Care Quality Commission

Oakdown House Limited

Oakdown House

Inspection report

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Burwash Common
East Sussex
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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?	**Requires improvement**
Is the service well-led?	**Good**

Overall summary

We carried out this inspection on 13 May 2015 and it was unannounced.

Oakdown House is a residential care home for adults with learning difficulties. It is set in a rural location and has three separate residential units which have the combined capacity to provide support for up to 45 adults requiring varying degrees of support.

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

People were kept safe from abuse and harm because staff were knowledgeable about how to respond to possible abuse. People were not at risk of unsafe practices when helped to move around the home as staff followed moving and handling best practice.

Summary of findings

The provider followed safe recruitment procedures to ensure staff who provided care and treatment were suitable for their roles. Staffing levels were based on people's needs and promoted their safety and wellbeing.

Medicines were stored, recorded and administered safely.

Staff had the necessary skills and knowledge to ensure they could meet people's diverse needs. Staff received the supervision and support they needed to enable them to carry out their roles effectively.

While the care and support staff gave people was of a high standard, care plans did not always accurately reflect people's current needs. We have made a recommendation about this.

Staff were kind and compassionate in their approach. Staff always listened to people and treated them with respect. Staff always responded to people's requests for help in a timely manner.

People received a personalised service as staff knew people well enough to care for them in a way that met their needs and preferences. People's preferences and social needs were respected. Activities were many, stimulating and varied and people were supported to maintain links with the community and their relatives.

People were supported to be as independent as possible. Visitors were welcomed and their involvement encouraged.

The service was well led. The registered manager had made improvements in the home to provide personalised care. Staff were clear about their roles and were confident they could raise concerns with the manager.

The registered provider had shown how they had learned from incidents in the home and had used the information to improve care.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People were supported by sufficient numbers of staff.

People were supported to take their prescribed medicines safely.

The risks to people's safety and welfare were assessed and managed effectively.

People were protected from the risk of the spread of infection in the service.

Good

Is the service effective?
The service was effective.

People were always asked for their consent before care and treatment was provided.

People received effective care from staff who had the necessary skills and knowledge to meet their needs.

People were supported to maintain good health.

Good

Is the service caring?
People were treated with dignity and respect and their right to privacy was upheld.

Staff had developed positive caring relationships with people.

People's privacy and dignity was respected.

Good

Is the service responsive?
Oakdown House was not always responsive.

People did not have their individual needs regularly updated in their care plans.

People received personalised care that met their individual needs and preferences.

People were enabled to maintain relationships with their friends and relatives.

Requires improvement

Is the service well-led?
The service was well led.

The registered manager promoted a culture that focused on people.

The registered manager demonstrated good leadership.

The service had a system to manage and report accidents and incidents.

Good

Oakdown 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 13 May 2015 and was unannounced.

The inspection team comprised two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience who joined the inspection team had experience of learning disabilities. Before the inspection we looked at information held by CQC about the home, notifications received concerning the home and previous reports.

We spoke with ten people about their experiences of living in the home. We also spoke with the registered manager, five care staff, kitchen staff, the maintenance worker, art and woodwork therapy teachers, relatives and two healthcare professionals. We examined records which included six people's individual care records, five staff recruitment files, supervision records, staff rotas and staff training records.

We sampled policies and procedures and the quality monitoring documents for the service. We looked around the premises and spent time observing the support provided to people within communal areas of the home. We observed medicines being administered. We looked at various records the manager kept, relevant to the running of the service.

Good

Is the service safe?

Our findings

People were safe because staff knew what to do if safeguarding concerns were raised. Relatives told us, "We have no concerns. X is very safe at Oakdown." People at the home said, "I am safe here because the staff look after me." Staff we spoke with had a good understanding of what constituted abuse and knew what to do and who to contact if they suspected it. They were aware of the home's whistle blowing policy and told us they would feel confident to whistle blow if necessary.

The risks people faced in their daily lives were managed appropriately to allow them to be as independent as they wished. We were told about one person who told their key worker they wanted to work with food and was employed in the kitchen for a wage. They were provided with health and safety training to facilitate this while protecting them from harm.

Risks to individuals had been assessed as part of their care plan. This included the risk of falls, monitoring and assessing skin integrity around developing pressure wounds, mobility and the risk of social isolation. Risk assessments included clear control measures with guidance for staff to follow. Staff understood the measures that needed to be taken to reduce these risks. For example, when people had been assessed as being at risk of choking, staff followed guidance and provided one to one support at mealtime and the correct consistency of food.

