Oakdown House Limited

Oakdown House

Inspection report

Ticehurst Road
Burwash Common
East Sussex
TN19 7JR

Tel: 01435883492
Website: www.oakdownhouse.co.uk

Date of inspection visit:
09 March 2020
10 March 2020

Date of publication:
16 April 2020

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

About the service
Oakdown House is a residential home providing accommodation and personal care for up to 45 people. People were living with a range of learning disabilities and health issues for example, diabetes and epilepsy. The service provides living accommodation in four buildings on the same site. At the time of the inspection there were 43 people living at the home who ranged in age from 19 to 83.

The service had been developed and designed in line with most of the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice and independence. People using the service receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

People's experience of using this service and what we found
The outcomes for people using the service reflected the principles and values of Registering the Right support by promoting choice and control, independence and inclusion. People's support focussed on them having as many opportunities as possible for them to gain new skills and become more independent.

People were mostly unable to tell us whether they felt safe but we observed people and staff together and saw that people were cared for and looked after well. Staff knew and understood safeguarding and were able to tell us what they would do in various circumstances. Relatives and professionals told us the service was safe. We saw multiple risk assessments within care plans that were bespoke to people's needs. Staff were recruited safely and there were enough on duty throughout the day and night to look after people. Medicines were stored and given safely.

New staff were provided with a comprehensive induction and ongoing support was maintained through regular supervisions and appraisals. Staff training was up to date and regular refreshers were in place and staff could chose to attend course relevant to their work. People had access to health and social care professionals and were supported to attend appointments off site. People were encouraged to be involved in food preparation and were provided with a nutritious and varied diet. Some people lived with diabetes and others required puree meals, these were prepared and provided freshly each day. Mental capacity assessments and best interest meetings had taken place when there was a recognised need. Deprivation of Liberty Safeguards were in place. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People were treated with respect and dignity. A relative said, "It's a beautiful home. The best thing is the love they give, there is a culture of supporting each other." Equality and diversity needs were respected and promoted. People's privacy was respected but safety never compromised. Everyone living at the home was

encouraged to be as independent as possible, in all aspects of their lives.

We saw numerous interactions between staff and people and in every case, it was clear that staff knew people well. Person centred care was documented and practiced. A range of activities were provided seven days a week. We saw small group activities and people being given one to one support. Most people were able to go out on short trips to local shops, recreational facilities and places of worship if they chose to. A complaints policy was in place and we saw that complaints had been correctly recorded and managed in a timely and appropriate way. End of life training took place and staff knew the important aspects of care at these times.

The registered manager was well thought of by everyone we spoke with. They provided a visible presence throughout the service and it was clear that people and staff knew the registered manager well. Auditing processes were in place which were overseen by the registered manager. Opportunities for learning and capturing best practice were in place and a regular series of meetings with staff and people allowed this information to be shared. Feedback was sought from people, staff and relatives and continuous learning was apparent from the feedback. The service is set in a rural location but maintained strong links with the local community.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
Good. (Report published 12 May 2017)

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-Led findings below.

Oakdown House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by an inspection manager, an inspector and an assistant inspector over two days.

Service and service type
Oakdown House is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service provides care and support for up to 45 people who live in four buildings across the site.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed all of the information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke to 16 people that used the service. We spoke with 19 members of staff including the registered manager, a care co-ordinator, the personnel manager, the chef, team leaders and care staff.

We reviewed a range of records including eight people's care plans and several medication records. We looked at four staff files in relation to recruitment, training and supervision. We looked at a range of documents relating to the management of the service including policies, procedures and auditing processes. We pathway tracked three people. This is where we check that care plan records for people matched the support they were receiving.

After the inspection
We continued to seek clarification from the registered manager to validate the evidence we found. We spoke to four relatives and four professionals.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same.

