Arundel Care Services Limited

Oxford 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

Overall summary

The inspection took place on 11 November 2015 and was unannounced.

Oxford House is registered to provide accommodation and care for up to six people with a learning disability, Asperger's syndrome and/or challenging behaviour. At the time of our inspection, there were six people living at the home. Oxford House is a large, Victorian, detached house close to Worthing town centre. Rooms are single occupancy, four having en-suite facilities and one person is accommodated in a detached bungalow in the grounds of Oxford House. Communal areas include a large kitchen, dining room and sitting room. People have access to a rear garden.

There was a registered manager in post. 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.

Some people's risk assessments had not been reviewed within a six month period, in line with the provider's policy. Some staff had not received an annual appraisal. However, this did not impact on people's care and welfare and both the provider and registered manager had identified these areas for improvement. People were

Summary of findings

involved in all aspects of the service and their feedback was obtained. Residents' meetings were held. Staff felt supported by the management and spoke positively about working at Oxford House. Systems were in place to monitor the quality of care delivered. Shortfalls had been identified by the provider and were similar to what we found at inspection.

People were protected from the risk of potential abuse and harm and staff knew what action to take if they suspected abuse was taking place. Risks to people were identified, assessed and managed appropriately. Advice and guidance was available to staff on how to look after people safely and to mitigate any risks. There were sufficient numbers of staff on duty to support people. Safe recruitment practices were in place. Medicines were managed safely.

Staff had received all essential training and there were opportunities for them to participate in additional training or qualifications. New staff followed the provider's induction programme and went on to complete the Care Certificate, a universally recognised qualification. Staff had received training relating to the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and put this into practice. People were not restricted unnecessarily and the registered manager had undertaken capacity assessments for people living at the service. Where people displayed behaviour that might challenge, staff used de-escalation techniques to calm people. People were supported to have sufficient to eat, drink and maintain a balanced diet. They had access to a range of healthcare professionals. People were involved in decisions and choices about the environment and had chosen decorations for their rooms and for communal areas.

Positive, warm, caring relationships had been developed between people and staff. Staff knew people well, how they wished to be supported and their likes and dislikes. Care plans were person-centred and provided comprehensive, detailed information and guidance for staff about people. People were treated with dignity and respect and their privacy was maintained.

People met with their keyworker every month to discuss their care. Keyworkers co-ordinated all aspects of their care and recorded discussions held at the monthly meetings, then people would sign the report. People were encouraged to stay in touch with their families and friends. They had access to the community and were involved in a range of activities, including attendance at college for some people. There was a complaints policy in place and complaints were managed appropriately.

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 protected from harm and staff were trained to recognise the signs of potential abuse. People's risks were managed safely.

There were sufficient numbers of staff on duty at all times and safe recruitment practices were in place.

Medicines were managed appropriately

Good

Is the service effective?
The service was effective.

People had sufficient to eat, drink and maintain a healthy diet. They had access to a range of healthcare professionals.

Staff had received all essential training and new staff followed an induction programme leading to the Care Certificate.

Staff understood the requirements of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards legislation and put this into practice.

Good

Is the service caring?
The service was caring.

People and staff knew each other well and positive, warm, friendly relationships had been developed.

People were treated with dignity and respect and their privacy was maintained.

Good

Is the service responsive?
The service was responsive.

Comprehensive, detailed information in care records provided staff with information and guidance about the way people should be supported.

People met with their keyworker for monthly meetings to discuss all aspects of their care.

Complaints were managed satisfactorily.

Good

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

People and their relatives were asked for their views about the service. Residents' meetings enabled people to feedback to staff on all aspects of the service.

Systems were in place and were effective in identifying any shortfalls that were identified as part of quality assurance.

Good

Oxford 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.

The inspection took place on 11 November 2015 and was unannounced. One inspector undertook this inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including three care records, three staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection, we met with four people and spoke with two. For some people, being asked questions by an inspector would have proved too distressing. We did, however, chat with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the registered manager and two care staff.

The service was last inspected in November 2013 and there were no concerns.

Good

Is the service safe?

Our findings

People told us they felt safe and protected from abuse and harm. One person confirmed he felt safe living here and added, "It's good". Another person said, "It feels safe at night. I feel safe in my room". Staff knew how to recognise the signs of potential abuse and knew what action to take. A member of staff explained, "Basically we're looking after vulnerable adults. They need to be safe and protected". They went on to talk about the action they would take if they had any concerns and referred to whistleblowing. They said they would report any concerns they had straightaway to the registered manager and would complete an incident form.