Staff were familiar with people's support needs to move around, socialise and eat and drink safely. They followed guidance and provided one to one support at mealtime when necessary. Risk assessments were in place to eliminate the risks of dehydration during hot weather. Drinks jugs were situated around the service and were topped up regularly. On the day of our visit it was very hot and staff offered people drinks throughout the day.

The premises had hand rails to help people move around and corridors were kept free from hazards that could cause them to trip. Windows above ground floor were fitted with restrictors and radiators had been enclosed to prevent contact burns. Staff ensured people were safe when moving around and provided the assistance they needed. When people required staff to assist them to move using walking aids, staff were available.

There were contingency plans to evacuate people in the event of emergency and arrangements in place to re-locate people to a sister home if necessary. The home had appointed a contamination lead to provide training and organise barrier nursing to prevent the spread of infection if the need arose. Fire equipment was regularly serviced and tested and the home held twice yearly evacuation simulation exercises. Care plans included individual assessments of people's support need in case of an emergency evacuation. This took into account their mobility, general health, communication levels and location within the building. There were plans to respond to any emergencies and these were understood by all staff we spoke with.

There were sufficient numbers of staff to support people and keep them safe. Staffing comprised three separate groups of 35 care staff members per unit plus ancillary day staff. Staff told us there were always sufficient staff to support people safely. In the conservatory, where a visiting singer

was entertaining people, there were four care staff supporting nine people as well as one care staff supporting somebody on a one to one basis. Staff told us, "There's always enough to ensure people get out into the community when it's planned, and staff offer over and above their paid hours in supporting activities." The provider used a dependency tool to ensure staffing levels were at a level to provide safe care. We saw that staff shift patterns ensured continuous cover to respond to people's needs. Additional staff were deployed to meet people's individual requirements when necessary, and to cover absences through sickness or annual leave. The provider used bank staff if necessary but limited this to a small number that people were familiar with.

The provider followed safe recruitment practices. Staff were subject to DBS (Disclosure and Barring Service) checks before being offered a position to ensure they were suitable to carry out their roles. They also had to provide at least two suitable references and proof of identity. Following successful interviews staff were given an induction to the service which included shadowing experienced staff until they were able to demonstrate their competence to work on their own. New recruits were requested to read the home's policies and procedures and getting to know the people living at the home as part of their induction. Staff induction programmes were comprehensive and included

Good

Is the service safe?

appropriate training relevant to the people who lived in the home. New recruits were subject to a six months' probation period before they became permanent members of staff. All staff were then required to work towards acquiring the 'Skills for Care Certificate' that was introduced in April 2015.

Medicines were stored in locked cupboards and cabinets in line with guidelines. All as required medicines had been approved by the person's GP and were subject to policy guidelines to ensure their appropriate use. Where medicines were administered in food or drink to people with capacity to understand, this was clearly documented along with the reasons for the practice. In these cases people were made aware that they were being given their medicines in this manner. Medicine Administration Record (MAR) sheets included photographs of the person for whom the medicines were intended, a list of their ailments and the medicines prescribed for them and any allergies they had. MAR sheets were audited monthly by the care co-ordinator. This system ensured that people could be confident their medicines were administered safely.

Safe procedures about infection control were followed by staff. There were three dedicated domestic staff who worked to daily schedules to keep communal areas clean.

Care staff maintained cleanliness in people's own rooms, with the support of people if they were able and willing. We saw staff wearing appropriate protective disposable gloves and aprons depending on whether they were providing personal care, cleaning or preparing and serving food. The home used colour coded cleaning implements for different areas of the home to maximise hygiene. The laundry room, which contained a locker for COSHH (Control of Substances Hazardous to Health) cleaning products, was locked for people's safety. The laundry operated a disposable bag system for soiled linen to protect staff from the risk of infection and keep other laundry separate. We saw staff supporting people when a visiting farmer had brought lambs for people to pet and feed. They were equipped with antiseptic wipes and gloves, which were used.

Maintenance and repairs of the premises were carried out to keep people's environment safe. The registered manager carried out environmental audits to identify improvements in the home. Staff recorded in a maintenance log when minor repairs were needed and the maintenance staff completed the requested tasks. This meant that people were protected from the risks posed by an unsafe environment.

Good

Is the service effective?