This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

● People looked relaxed and comfortable in each other's and in staff's company. We spoke to staff who told us they were confident in identifying and dealing with any safeguarding issues. Staff were able to describe scenarios and tell us what action they would take, including the recording and reporting processes they would follow. A member of staff told us, "We have a safeguarding checklist. We'd deal with every situation and make sure people were ok. We record safeguarding on cura (service computer system), contact managers and family and make sure any interventions were complete." Another said, "We can contact social care connect any time, East Sussex council and the CQC."

● All staff had received safeguarding training and regular refreshers took place. A member of staff said, "We did safeguarding as part of the induction and then we have repeat training regularly."

● Staff were aware of the service whistleblowing policy and told us that they had the confidence to use the policy if needed. Whistleblowing was a way that staff could raise concerns whilst having their safety protected.

Assessing risk, safety monitoring and management

● Risks to people continued to be assessed and well managed. People had risk assessments in place that were relevant to them. For example, we saw risk assessments relating to smoking which gave detail of where people could safely smoke and what protective clothing should be worn. Other assessments included some people's support needs when eating and other relating to mobility. We observed people being supported with eating and moving safely around the home.

● Staff knew people well and told us about specific risks that they supported people to overcome without being restricted. For example, two to one support was provided to people living with epilepsy when swimming We observed staff supporting people safely and responding to people's needs. Risk assessments were regularly reviewed and updated when necessary.

● The service had annual fire safety checks and only minor issues had been raised and all had been dealt with. In support of this annual check the service had a fire risk assessment and regular checks were completed on equipment for example, fire extinguishers, smoke alarms and fire doors. Personal emergency evacuation plans (PEEPs), were in place which detailed people's individual needs in an emergency.

● We saw safety certificates for gas, electricity and plumbing equipment. The maintenance manager showed us a schedule used to prioritise work around the service which included ongoing repairs and upkeep as well as regular safety testing of systems and equipment.

Staffing and recruitment

●There continued to be enough staff to meet people's needs. Since the last inspection a new role had been introduced of senior support worker. Staff told us this was an improvement as meant that there was always a senior staff on duty and helped their career development.
● Staff were safely recruited with checks being carried out before staff could start working at the service. Checks included employment history, references and disclosure and baring service (DBS) checks. DBS checks inform employers of any past criminal convictions or cautions that may make it unsafe for them to be employed by the service.

Using medicines safely
● Medicines continued to be managed safely. Staff were trained and their competency assessed before they started to give out medicines. Competency was then assessed every six months which included observations. Storage of medicines was safe and organised.
● Support people needed with medicines was recorded and medicine administration records were accurate. We saw staff administering medicines to people. Staff were patient and gave people the time they needed. People were supported to take as much control of their medicines as they were able. We saw a staff member kneel down beside a person when administering their medicine, explaining what it was and politely asking them to take it.
● As required (PRN) medicine was available and subject to a separate protocol. Staff knew people what steps to take if a person was in discomfort, to ask a supervisor and record on a separate medicine administration record.
● A professional told us, "They have developed a robust internal audit and work hard to analyse any errors or near misses with medication." Medicine errors were looked at individually with additional training and knowledge assessments put in place if required.

Preventing and controlling infection
● All parts of the home mere clean and well maintained. Housekeeping staff were employed and we saw people being encouraged to take part in the cleaning and laundry.
● Water temperatures were monitored and we were shown a current legionella certificate confirming that regular testing had taken place.
● We saw people using personal protective equipment (PPE), for example aprons, gloves and sanitiser. These were available throughout the service and were used during personal care and in the kitchen during food and drink preparation.
● At the time of the inspection the service held daily management and staff meetings providing updates about Covid-19. Instructions reminding people and staff to frequently wash hands and the need to self-isolate if showing symptoms had been given. People had recently joined staff in infection control training where glitter was used to signify germs, highlighting the need for thorough hand washing.