Risks to people were managed so that they were protected and their freedom supported and respected. Risks had been identified and assessed for people living at the service. A care record showed that one person had risk assessments in place for horse riding, bike riding, temperature in the shower, travelling in the car, swimming, physical aggression, finances and acting inappropriately. Risks were assessed from a rating of 1 (very unlikely) to 5 (certainly); all risks were then scored and totalled providing an overall risk rating for the person. Risk assessments provided information and guidance to staff on how to manage people's risks and action to take to mitigate the risk. However not all risk assessments had been regularly reviewed. Where accidents or incidents had occurred to people, these were recorded and reported by staff. Records showed what happened immediately before an accident or incident took place, what happened at the time it took place and any contributing factors that led to the incident. Staff had recorded whether physical intervention had been implemented, the steps taken to prioritise the safety of the person and others and whether an injury resulted. Follow-up actions arising from the accident or incident were appropriately recorded and instigated.

There were sufficient numbers of suitable staff on duty to keep people safe and meet their needs. At the time of our inspection, there were five support staff on duty between 7.30am and 3.00pm. Some staff were out supporting people in the community. Support staff provided personal care and support to people and, in addition, undertook housekeeping and cooking duties. Some people had been assessed as requiring 1:1 support and this was in place. Handover meetings took place between staff shifts and enabled staff to discuss people's care and any incidents that might have occurred during that shift. Staff rotas were completed a month ahead and agency staff were rarely used. At night, there were two waking staff on duty. A relative told us, "There have been various changeovers of staff. Some staff are better than others". Safe recruitment practices were followed and staff files showed that all appropriate checks had been undertaken, to ensure that new staff were safe to work in a caring capacity.

Medicines were managed safely and administered by trained staff. We observed medicines were administered by two members of staff and that medication administration record (MAR) charts were completed appropriately. Staff confirmed that their medicines' training was refreshed yearly. Guidance for staff was in place relating to the administration of medicines and medicines to be administered to people as required (PRN). A member of staff told us, "[Named registered manager] checks everything, whether it is signed, stock levels, etc". They explained that if a person refused their medicine, this was recorded on the MAR and the medicine placed in a special plastic sleeve. The medicine would then be offered to the person a little later, possibly by a different member of staff. One person confirmed that staff gave him his medicines. He said, "They give it to me each morning". Controlled drugs were managed appropriately. Controlled drugs are drugs which are liable to abuse and misuse and are controlled by the Misuse of Drugs Act 1971 and associated legislation.

Good

Is the service effective?

Our findings

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. A relative thought that staff were well trained and said that they were pleased overall. All staff received the essential training they needed. One member of staff confirmed this and gave examples of the training they had received, in medicines, health and safety, moving and handling, autism, safeguarding, epilepsy awareness and conflict management. They went on to tell us that they could take additional training if they wished and there were opportunities for this. The same member of staff said they had supervision meetings every six weeks. Items such as keyworking, personal development, client issues, their performance and any other issues were discussed. Outcomes of the supervision meetings were recorded and any actions arising at supervision were discussed at subsequent supervision meetings. Staff received an annual appraisal, however, they had not been completed for all staff. Staff told us that staff meetings were held every month and records confirmed this. Staff were encouraged to participate and share ideas on team building, areas to improve and any issues relating to supporting people.

Some staff had received an annual appraisal within the past year. However, the registered manager told us that not all staff had received an annual appraisal within the last year. All these matters were discussed with the registered manager when we provided our initial inspection feedback summary. The provider had also identified these issues as requiring attention in a review undertaken in September 2015.

New staff followed an induction programme and were required to complete training relating to safeguarding, medicines, health and safety, risk assessment, infection control, food hygiene, nutrition, fire safety and other topics relating to their role. They were also required to complete the Care Certificate, covering 15 standards of health and social care, which the provider had introduced. These courses are work based awards that are achieved through assessment and training. To achieve these awards, candidates must prove that they have the ability to carry out their job to the required standard. Training was organised by the provider and an annual training programme enabled the registered manager to book staff on to relevant training.

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 make particular decisions, any made on their behalf must be in the 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Five people had been assessed as requiring DoLS and applications had been made to the local authority; two had been authorised. The other three were awaiting consideration from the local authority. Each person had a capacity assessment in place which clearly stated how a decision to deprive them of their liberty had been arrived at. Staff had a good understanding of MCA and DoLS. One member of staff explained, “All the people we look after have capacity on certain decisions, even choice. If they cannot, a best interest meeting is held here and we would organise an advocate”.

