

Hamilton Lodge Trust Limited

# Hamilton Lodge Trust

## Inspection report

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### Ratings

Overall rating for this service

Good ●

Is the service safe?

**Requires Improvement** ●

Is the service effective?

**Good** ●

Is the service caring?

**Good** ●

Is the service responsive?

**Good** ●

Is the service well-led?

**Good** ●

# Summary of findings

## Overall summary

The inspection took place on 4 May 2016 and was unannounced.

The service provides care and support for up to 40 people who have autistic conditions, learning disabilities and physical disabilities. At the time of our inspection there were 24 people using the service.

The service had a registered manager in place. 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.

Staff were trained in safeguarding people from abuse and systems were in place to protect people from abuse. Staff understood their responsibilities to report any safeguarding concerns they may have and were confident they had the skills to do this.

Risks to people and staff were assessed and action taken to minimise these risks. People were encouraged to remain as independent as possible and any specific risks related to this were assessed.

Staffing levels meant that people were safe but levels were in need of review as staff could not ensure that people's social needs would be met promptly. Staffing in one particular bungalow was not enough to support everyone effectively when one person's distressed behaviour occupied a lot of staff time. This was having a negative impact on others. Staffing levels had begun to be reviewed across the service as there was an acknowledgement that they did not always allow for people's need to be met promptly.

Recruitment procedures were designed to ensure that staff were suitable for this type of work and checks were carried out before people started work to make sure they were safe to work in this setting. New staff were able to shadow more experienced staff to help them gain confidence. The high level of vacancies at the service meant that agency staff were often used and support and guidance for these staff could be improved.

Training was provided for staff to help them carry out their roles and increase their knowledge of the healthcare conditions of the people they were supporting and caring for. Some training refreshers were overdue. Staff were supported by the managers through supervision and appraisal.

People gave their consent before care and treatment was provided. Staff had been provided with training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The MCA and DoLS ensure that, where people lack capacity to make decisions for themselves, decisions are made in their best interests according to a structured process. Where people's liberty needs to be restricted for their own safety, this must be done in accordance with legal requirements. People's capacity to give consent had been assessed and decisions had been taken in line with their best interests. There was a good understanding of

processes related to DoLS.

People were supported with their eating and drinking needs and people were fully involved in shopping and cooking. Staff helped people to maintain good health by supporting them with their day to day physical and mental healthcare needs.

Staff were caring and treated people respectfully making sure their dignity was maintained. Staff were positive about the job they did and enjoyed the relationships they had built with the people they were supporting and caring for.

People, and their relatives, were involved in planning and reviewing their care and were encouraged to provide feedback on the service. Care was individualised and subject to on-going review and care plans identified people's particular preferences and choices. People were supported to play an active part in their local community and follow their own interests and hobbies.

Formal complaints were well managed and had been investigated and resolved satisfactorily. An overall complaints log was being put into place.

Staff understood their roles and were well supported by the management of the service. The service had an open culture and people felt comfortable giving feedback and helping to direct the way the service was run. Staff were positive about their work and the manager, who had been in post a few months only, had worked hard to create a positive and inclusive staff team.

Quality assurance systems were in place and audits were carried out regularly to monitor the delivery of the service. Improvements were evident and the manager had a clear idea of the priorities for the service.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement** 

The service was not always safe.

Systems were in place to safeguard people from abuse. People who used the service and staff had received safeguarding awareness training.

Risks were assessed and action taken to minimise them.

There were enough staff to keep people safe. Staffing levels in one area of the service were very stretched at times which had a negative impact on people's lives.

Medicines were managed well.

### Is the service effective?

**Good** 

The service was effective.

Staff received an induction and training to support them to carry out their roles. Some refresher training was overdue.

People consented to their care and treatment.

People were supported with their dietary and healthcare needs.

### Is the service caring?

**Good** 

The service was caring.

Staff were patient, compassionate and kind and relationships between staff and the people they were supporting were good.

People, and their relatives, were involved in decisions about their care and their choices were respected.