Learning lessons when things go wrong
● Accidents and incidents were recorded and opportunities for learning captured and taken forward. For example, a person had injured their foot and had to go to hospital. This prompted a review of the person's footwear. Forms had the following sections: 'outcome', 'impact' and 'lessons learned.' Clear guidance was available to staff about the type of incidents that needed reporting and learning opportunities shared.
● Similarly safeguarding incidents were analysed by managers and steps taken to understand incidents and minimise future harm to people. These were overseen by the registered manager. For example, some people could sometimes hurt themselves. Analysis of incidents including triggers and what signs to look out for have helped to reduce the number of incidents. Increasing one to one support and moving people to soft areas had helped to reduce physical harm.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now improved to good.

This meant people's outcomes were consistently good, and people's feedback confirmed this.

Ensuring consent to care and treatment in line with law and guidance
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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being.

At our last inspection we recommended the provider sought guidance on the implementation and embedment of the MCA. For people whose DoLS applications had not yet been authorised by the local authority, the registered manager could not demonstrate that people had consented to restrictive practices. The provider had made improvements. For example, people were now consulted as part of best interest meetings, before DoLS applications were made.

- People were encouraged and supported to make their own choices. For example, most people went out each day and a staff member told us that they could choose where they had lunch and if they wanted to buy anything. They said, "Today (person) bought a toy car at a toy fair they had asked to go to. They chose lunch and used their own money."
- Staff demonstrated and told us about the importance of consent. We observed several interactions between people and staff where consent was sought. For example, at lunchtime, "Are you happy to come to the table to eat," and when being provided medicine, "Here are your pills, are you ready for them." Staff told us that they would never force people to do things and that if anything became an issue, they would consult with family members.
- Most people had capacity to make day to day decisions, for example about where they wanted to go on trips, what clothes to wear and what food to eat. Most people lacked capacity to make complex decision

and we saw decision specific mental capacity assessments within people's care plans.
● Similarly, best interest meetings had taken place involving the person, their relative or advocate, staff from the service and where appropriate, professionals. We saw details of meetings concerning the use of door locks and the use of CCTV in some communal areas. A more complex meeting involved a person in need of surgery following a cancer diagnosis. This had been handled sensitively and with compassion.
● Most people were living with a DoLS in place. We saw DoLS relating to personal care, locked doors and one to one support with road safety. Conditions had been complied with.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The registered manager and care co-ordinator carried out initial assessments on people before they came to the service. We were told that the transition process was much improved and people were given several opportunities to visit the service before moving in. They attended for a meal and then for a morning or afternoon before spending their first night at the service.
● The registered manager told us that care plans were developed from the first visit to a person and were complete at the time they moved in. Care plans were reviewed constantly with people and their relatives and advocates. We saw a care plan for a person who had been living at the service for many years and were able to track how their care and support had developed and changed over time as their needs changed and had become more physically dependent on staff.
● The service used the Braden Scale which is a recognised and approved method of measuring people's likelihood of pressure sores and the required response from staff in the event of soreness or ulcers developing. Speech and language therapists (SALT) had been regularly consulted for advice about appropriate food consistency for people.

Staff support: induction, training, skills and experience
● We saw staff induction records which showed the comprehensive process staff underwent when joining the service. Emphasis was on training and shadowing more experienced staff and spending time getting to know people. A member of staff told us, "We covered everything. It gave me confidence right from the start."
● Staff were supported with regular supervision meetings, appraisals and training. Training covered for example, safeguarding, moving and handling and food hygiene. Training was provided in key areas so that staff could support people with particular needs for example, epilepsy, challenging behaviour and dementia. A member of staff told us, "I've done positive behaviour support training and know now it's more about keeping people happy and risk avoidance." We saw staff interacting with a person living with dementia, they spoke clearly and slowly and held their hand which helped them focus on what was being said to them.
● Staff personnel files contained up to date records of supervision and training.