The use of restraint on people who lacked mental capacity was clearly monitored and in line with legislative guidelines. Staff had a good understanding of people and the management of behaviour that might challenge. Behaviour support plans were in place for people. These showed the sequence of events through a colour coding system, that might lead to an incident. For example, ‘green’ related to calm, settling events and prevention strategies to be followed by staff. Triggers that might precede an event, warning signs and early intervention strategies were described under ‘amber’ and the crisis phase or management was included in ‘red’. A recovery phase for the person provided information to staff under ‘blue’. A member of staff told us, “First we try and spot that someone is getting agitated” and referred to the need for staff to be pro-active without the use of physical restraint. They added, “Communicate with the person. Suggest they go to their room, Ten or 15 minutes is okay, but it depends on the individual”. They described the importance of ensuring the safety of other people at the service and the

Good

Is the service effective?

use of calm-down techniques with the person who had become agitated. The staff member said, "We don't actually do physical intervention. We talk to them, try and distract them. We'd offer them something to do, go for a walk, watch TV, things like that". When staff were involved with incidents of challenging behaviour, they were supported by the registered manager and other staff and a debriefing meeting took place. Communication relating to these incidents was shared with all staff in the communication book, together with the incident report number, so that staff could refer and read up on the incident.

People were supported to have sufficient to eat, drink and maintain a balanced diet. People were involved in choosing what they wanted to eat and 'menu meetings' took place. Cookery books were utilised and people could look at the recipes and associated pictures to help them decide meals for the week ahead. People were encouraged to help with cooking meals, supported by staff. One person said they helped to cook spaghetti Bolognese, sausage and mash and chicken fried rice. A roast meal was served every Sunday, in line with people's choice and the main meal was served in the evening, as many people were out during the day. One person told us, "I like my food" and that everyone had a weekly planner that incorporated menu choices. They added, "Everyone has a favourite meal". Special diets were catered for and some people chose to have a takeaway meal once a week. A member of staff said, "We encourage people to go for healthy options, but it has to be their choice". One person said, "I prefer sweets and things, biscuits. We can choose what we want on the menu". Staff sat with people and participated in the evening meal. People were encouraged to sit round the table and we observed a warm, chatty, engaging atmosphere as people and staff ate their supper.

People were supported to maintain good health and had access to healthcare professionals and services. One person confirmed that they were weighed regularly. No-one had been assessed as being at risk of malnourishment. The same person confirmed they saw a dentist and said, "I take care of my teeth" and had recently visited a GP. Contacts with health professionals were recorded within people's care records. These showed that people had received care from a range of professionals such as the GP, speech and language therapist, dentist, chiropodist and optician. Health action plans had been drawn up for people. A health action plan holds information about the person's health needs, the professionals who support those needs and their various appointments. People also had hospital passports in place. The aim of the hospital passport is to assist people with learning disabilities to provide hospital staff with important information about them and their health when they are admitted to hospital.

People were involved in making decisions about the environment, for example, in choosing colours recently when the communal areas were decorated. People personalised their rooms and had a television, if they wanted one; many had their own computers. One person's bedroom was painted blue as they were a Chelsea FC supporter. People were encouraged to have their own furniture and one person had a double bed, which was their choice.

Good

Is the service caring?

Our findings

We observed that positive, caring relationships had been developed between people and staff. Genuine friendships had been formed and staff treated people as their equal. One person said, “Staff are all right” and added, “It’s important to be independent”. People living at the service had their own keyworker, a member of staff who co-ordinated all aspects of their care. One person told us about their keyworker and said, “He does a monthly report with me. He asks me how I’m feeling”. They added, “They try and keep me clean, change and bathe properly. Otherwise I just neglect myself”.

Staff knew people well, their likes and dislikes and encouraged them to be involved in making decisions about their care, treatment and support. Care plans for people included a document entitled, ‘This Book Is About Me’ which used pictures in an accessible format. The document compiled information about people under the following headings: ‘All about me’, ‘You need to know …’, ‘Friends, special things and things I like to talk about’ and ‘How I communicate’. It also included information to staff about how people wanted to be supported in a person-centred way. The essence of being person-centred is that it is individual to, and owned by, the person being supported. One member of staff described person-centred care and explained, “We treat people according to their needs. Everyone is different”. People were involved in drawing up their support plans and some people had signed their plans to confirm this. One person communicated through the use of Makaton, which uses a system of symbols and line drawings. Staff knew how to communicate with people effectively. One person would physically lead staff to what they wanted and objects such as a cup, would be pointed at to show they wanted a drink.

People’s privacy and dignity was respected and promoted and we observed this on the day of inspection. One member of staff gave an example of supporting a person with their continence and said, “Always make sure the door is shut”. They added that they would knock on people’s doors and say who they were. They would wait for people to open the door themselves before entering. The staff member added that they would come back later if people did not wish to be disturbed.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Each person had an activity plan and diary which showed what they would be doing on a day-to-day basis. Some people attended college. One person told us they were studying for their GCSE qualifications and wanted to go on to study web design. Another person attended a local agricultural college and a country centre. People were encouraged to pursue activities or educational opportunities and were supported by staff to do this. One person told us they wanted to be more independent and hoped to live on their own one day. Another person was able to go out on their own and had a more independent lifestyle. They talked about Oxford House and said, "It's okay, but it's quite noisy sometimes. I stay up late and enjoy the quiet".