People were treated with respect and their dignity maintained.

### Is the service responsive?

**Good** 

The service was responsive.

People were involved in assessing and planning their care. Support was provided in a way which catered for people's individual needs and choices.

People were supported to play an active part in their local community and follow their own interests and hobbies.

Complaints were responded to appropriately.

**Is the service well-led?**

**Good** ●

The service was well led.

People who used the service and staff were involved in developing the service.

Staff understood their roles and were well supported by the manager. The new manager had worked hard to bring about positive changes in the culture of the service and had a clear set of goals for the future.

Quality assurance systems were in place to monitor the delivery and safety of the service.

# Hamilton Lodge Trust

## **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 4 May 2016 and was unannounced.

The inspection team consisted of three 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. Our expert was a family carer for children with autistic spectrum disorder.

Before we carried out our inspection we reviewed the information we held on the service. This included statutory notifications that had been sent to us in the last year. A notification is information about important events which the service is required to send us.

We spoke with eight people who used the service, six relatives, nine care staff and the registered manager. We also gathered feedback from adult social care professionals connected to the service.

We reviewed nine care plans, eight medication records, five staff recruitment files and staffing rotas covering eight weeks. We also reviewed quality monitoring records and records relating to the maintenance of the service and equipment.

# Is the service safe?

## Our findings

There were systems in place to reduce the risk of abuse and to ensure that staff knew how to spot the signs of abuse and take appropriate action. Staff were able to tell us what they would do if they suspected or witnessed abuse and knew how to report issues both within the company and to external agencies directly. Whistleblowing helpline numbers were prominently displayed and the manager told us that one person had acted as a whistleblower and reported concerns via this internal helpline. We noted that the service had responded quickly and appropriately to this and found that the matter could not be substantiated. Financial procedures and audit systems were in place which were designed to protect people from the risk of financial abuse.

We saw that safeguarding people from abuse had been discussed in staff meetings. Staff, including staff new to care, had received training in safeguarding people from abuse and were knowledgeable about safeguarding matters. They told us they would be confident dealing with safeguarding concerns. One staff member said, "It's all drummed into us!"

We saw that risks had been assessed and actions taken to reduce these risks. Relatives told us that their family members were kept safe. One person said, "They are very safe here. Before [my relative] came here, in a previous home, [they] had to be confined. Here [they] are very safe in the garden. There is always someone with [them]". The service had a series of health and safety checks in place which were designed to ensure that risks were reduced. We saw that fire alarms and equipment were tested and serviced regularly and 'silent evacuations' were practised which enabled people who used the service to practice leaving the building in an emergency.

Risks associated with day to day activities such as going on day trips, eating and drinking and using public transport had been assessed. Specific risks associated with people's mental and physical health conditions had also been assessed and strategies put in place to help people manage these. We saw that one person's risk assessment contained specific information about exactly where they should be seated in a car and what strategies staff should employ should the person become anxious whilst out in the community. Another person who liked to build computers and play computer games had a risk assessment to reduce the likelihood of their electrical sockets becoming overloaded and creating a fire hazard

Some people with very high support needs had been assessed to need three or four staff to support them safely in the community. We observed one person, whose behaviour could be unpredictable and could put themselves or others at potential risk, being supported to walk around outside. The staff member provided support and remained vigilant but enabled the person to access the large grounds which clearly calmed their mood.

Risks had been assessed which related to people being supported to increase their independence. One person liked to help in the gardens and we saw a risk assessment about the building of bonfires. The assessment documented very specific action for staff to take to minimise this risk, such as having a mobile phone on them and ensuring the bonfire was only a specific height.

Each assessed risk had been recorded and the majority that we saw had been reviewed appropriately, although some were overdue. We raised this issue with the manager who assured us they would take this forward.