Supporting people to eat and drink enough to maintain a balanced diet
● Most food and drink was prepared in a central kitchen. Other buildings at the service had their own smaller kitchens where drinks, snacks and breakfast could be prepared. We were shown a seasonal, rotational menu and we saw people being offered choice. Meal choices were offered pictorially as well as verbally to people. People were encouraged to help prepare meals and we saw a person helping to cook eggs.
● Some people lived with diabetes and others required help with cutting up their food. Some people required a puree diet and the chef prepared these meals to look the same shape and colour as the original food. The kitchen had clear charts indicating people's specific needs, likes, dislikes and allergy details. A relative told us, "The chef comes out after every meal and asks people if they enjoyed their meals ."
● People's fluid and food intake was monitored and if concerns were raised that a person maybe over or under eating, charts would be attached to care plans and regularly weighed. The service had called in a

speech and language therapist (SALT) and dietician to provide expert advice if concerns were raised about nutrition or hydration. A staff member said, about a person they supported, "We total up the amount they drink for the GP to check."

● We observed mealtimes and people were supported by staff when needed. The atmosphere at mealtimes was positive with people interacting with each other and staff. We heard people talking about what they had been doing that morning and what their plans were for the rest of the day. Staff engaged and involved everyone in conversation. Before lunch was served everyone sang happy birthday to a person who was then presented with a cake and presents.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support

● People were supported to access health and social care professionals. GPs, nurses, chiropodists and the community learning disability team regularly visited the service. Some people were taken out for appointments and others would receive visits at the home from for example, a dentist.

● Most people were able to tell staff when they felt uncomfortable or unwell. Some people could not express this verbally and the disability distress assessment tool (DisDAT) was used. This tool helps staff to recognise non-verbal signs that a person maybe distressed. We observed a staff member holding the hand of a person, the person was squeezing the staff member's hand in response to parts of the conversation. The staff member was able to tell that the person was thirsty on this occasion but would have recognised if they had been unwell.

● The registered manager told us that people had regular health checks and we saw this documented in care plans. Key information about people's health needs were highlighted in care plans for example, if a person lived with epilepsy or diabetes. These contained guidance how to deal with for example, seizures or a person with sugar levels to high or low.

● Relatives, advocates, loved ones were all involved and were kept informed of important appointments. A relative told us, "(Person) was gaining weight so they called in a dietician. I know they call the GP if needed."

Adapting service, design, decoration to meet people's needs

● The service is in a rural area and consists of a main house and three other smaller residential buildings. People were able to access and enjoy the outside spaces surrounding the buildings which included a barbeque area, woodland walks and a greenhouse. The service was accessible to people using wheelchairs with lifts available between floors.

● The service was in a good state of decoration and repair. People's bedroom doors had personalised pictures and names on them and throughout the service there were photographs of residents and examples of their pictures and craft work.

● Parts of the service when people living there presented a high risk of falling, had soft furnishings and padded areas to minimise the risk of injury resulting from a fall.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question remained the same.

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

● People were treated with kindness and respect. We saw positive interactions between staff and people throughout the inspection. Staff spoke in friendly way to people when supporting them one to one or when passing by. For example, "You've got new paints, there're really nice, I've not seen them before." A person asked where their friend was and was told, "They are just coming up to see us. I'm going to make some drinks; would you like one?" During activities a person entered the room and the activities co-ordinator greeted them saying, "How lovely to see you," in a loud voice and gave them a hug. We saw people were relaxed and responded to staff by smiling.

● Relatives told us that staff were attentive to people, that they knew them well and always treated them kindly. A relative who had been visiting the service for many years said, "I'm always greeted by staff who tell me the latest, 'they didn't fancy their breakfast today,' or 'they have been looking forward to seeing you.' They all just know, it's superb." A professional told us, "In my experience staff are approachable and caring towards people."

● Staff knew people well and were passionate about their care for people. Staff comments included: "The residents make this job worthwhile," "It's lovely here, I'm really enjoying my placement," "I'd send a family member to live here. Everyone is so caring, it's a great place" and "I always give people time, use the right tone and offer to help."