Our findings

People told us, "I can get a drink whenever I want or if you ask the staff will always bring you something." They also said, "The food here is lovely, all fresh cooked." People's relatives told us, "The staff are lovely, and know how to talk to X." One person told us, "They know what they're doing and look after X very well." People were supported by care staff who had the necessary skills and knowledge to meet their assessed needs, preferences and choices. Some people at the home received their nutrition via percutaneous endoscopic gastrostomy (PEG) feeds and a District Nurse attended regularly to provide training for staff in relation to PEG site hygiene. Staff had handovers whenever they came on shift. If staff had been away from work for some time, the team leader ensured they were aware of updates and of any changes in people's needs. Staff told us, "We had to read all care plans during induction, but it's difficult retaining information from then. We have opportunities to catch up on care plans especially for key clients." A key worker is a named member of staff with special responsibilities for making sure that a particular person has what they need.

Staff received one to one supervision sessions every six weeks from their unit coordinator where they could access support in their personal and professional development. Staff told us, "It's an in-depth experience every time, and you can ask for additional support if you need it. Some people prefer taking issues to additional supervision rather than deal with it in staff meetings." There were annual appraisals scheduled for all staff. This meant people received effective care from staff who had the knowledge and skills necessary to carry out their roles and responsibilities.

Staff told us that their training was consistently monitored. When update or refresher training was due, it was flagged up and staff were supported to complete it in a timely manner. Some staff were completing their diplomas in Health and Social Care. They told us the manager was very supportive of this. Two staff were qualified to teach other staff how to support people to move around safely and comfortably and they carried out this training regularly. Management had also agreed staff requests for staff to move between different units within the home to expand their experience. Staff received additional training specific to people's individual needs, such as autism awareness and epilepsy. Staff felt this equipped them to provide effective care and support.

Staff told us, "We look at the communication books all the time." Staff said they felt that care plans gave them guidance and contained the information they needed to support people effectively. The home's policy did not allow the use of restraint and staff were trained in Positive Behaviour techniques to safely support people with behaviours that challenged. There were specific behaviour guidance plans for some people. They described triggers, how behaviour could escalate and how best to respond at each stage. This meant that staff had effective support, induction, supervision, appraisal and training.

There was clear evidence in some care plans of people's involvement in decisions around their care. One care plan stated, "I was really happy to be offered this move. My Mum has been called. My care manager was informed." The section of care plans entitled 'Communication/Interaction' gave clear guidance on people's communication needs and how to facilitate consent. Staff followed this guidance and understood that people had a right to refuse personal care. They told us that if a person refused care they respected their decision, and would offer the care again under different circumstances. This may be at a later time or by a different care staff.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. The manager and staff understood what was meant by a deprivation of a person's liberty and staff had completed training in this. Appropriate DoLS applications were being made for people who used the service to ensure that they were not deprived of their liberty unnecessarily. Staff we spoke with were able to describe their responsibilities under the Mental Capacity Act 2005 (MCA), and had a good understanding of DoLS. When people had been assessed as not having relevant mental capacity, meetings were held to decide the action necessary which was the least restrictive for the person and in their best interest. Independent mental capacity advocates had been called to attend these meetings to represent people's views when appropriate. Care plans included sections entitled "How I choose", which detailed prompts for staff to ensure the person's wishes were properly ascertained. Some people would

Good

Is the service effective?

point, some could verbalise and others would make discernible signs of approval when offered the activity, item or clothing they wanted. In this way the provider supported people to express their views effectively and be actively involved in making decisions about their care, treatment and support.

Care plans held detailed information about the consistency and texture of food and drink people required. The kitchen staff had detailed information about people's specific dietary needs and catered for them. This included allergies, diabetic diets and diets to support people in gaining or reducing weight. The staff had involved the Speech and Language Therapy (SALT) team in people's nutrition and hydration assessments to advise where they needed pureed or soft food. Staff had a quick reference guide to what support people needed to eat safely. There were seasonal menus for winter and summer to give people a varied and interesting diet. Staff told us that they quickly adapted to people's changing individual eating needs and this was also passed on to the chef in the kitchen. We spoke to the chef who was preparing the lunch and who was very proud to show us around the kitchen and what was cooking. He told us, "The meal is all home made from fresh ingredients." All the meals were given at the same time. People chose where they wanted to eat and if they needed support, this was provided in a relaxed manner. In this way people's nutritional and hydration needs were met.

People were supported to attend health clinics when necessary and some people received visits from GPs or District Nurses within the home. When people's needs changed, referrals were made promptly to relevant health services. We saw evidence within care plans of regular recorded appointments with doctors, dentists and chiropodists. Staff monitored people's health and ensured their attendance at appointments to ensure their health care needs were met effectively.