The service had 27 full time vacant posts at the time of our inspection and the manager was attempting to recruit new staff to fill these, although the somewhat remote location of the service was presenting an added complication. Bank and agency staff were used to cover the vacant hours along with overtime for permanent staff. Although the same agency staffed were used whenever possible, sometimes new agency staff were required to support people. A member of the permanent staff told us, "[Agency] staff can get thrown in to get on with it and not have time to read information about people. It can be difficult but we try and get agency staff to sit and read the plans, especially the behaviour support plans, so that they know the most important information". Another staff member echoed this saying, "Agency can get landed in it – it does depend".

Rotas we sampled showed that the service did not operate with fewer than the assessed staffing numbers other than in an unforeseen emergency. People who used the service told us they were able to have the support they needed and we saw that people went out regularly to specific activities and appointments with staff support. On the day of our inspection some people went out for lunch or coffee and cake, people took part in a pottery class, and one person had gone to hospital with a member of staff supporting them.

Rotas did not clearly identify all the one to one funded hours and some staff were unclear what the exact hours were. A new rota had been designed to ensure this was clearer and to meet people's specific needs more successfully but this could not be put into place until the service was fully recruited. Staff worked flexibly across the site to ensure that permanent staff who knew people well could provide a consistent approach to care and support. One staff member said, "Staff are flexible and will work across different bungalows to ensure that people can go out for activities".

Staff told us that staffing levels meant they were able to keep people safe. An on call system was in place for staff to seek guidance and advice out of office hours. One staff member said, "There are enough staff. If there are problems we can call on staff in other bungalows or [staff] in the offices to come and help".

However we saw that there was a staffing concern in one part of the service related to one person whose behaviour could become unpredictable and put themselves and others at risk. Staff told us that this was having an impact on all the people who shared the house and on staff. We saw that the person had specific allocated hours to provide additional support but these were not felt to be enough and were not clear to all staff. Steps had been taken to urgently review this person's hours, and risk assessments and additional professional support was in place, but in the meantime the impact on others was significant. Staff described people who used the service as being in fear of this person. One staff member said, "The impact is huge... Incidents are worse and more frequent". We observed that the capacity for staff to take people out was dependent on the mood of this one person. One staff member told us that the person had been particularly distressed earlier that morning and said, "This morning was very difficult... I could have done with 10 staff!"

We spoke to the manager about this staffing concern and they assured us that actions were in place to try to address this and we saw that partnership work had taken place with other healthcare professionals and the local authority but the situation needed to be resolved promptly. The manager agreed to keep us informed about this issue. In addition they said that they were seeking a fundamental review of staffing hours across the service to ensure that funded hours more accurately matched people's needs for staff care and support. Several staff told us that although there were enough staff to keep people safe, they did not feel that staffing

levels made it easy for them to meet people's social needs or to increase their independent living skills.

Recruitment records showed that staff had followed an application process, been interviewed and had their suitability to work with this client group checked with the Disclosure and Barring Service before taking up their employment. We reviewed five staff files and found them to be in good order.

We saw that there were robust procedures in place for the obtaining, booking in, storage, administration and safe disposal of medicines, including controlled drugs. Staff were trained to administer medicines and their competency to do this was checked twice a year. Each bungalow had its own individual stock of medicines and we saw that medicines were managed safely across the site. Stocktaking procedures were robust and stocks of medications we checked were correct and tallied with the recorded amount. Regular medication audits were carried out and we saw that over time medicines management had improved.

There were detailed protocols in place to guide staff when to give PRN medicines, which were required only occasionally to reduce people's anxiety. The protocols, which had been signed by the GP, clearly identified distraction techniques to be used first, as these might remove the need to administer this type of medicine. We did identify one protocol which was not clear for staff to follow, and one which had not been followed with regard to one person's medicine for constipation. We raised this issue with the manager. We also noted that when people left the service on social leave, to go out for lunch for example, their medicine was taken with them but this was not recorded anywhere. We raised this with the team leader responsible for medicines on that unit.

There was a medication information sheet for each person which covered how they liked to take their medicines and to give staff advice and guidance. One person liked to have an occasional alcoholic drink and staff were advised to check that this did not interfere with the medicine the person was taking. Another person liked to get up late and the service had checked to establish what was the minimum interval needed between doses of medicines to make sure the person was safe and that their medicines would be effective. We saw that one person, who was sometimes given their medicines covertly in their food, had a very good and detailed plan which encouraged staff to try and give the person their medicines openly first.

