emergency assistance was. It was also noted the day care room was messy and required attention before it was completely functional. Actions were identified as a result of this audit which included staff being made aware that the emergency procedure should be discussed with all visitors when entering the home. Also that action needed to be taken by maintenance to ensure the day care room was a useable space. Upon our arrival at this inspection we were provided with detailed information about what action we should take in the event of an emergency. We also found that a sensory room had been created in the garden which was an independent building providing people with the opportunity to enjoy physical and auditory stimulation. This included the use of interactive equipment to encourage people to participate in activities.

Quality assurance audits were not often announced which allowed the provider and registered manager to obtain a realistic reflection of the home when staff would not be expecting their visit. The provider had completed a night visit in August 2016 during which they checked the security of the building, whether staff were awake and completing their tasks and one to one care appropriately. No concerns had been raised as a result of this visit. When actions had been raised as a part of the provider's quality assurance processes these had been documented and action taken in a timely fashion to improve the quality of the service provided to people living in the home.

The registered manager and staff identified what they felt was high quality care and knew the importance of

their role to deliver this. The registered manager told us, "(high quality care) is people being safe, happy and content, (staff) meeting their needs, developing their skills, actively involving them in the community with social relationships"'. Another member of staff told us high quality care was, promoting "A happy environment, a happy and safe environment, like a big family".

Compliments viewed documented that visitors, including health and social care professionals, and relatives agreed that high quality care was provided to people living at the home. A manager who was responsible for referring people to services had written to say, 'Just a quick email to say a massive 'thank you' to the registered manager and the staff at Otterbourne for all the hard work they had done with (person) who is one of the most complex service users that I have ever assessed. We have just had a six week review and both (person's family member) and their social worker were very pleased with the way (the person) had settled in, well done'. A social worker from a neighbouring county wrote, 'Having placed a young lady in this service I have been impressed with the service, dedication of staff and excellent understanding of autism, I have never had any concerns and would recommend to other service users'. People were assisted by staff who were able to recognise the traits of good quality care and ensured these were followed and demonstrated when supporting people.