People's individual wellbeing was enhanced by the adaptation, design and decoration of the home. The day room contained a state of the art "Magic Carpet". This was an interactive gaming facility with a large screen and subtitles. This was very popular with people at the home. The day room also had a ceiling track and overhead hoist so that people with different needs could be supported to move around and benefit from the facilities. All corridors were wide and had handrails to help people move around. There were specially adapted bathrooms and wet rooms with wheelchair shower facilities, as well as a new moveable hoist to assist staff in supporting people to have baths or showers safely. One bathroom had its own tracking and hoist, and the room had been personalised with stencilled clouds and sailing boats to make it more homely. The main house had a stair lift. This made it possible for people with limited mobility to move between the first and ground floor. This ensured people were protected from the risk of social isolation.

Adaptations had been made and facilities provided so that people were not excluded in any way by their physical challenges. Transition plans were individualised and adapted to the specific needs of people. New people were able to choose their décor and furniture to personalise their rooms. One person was supported to have their own Motability vehicle and one person had been moved down stairs to a ground floor bedroom due to a change in their health needs. Baths throughout the home were specially adapted so that people with diverse needs were able to use them. This showed that the environment enabled staff to meet people's diverse care and support needs.

Good

Is the service caring?

Our findings

People told us, "I love it here. The staff are wonderful" and "They are all very kind." The home had its own day care centre and some of the residents were supported with one-to-one day care as well as the support provided by the core care team. The staff approach was kind and attentive. For example, we saw people being supported with kindness to pet and feed lambs. One person was being supported by a member of staff to access the garden from the house and there was a chatty conversation going on the whole time. People were assisted in using the handrails to get down safely to the garden level and staff respected their pace. We also saw a member of care staff assisting a person in a wheelchair to transfer to a car, as they were going out on a trip to the beach. We heard gentle verbal support and reassuring physical guidance as the staff described where to place their hands and feet.

A number of people were supported to attend the local church. One person used to attend a Catholic church with her family so their key-worker supported them to attend the local Catholic church and they really enjoyed this. One person's relatives had expressed a wish for their family member's care to be provided only by staff of the same gender and this had been respected. This showed that people's individual diverse needs and wellbeing were understood by the staff who supported them in a caring way.

Staff knew the people they were caring for and supporting, including their preferences and personal histories. Care plans contained information for staff about people's individual means of demonstrating how they felt when their communication was limited. One stated, "Will hum or laugh when happy." We were shown a personalised memory book of someone who had passed away recently. There were lots of photos and recorded memories of this individual about their past life. Staff had ensured this was completed before their funeral service. People who knew the person had all been involved in this and were very proud to show us the hard work that had gone in to it.

People were involved in their own care as much as they were able; staff supported and involved them in planning and making decisions about their care, treatment and support. All people had a dedicated key-worker who sometimes took on an advocate role on behalf of the person with their consent. Following discussion with their GPs and people at the home, or after best interest meetings if appropriate, people's dignity was taken into consideration by staff when medicines was administered, such as when people experienced seizures.

One person had been supported to set up a car washing activity as a business with his own business cards and price list. He was supported to buy materials from his income. Another person had told their key worker they wanted to work with food and was employed in the kitchen for a wage. Another person looked after the greenhouse and helped with security issues such as checking the front gate and car park and working with the maintenance man. He invoiced the management for what he did and was given a weekly wage. Like other residents we spoke with, he liked the structure of his working day and the feeling of responsibility. He told us," I go out whenever I want to." As part of his job, he went to the recycling centre and occasionally went shopping for his personal needs. He told us, "I like buying tools and using my bank account. " People benefitted financially from the sale of paintings or craft work they had made. This enhanced their independence and people we spoke with were very proud of the work they had done and pleased with the monies they received. One said, "I like getting paid for what I do. It makes me feel important." In this way the home supported people to be as independent as they wanted to be.

The home had a 'Learning for living' room which provided support to people to run coffee mornings, and make cakes. As well as the in-house laundry there was a washing machine provided in the day centre so that people who wanted to be independent could do their own laundry. Otherwise a support worker had responsibility to ensure people's washing was done in the home's main laundry system, encouraging people to be as involved as they wished.