# Is the service effective?

## Our findings

The people who used the service, and their relatives, told us they were happy with the care and support they received and we observed positive interactions between staff and the people who used the service. One person told us, "I like living here. I have lots of friends and I am happy". A relative commented, "Everybody works hard and they are a really good team". Another relative was also very positive about the service saying, "We know that [my relative] is safe and happy. [They] never refuse to get in the car to come back after [they] have been to stay. [They] consider this to be [their] home now, [and] not our house".

We saw that staff met people's needs in a skilled and competent manner which demonstrated that they knew the people well. Staff told us how they were committed to encouraging people's independence and one relative explained, "[My relative] has progressed so well here that the social worker is looking at independent living in the community. It's time to move on. We have been extremely lucky to get a place here. It will be hard to find somewhere equally as good".

When staff first started working at the service they received a comprehensive induction which covered aspects of delivering care and support and were able to shadow more experienced staff for a period of time. We found that some agency staff had not completed an induction, despite the reliance on these staff in recent months.

Staff told us they felt they had the training they needed to carry out their roles. One staff member told us, "The training is good. I have had de-escalation technique training recently... and dementia training. If you ask they will arrange training. A lady is coming in to train us about end of life".

Training records confirmed that staff received a varied training programme although some training was overdue for a scheduled refresher and some people had occasional gaps in their training record. One relative commented, "There were issues at the beginning. We didn't feel that the staff had the right training but there have been lots of staff changes and they seem to be getting a better standard of staff". Specific training related to people's behaviour when they became anxious or distressed had been provided. Staff told us that they were already working in partnership with the local hospice service in preparation for supporting one person at the end of their life.

Staff received regular support and supervision from their managers. An annual appraisal system was in place and staff told us that they felt they received the formal and informal support and guidance they needed from their managers and senior staff.

We noted that people's consent was asked for before care and treatment was provided and the management and care staff demonstrated a good understanding of the Mental Capacity Act (MCA) 2005 and staff had received training. We saw that people's capacity to make day to day decisions such as managing finances or taking medicines, had been assessed. Where significant decisions were required in people's best interests, meetings had been hosted to consult openly with relevant people before decisions had been taken. We saw that one person had been the subject of a decision about wearing specific clothing in the

community. Although this had been discussed and agreed by the person's parents and healthcare professionals it did not appear to have been carried out as part of a structured Best Interests process. We discussed this with the manager.

The manager was aware of the need to apply to the local authority if there was a need to restrict someone's liberty for their own safety under the Deprivation of Liberty Safeguards (DoLS). We saw that appropriate DoLS applications had been submitted for people who required this.

Before our inspection we had been notified about a high number of physical interventions where staff had been required to restrain someone in order to keep them, or others, safe. Staff received training in Physical Intervention and two staff had recently completed the Train the Trainer course so they would be able to train staff more quickly and check people's practice, especially those who rarely used the techniques.

Staff supported people to buy, prepare and cook their meals and ensure they had access to healthy food and drink. Menus were decided in collaboration with the people who use the service and people were free to have alternatives to the menu if they wanted. People told us they were happy with the food provided and liked being involved in decisions about their food. One person explained to us that they had managed to lose weight by cutting out fizzy drinks and were very proud of their achievement. Others had also been supported to achieve and maintain a healthy weight.

Where people were at risk of not eating or drinking enough we saw that the service monitored their intake and encouraged them to receive the correct nutrition. One person, who regularly refused food, had a care plan with detailed guidance for staff to follow in order to encourage them to eat enough. Another person had their food and fluid monitored on daily charts. We found that these charts were not always detailed and specify exactly how much fluid the person had been given. We found one day where the person had not eaten all day but there was no record of staff contacting a senior member of staff which was the required action, according to the care plan. This may have been a records issue but may also have indicated that the person did not have their needs sufficiently monitored.