● We saw that people were treated fairly and equally with those unable to leave their rooms receiving as much attention from staff as those in communal areas. Diversity was respected and promoted. Care plans reflected people's faith needs and commented on people's relationships. For example, some people had formed close bonds and friendships with people. A strong link had been forged with the local church and some people attended services each week. The vicar and members of the church regularly visited the service to provide spiritual support for those that wanted it and to help with some activities.

Supporting people to express their views and be involved in making decisions about their care

● People's views, preferences, likes and dislikes were all considered and recorded in care plans. A person told us, "They know what I like to do." People were given opportunities to express their wishes and their care and support plans were under constant review. Relatives and professionals were involved in reviews of people's needs. A relative told us, "I'm very much involved in what goes on, the ongoing support is wonderful."

● Throughout the inspection we saw people being offered choice. Staff always presented options to people

which included which activity they wanted to do, where they wanted to do it, what they wanted to wear when they went out and what drinks and snacks they wanted. A member of staff said, "We give them choices and talk in a way they understand that they can choose."

Respecting and promoting people's privacy, dignity and independence

● People's privacy, dignity and independence was respected and promoted. Staff told us that they ensured doors were closed and curtains pulled when people were dressing, washing or in receipt of personal care. A staff member said, "I'll let them do whatever they can but make sure they know I'm there to help with maybe, washing themselves, if they need me."

● A staff member had been identified to be the 'dignity champion.' They were due to attend a course and then return and share knowledge. We saw a senior member of staff walk through a communal area where people were involved in various activities. They took the time to stop and talk to every person and showed interest in what they were doing. A person was dancing to music alone and a staff member encouraged others to join them. After a few minutes four people were dancing together, including the staff member, all smiling and enjoying themselves.

● Each day people were encouraged to be as independent as possible. People were encouraged to help with preparing meals, preparing shopping lists and carrying out household tasks. The service was set in a rural location but most people went out each day into the community or further afield on shopping trips. We saw a staff member ask a person what they wanted to do that day and the responded, "I want to go shopping to Crowborough." Some people had access to money that they could budget and use on food and small items that they wanted to buy.

● Staff respected confidentiality. All personal information was held securely and handover meetings where people were discussed were held privately. A staff member said, "People trust us. They come to us with issues and things they want to talk privately about."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same.

This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Person centred support was understood by staff. A member of staff told us, "We read body language, facial expressions, if they are quiet. We are aware of mental health and it's on our agenda. We support each other." We saw staff spending time with people, talking with them to find out how they were feeling and what they wanted to do.

● We saw person centred support plans that documented the journey people had taken and focussed on their current care and support needs. People's likes, dislikes and personal preferences were documented. Headings in care plans included, 'what I am good at,' 'my places,' 'important people' and things you need to know about me.' Care plans covered oral health care for people and a dentist was regularly consulted for advice.

● People's behaviour was clearly recorded to inform staff about how people might react to certain things. For example, a person tapped their head if they became anxious and needed a few minutes to themselves before being able to tell staff what was wrong. Another person who smoked had a regime of when and where they liked to smoke, safely, and steps staff took if this regime was interrupted. In another care plan we saw, 'when I tap my cheek it means I'm thirsty.'

● Despite the size of the service there was a family atmosphere where everyone lived happily together and supported each other. A relative told us, "There is a culture of residents supporting each other." Another said, "I visit a lot. This is like my second family." Managers told us that they promoted a family atmosphere where people felt comfortable and supported. A professional told us, "I've seen them a lot, the staff are totally engaged with people, it runs like a family."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People's communication needs varied with most being able to communicate verbally. Several people used Makaton which is a recognised non-verbal language that uses hand signs and signals to represent words. Others used body language and touch to communicate their needs. We saw staff using touch to help communicate for example holding a person's hand and arm to help the person focus. A staff member told us, "Some people can tell you, others I know what they want by the expression on their face. We do use picture cards as well."