People's rooms were treated with respect and were kept as tidy or otherwise as people wanted them, as long as they did not present a hygiene or health and safety risk. Staff always knocked on bedroom doors before entering. Staff told us they took measures to ensure people's dignity was respected when they help them with their personal care or hygiene needs. When people wanted to be alone this was respected. One person had been left alone so that they could skype a friend in private. In this way people's dignity was promoted and respected.

Good

Is the service caring?

There was a visiting counsellor who told us they attended the home weekly and assisted people with any concerns they had, for example, transition issues following on from admission. Two people told us they were waiting to see the counsellor, and spoke very positively of how helpful they were. This showed that the provider was concerned for people's wellbeing and had taken steps to ensure this continued.

We saw in people's care plans that they had expressed preferences and choices for their end of life care. There were funeral plans in place for some people as well as records of their wishes regarding resuscitation. Staff had received training in end of life care as the provider wanted the home to be a 'home for life'. This view was echoed by staff we spoke with and demonstrated in their interaction with people during our visit. These were clearly recorded and showed involvement with people's families. Staff were familiar with these and told us they were always respected. This showed that people expressed preferences and choices for their end of life care were clearly recorded and acted on.

Requires improvement

Is the service responsive?

Our findings

People received care, treatment and support when they needed it but this was not always underpinned by written guidance. In one care plan we saw separate guidelines regarding how to respond to the person's seizures. The plan did not contain sufficient information and specific guidelines about how to manage several types of seizures. The staff described to us how they would manage these seizures although there was not sufficient information and guidance in people's care plans for them to follow. In some care plans there was no summary of the current status of people's health-related needs although staff we spoke with knew people and their needs well so they were able to respond appropriately. One plan noted a person's 'current weight', but this was dated June 2013 and had not been updated.

We recommend that the registered manager review the care plans to ensure they accurately reflect people's current needs.

The home had a residents' notice board which displayed details of clubs and regular activities. These included an IT workshop, 'skalextric' car racing, woodwork workshop, model making, pub games and a monthly disco. There were also men's and women's groups, in the form of social and discussion forums. Menu plans were decided at regular residents meetings. People were also actively involved in the process of recruiting new staff. They had been asked to provide questions to be put to prospective employees. The new staff then undertook trial shifts and people were asked for their feedback about them. In this way people were encouraged and supported to express what was important to them and be actively involved in how they were supported.

Arts and crafts items that people made were sold and the proceeds were divided equally between the maker and the Friends of Oakdown Trust, a charity which provided facilities, events and outings for people at the home. We saw a well- equipped sensory room, which was used daily. It could be adapted for multiple uses such as loud, quiet, restful, or stimulating. There was also a visiting aromatherapist and many bedrooms contained sensory equipment such as coloured projecting lamps. This meant that people had access to activities that were important to them and that responded to their individual needs.

A team of people made up an editorial team who produced a newsletter for the home. This included jokes, stories, information, photos and biographies. This newsletter was produced under the guidance of a college tutor. There was a whole wall display about the general election with information about each of the candidates and a guide to how to complete a ballot paper. The manager said people had been encouraged to register and to vote. Residents chose what subjects featured in the display and helped find information. People told us, "We really enjoy doing this", and it's been lovely to be involved in doing the wall display." Information about current affairs was displayed for people in formats such as easy-read so people did not feel isolated. In this way people were involved in activities that interested and informed them and were protected from social isolation.

The day-centre coordinator told us, "We're very fortunate we can access so many resources, and we have a wonderful staff team, they have a variety of skills and are so committed." She described the involvement of people who required a higher level of support and told us that activities were taken to them. For example, the singer who came would entertain them in their own unit rather than the day centre. A popular activity was making smoothies, and this allowed for experimenting while enhancing people's intake of vitamins. Some people chose not to partake in regular activities and this was respected although staff always encouraged them to be involved. In this way the provider had recognised the risks of social isolation and loneliness and had provided activities to minimise this.

One member of staff ran a gardening club twice a week, including sensory and table-top gardening. All the pots in the garden were planted and maintained by residents with support from staff. A visiting farmer told us he attended the home once a week with some animals and a group of people came out to his farm regularly to provide hands-on care to animals. We observed an organised session in a penned off area of the garden, where people were able to pet and feed lambs with the support of the farmer and staff. People appeared to enjoy this activity. The garden had a safely enclosed pond which was a source of interest to people. Other activities included discos, African drumming sessions, reflexology, computer skills, sensory cooking and music therapy.