People were assessed before they came to live at the service. An initial assessment was drawn up which provided information to staff about people's behaviours, personal care needs, daily living pattern, social interaction, family involvement and financial management. Additional information included guidance for staff on people's medical needs, mobility, communication, eating and drinking, food likes and dislikes, personal care, relationships and sexuality. In one person's care plan, we read about the support they needed with daily living activities. The plan stated, 'Will need support in all areas of daily living. Outside of the house he has a staff ratio 1:1. [Named person] assists in the kitchen with simple tasks. He can sweep, mop, dust and hoover. [Named person] can do his own laundry with staff support and prompts. He can purchase simple items from shops'. People's care plans had been signed by staff to show they had read and understood them.

People spent 1:1 time and had meetings with their keyworker. Monthly reports had been completed which asked people, 'How are you feeling? Are you happy living here? Are there any new activities or college courses you would like me to help you look into? Are you getting along with your housemates? Are you getting along with staff who support you? Is there anything you would like to talk to me about?' Reports recorded people's responses and any action that might be required. People confirmed they felt comfortable with their keyworkers and were happy to talk with them. Where they were able, or had chosen to, people signed a copy of the meeting record with their keyworker. A member of staff confirmed that they had meetings with the person assigned to them on a monthly basis. Daily records were completed for each person living at the service. These contained detailed information about how people had spent their day, what they had eaten, housekeeping tasks they might have helped with and how they were feeling. One person described their daily routine and said, "I go to the shop each morning". Another person said, "We go out quite a lot. I go shopping and ten pin bowling".

People were encouraged and supported to stay in touch with people that mattered to them. One person told us that they visited their grandmother and father regularly and added, "Every two weeks, Mum comes to visit. We'll go into town and do some shopping".

The provider had a complaints policy in place. One person said, "If I have a problem, I go straight to [named registered manager]". A relative told us, "I've never had to make a complaint" and added that if they did, they would contact the registered manager or, as a last resort, the local authority. Complaints were recorded and any actions arising and outcomes were documented. A recent formal complaint was being handled by the provider, with the support of West Sussex Social Services.

Good

Is the service well-led?

Our findings

According to the provider's policy, risk assessments for people should be reviewed every six months. One person's risk assessment, which was due to be reviewed in September 2015, had not been done at the time of our inspection. We discussed this with the registered manager who agreed that they were, "Slightly behindhand" and that not all risk assessment reviews had taken place within the stipulated six month timeframe. Staff met with people on a monthly basis and recorded people's views through keyworking meetings. However, records had not been completed since September for some people, so it was difficult to see whether any meetings had taken place since then.

People were asked for their views about the service and were involved in developing the service. Residents' meeting were usually held regularly and a record of a meeting held in September 2015 showed discussions had taken place on the following: How people were feeling, menus, shopping, group activity ideas, lunches out, bedrooms, laundry times, staff and keyworking. However, monthly meetings had not always taken place and this was identified by the provider in a recent periodic service review. Nevertheless, people told us they felt happy with the care they received and liked living at Oxford House. One person told us, "This is probably the best place I've stayed". The provider had systems in place to obtain feedback from people using the service. Letters to relatives and social care professionals had also been sent out by the provider, to ask for their views about the service provided at Oxford House. However, the results for 2015 had yet to be co-ordinated and were not available at the time of our inspection.

Staff spoke positively about the management of the service and felt supported by the registered manager. They said that they could talk with the registered manager whenever they wanted and we observed this to be the case when we inspected. The registered manager was involved in all aspects of the service and knew people and their relatives extremely well. It was evident that staff enjoyed their work and one staff member said, "When I support someone, it's satisfying to me. I make them happy". They went on to say, "It's a good company, we have frequent training". The registered manager felt supported and referred to the provider saying, "They're just up the road. If I need any help, they're straight here. If I ask for something, money's tight, but they always listen". Representatives of the provider visited the service regularly.

Systems were in place to monitor and measure the quality of the care delivered. Accidents and incidents were looked at by a behaviour specialist at the provider's head office. Any trends or patterns were identified and a plan of action put in place. Periodic service reviews took place every couple of months and records confirmed this. These reviews identified any performance and outcome standards not met, the action to be taken to achieve the standard and who would be responsible for the action. At a review held in September 2015, action had been identified in relation to health action plans and hospital passports, behaviour support plans, annual reviews, supervisions, appraisals, medication, fire, emergency lighting, nutritional needs, finances, staff personal development plans, mandatory and additional training and residents' meetings. A total score of 65 was achieved which related to the number of standards met. Eighteen standards had not been met and the total overall percentage score achieved was 78%.

The registered manager enjoyed working at the service and talked about, "The whole ethos of the place – we're all in it for the same thing". He felt that a challenge was, "Keeping ourselves updated training wise. This is a complex group of people. We need to know a lot".