● Care plans reflected people's communication needs. One person used facial expressions, some audible noises and hand and arm movements to communicate their needs and wishes. This was clearly documented and updated when new words were adopted. We saw staff interacting with people with different communication needs and everyone was able to make themselves understood.
● Easy read documents, picture cards and iPads were used by people to help with communication. People had photographs and pictures on their bedroom doors bespoke to them. We saw a person's room that was full of sensory items for example coloured lights, reflective furniture and quiet music. Communal areas were clearly recognisable to people with pictures of doors to indicate the dining area and the kitchen for example.

● A number of documents were available in easy read formats including communication passports which contained a person's important information should they have to attend hospital or go on holiday. The registered manager told us that they were working on a project to produce videos of key information for people for example, the complaints policy.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● A comprehensive activities programme was in place with a range of different things available for people every day. An onsite day centre was available for people and activities included: walking groups, arts and crafts, music and a coffee shop. Sensory activities were available as well as practical activities for example, baking and gardening.
● Some people were not able to leave their bedrooms and activities were offered one to one support. We observed a staff member reading to a person who was living with dementia and hearing and sight loss. The staff member held the person's hand and held the book in front of them so they could see the pictures. We saw another person receiving a hand massage which they enjoyed, appearing relaxed and smiling.
● Most people were able to leave the service accompanied by staff. Some people attended church, others went swimming, shopping and some attended a local college a few days each week. A relative told us, "I've seen the service develop over a number of years. The advances they have made have been amazing. I know there are activities for everyone, seven days a week now."
● Most people were able to take holidays each year which included trips to seaside resorts, Centre Parks and Butlins. Others had 'staycations' and staff arranged themed weeks for example, the seaside. Arts and crafts then focussed on beach themes as did the food with fish and chips and ice creams made available. People were encouraged to raise pocket money for themselves by offering to help with tasks, for example, washing cars. The service welcomed visitors from the local community to celebrate festivals and enjoy a summer fayre. Birthdays were celebrated, not just people and staff but close relatives and important people in people's lives.

Improving care quality in response to complaints or concerns
● The service had a complaints policy that was easily accessible to everyone with easy read versions available in different buildings across the service. Staff knew people well and told us that they could tell if someone was not happy about something. Staff told us they would alert senior staff members and contact family members immediately if there was a concern. A person told us, "I have never been so unhappy as to need to complain. I'd just speak to (name of staff.)"
● Few complaints had been made about the service, not enough to draw any conclusions about trends or themes. The registered manager told us that they compared complaints and were beginning to look at minor incidents and concerns but there remained too few to compare.
● We looked in detail at a complaint that had been made and saw that it had been recorded and investigated in accordance with service policy. The complaint had been dealt with in a timely way with the person and relatives being informed of progress and receiving a letter of apology. A relative told us, "I have

every confidence in them. I know if I raise any issue it will be dealt with."

End of life care and support

● People were supported with dignity at the end of their lives. Staff had received training in end of life care and were able to tell us what the important elements of care were at this important time were. A staff member said, "We all attended a course at a local hospice. For me it's about dignity and keeping people comfortable." A senior member of staff told us that following a person passing away the service celebrated that person's life and invited family and friends to an event at the service. They told us that other people living at the service enjoyed the event and that it helped them understand what had happened.

● Care plans contained an end of life section where people and relatives were invited to have initial and ongoing conversations and people's wishes were recorded.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same.