We saw a music session taking place in the conservatory which was well attended and people were animated and

Requires improvement

Is the service responsive?

involved. Percussion instruments had been provided to increase participation. The participants had come from all parts of the home. The home had seven cars in total to use so staff and people could plan trips out where and when suited them. The visitors to the home as well as the use of the vehicles and staff support meant people did not become socially isolated and remained involved in the life of the local community.

One person showed us a craft area and demonstrated a sense of ownership and pride in it. It was well resourced with reference books, paints, other materials and tools. There were paintings by several people from the home on display. It was apparent that staff did not impose any restrictions on people's access to this work. They told us, "There is a specialist teacher who teaches and supports people in craft work and painting." Another person's room showed evidence of recent work they had been supported to do to explore their family background. This included flags, maps and posters. One person told us he was going home to visit his family soon for a couple of weeks. He told us, "I am really looking forward to it." He told us that staff had helped him to plan it. Others told us, "My relatives and friends are able to visit whenever they want." In this way people were helped and encouraged to maintain relationships with their friends and relatives.

There were notices around the home for people about the complaint process. This was also displayed in easy-read format for people. The home had a policy ensuring a response to any complaint should be made within five days of the complaint being received. People had complained that they had missed out on shopping trips because of staff shift changeovers. The staff had arranged for shopping trips to be supported by the early shift staff and this had resolved the problem. This showed that people's concerns and complaints were encouraged, explored and responded to in good time.

Good

Is the service well-led?

Our findings

People's relatives were involved in six monthly forums at the home to raise any concerns, discuss improvements and suggest activities. The staff also sent out a quarterly newsletter which people were involved in making to keep relatives informed about all aspects of the running of the home. Results of annual questionnaires sent out to relatives were analysed and published to help identify and drive areas for improvement. This showed that the provider took account of people's relatives' views to improve services there and had an open and inclusive relationship with them.

Staff told us that the team leaders and registered manager were very supportive and gave consideration to how they worked in relation to individual people. Staff could ask for supervision any time as there was always somebody available. All staff we spoke with were proud of their teamwork ethos. They told us, "We all work as a team." There was a clear set of vision and values at the home which included involvement, compassion, dignity, independence, respect, equality and safety. This was set out in the provider's Code of Practice which all staff had signed up to. The staff displayed these values throughout the inspection.

We saw that the registered manager had a good rapport with people and supported people with their needs. At one point she gently led a lady who was disorientated back to her room, chatting to her all the way and comforting her. One staff told us, "It's a hard working team, we are very close and can depend on each other, including management." Staff told us that communications at the home were excellent, through handovers and staff meetings. Good leadership was apparent at all levels during our visit. Staff were very open and told us how they enjoyed coming to work. They told us they were very happy and proud to be supporting people at Oakdown House.

The service had a system to manage and report accidents and incidents. Accidents were reported properly and the action taken was recorded. The care co-ordinator was responsible for reviewing accidents and incidents on a daily basis and the registered manager made three monthly checks to summarise these and identify trends. Guidelines were then put in place to reduce the likelihood of re-occurrence. This showed that the provider analysed incidents and accidents to drive improvement and improve safety.

We saw that the registered manager had dealt with complaints in an honest and transparent way. Where a complaint was upheld the registered manager apologised to the complainant and described the action taken to put things right. A person told us that a complaint they made was dealt with the same day to their satisfaction. A record was kept of all complaints received by the provider and the action taken to deal with them.

The staff and registered manager worked closely with the local authority to assess and tailor people's care when they were new to the home. One comment from the Transition Team stated, "I'm really impressed so far with how X's move has been managed which is a credit to the manager and her staff." This showed that the staff worked in partnership with key organisations, including the local authority, to support care provision and service development.

Supervisions were described as two-way meetings. Staff told us, "Management want to know what we think and things get quickly allocated for action and sorted." As an example, one staff had raised a suggestion to improve arrangements around incontinence pads in part of home and this had been implemented. This showed that management gave feedback to staff in a constructive and motivating way, and took note of staff suggestions.

A compliance and care management system was used by the provider to ensure policies were reviewed and updated continually. The registered manager told us, "There is always room for improvement but I think we are doing really well." We saw that a range of audits were undertaken including infection control, environmental health and safety, staff training and medicines. This showed that there were robust quality assurance and governance systems in place.

The registered manager understood their responsibilities for notifying the Care Quality Commission and referring concerns regarding people's safety to the appropriate authorities. Notifications were made appropriately and in a timely manner. CQC registration requirements, including the submission of notifications and any other legal obligations were met.