This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The registered manager promoted a positive atmosphere and culture across the service and had made recent improvements to communication. For example, staff de-brief forms had been introduced to capture examples of good practice and to ensure that staff were supported. A form had been introduced called 'Going the extra mile.' These recorded examples of things that had been done well. For example, a member of staff had completed a well written MCA, another had done a great job with staff allocations. The forms were available for everyone to read.
- Everyone spoke highly of the registered manager. Staff told us, "(Registered manager) is absolutely brilliant, she's been here for years" and "Really supportive and approachable." A relative said, "They are brilliant, they know everyone individually." A professional said, "The manager is always responsive to any advice I give and will contact us with any queries they have."
- We saw person-centred support for people in practice and in care plans. Care plans gave details of aims and achievements. They were forward looking documents which detailed people's future plans and wishes.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong. Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager understood their obligations under the duty of candour. Throughout the inspection the manager was open and honest with the inspection team. Registered managers are legally obliged to inform CQC about events that affect their service, this had been fulfilled. The ratings from the previous CQC inspection were displayed in a prominent place at the service and on the service website.
- A robust system of auditing was in place at the service. Responsibility was delegated to staff team leaders who completed audits of systems and processes that were grouped under CQC domain headings. For example, under the safe heading the team leader would audit moving and handling, ensure fire safety checks had been completed and look at accidents and incidents and medicines. The registered manager maintained oversight of auditing and reviewed the feedback from the staff returns each month.
- In addition to audit responsibility, several senior staff had 'champion' roles. Champion roles provide staff with opportunities to become expert in a particular field and to improve and share best practice with colleagues.
- The registered manager attended regular forums and meetings including the learning disability forum.

The registered manager kept themselves up to date following both the local authority and CQC websites. A trustee of the service chaired a county wide root cause analysis (RCA) meeting which shares best practice from across several providers.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Everyone was provided an opportunity to feedback about the service. Resident meetings were held each month and easy read minutes were produced. Opportunities were provided to enable everyone to participate including those that remained in their rooms. The registered manager knew their staff team and people well and regularly spoke to everyone and captured individual feedback. Relatives and professionals were given regular opportunities to feedback and this had recently been made easier by the introduction of a card which could was used to rate a range of aspects of the service by simply ticking boxes.

● A range of staff meetings took place which provided opportunities for staff to share best practice and to feedback about the service. A staff member told us, "There are team meetings, co-ordinator meetings and team leader meetings. We discuss new ideas and record them then and there." Another staff member said, "I suggested it would be nice to set the tables before meals and they changed to doing it that day." Staff could feed back one-to-one with their managers at monthly supervision meetings. Daily handover meetings between shifts provided a further chance to update colleagues about developments each day.

● The service produced a monthly newspaper. Available in a variety of easy read formats they included upcoming events, birthdays and ideas and feedback from relatives so that everyone had an opportunity to discuss suggestions before changes were made. An example was a relative asking for art workshops to be introduced. This was published, discussed and introduced.

● The registered managed kept a compliments folder and was looking for new ways to celebrate the praise that the service, staff and people often received. The majority of compliments came from relatives and loved ones thanking individual members of staff for their ongoing care and support. One letter received described the improvement their relative had achieved in all aspects of their life since moving to the service.

● The service welcomed people from all cultural and religious backgrounds and explored people's equality characteristics during pre-assessment. People were provided opportunities to talk about difference if they chose to and were respected if they chose not to.

Continuous learning and improving care

● The registered manager told us that they constantly looked for best practice and new ideas to introduce to the service. A suggestion was made that advent calendars could be made with a photo of a different resident each day. This was introduced and everyone looked forward to opening the window each day.

● A person returned form holiday with an infection, only discovered after returning to the service. The registered manager contacted Public Health England for advice and introduced immediate guidelines for all staff relating to infection control. A simple risk assessment was created to guard against it happening again.

Working in partnership with others

● The service had established positive working relationships with professionals, local faith leaders and others who provided a service to people for example hairdressers, chiropodists and those providing entertainment and activities. A professional told us, "I find the home well-led. The management support their staff. I run courses at the home and they are always well attended." Another said, "I like the way they deal with things. They are always friendly but they get the job done."