We saw that some people had specific dietary needs and these were recorded in their care plan and people were supported by healthcare professionals such as dieticians and speech and language therapists. One person had a stock of pureed meals in the freezer.

People were supported to attend health checks, such as cancer screening, as well as routine appointments with opticians, chiropodists and dentists. Each person had a Health Action Plan in place which contained important information about their health. For those people who would find it too distressing to visit the GP arrangements had been made for GPs and district nurses to visit the person at the service, ensuring they did not wear their usual uniform, as this contributed to some people's anxiety.

Staff worked in partnership with other healthcare professionals and regular multi-disciplinary meetings were held at the service. A keyworker and the assistant psychologist would also attend which helped to ensure that a person's needs were monitored and any findings were communicated to the staff at the service to help support people more successfully.

During the inspection we noted that the smaller bungalows were not entirely suited to people with autistic spectrum disorder. The layout did not flow well and plasterboard walls were easily damaged. The manager had pointed this out to us before we began our inspection. Some people had moved their fridges to the staff room as they were noisy which made it difficult for people to cope, especially at night. The washing machines also added to the sensory overload for some people. The manager was aware of the issues with

these buildings and was beginning to look at options which would benefit the people living there.

# Is the service caring?

## Our findings

People who used the service, and their relatives, told us they were very happy with the way staff provided care and support. One relative said, "[My relative] has been in institutions since [they] were young. I have lots of comparisons to make. [They] look much happier. This environment is much better for [them]. [they] look much happier and [their] presentation is so much better". Staff demonstrated that they knew people well and we saw that they had built good relationships with the people who used the service. Another relative told us, "When our [relative] returned after a weekend with us, [they] left something behind. We weren't able to get it back quickly so they came to collect it. It would have worried [them] if [they] hadn't got it back".

Staff demonstrated a detailed knowledge of people's likes, dislikes and their past histories. Care plans were very personalised and contained detailed information for staff to help them develop meaningful relationships with people. Several staff in one part of the service had been working for many years with some of the people who used the service. These longstanding relationships contributed to staff understanding of people.

Staff chatted and joked with people in a relaxed way and were friendly, reassuring, encouraging and respectful. One of the agency staff commented to us, "I like working here, there's always a good atmosphere". We observed staff taking time with people and following specific guidelines in people's care plans to help reduce anxiety and calm people. We also noted how quickly staff responded when someone was in pain, providing reassurance in a kind and caring way.

People, and their relatives if appropriate, were involved in decisions about the service. Information was shared with people who used the service in a way they understood and which helped to increase their independence. The care plan for one person who was not able to use verbal language contained detailed information about how to communicate with them using Makaton (a sign language for people with learning disabilities) and also how to recognise physical gestures the person might make which would indicate that they were in pain.

Advocacy services were used to support people at reviews but had not been involved in any Best Interests decisions and had only been involved with some of the people who used the service. The manager had begun to restructure these arrangements so that advocacy would be more available to everyone for day to day matters which affected people's lives.

Staff practice promoted people's dignity and privacy and provided the support people needed whilst encouraging them to be as independent as possible. Staff were clear about people's rights and care plans reflected that people had been consulted about their care and their views recorded and respected. Where people were not so able to contribute to their care plans it was recorded that the care plan had been written after staff had observed them during their daily routines.

We saw that the service took action to ensure people's dignity was maintained. We observed staff chatting to one person who was planning to go out into the community unsuitably dressed. The staff member gently

raised the issue and guided the person to make a different choice about their clothing. Another person was seen to ask various staff members the same thing throughout the morning. Each time the staff member demonstrated patience and listened to them, explaining the situation again for them to help them understand. We saw that this behaviour was captured in the person's care plan and staff were clearly following the guidelines related to managing this person's anxiety.

We observed staff knocking at people's doors and waiting to be invited in which showed respect. We also noted that one person's plan contained information about their relationship with another person who used the service. This second person was not named in order to maintain their confidentiality but staff were directed to speak to a senior member of staff who would give them the information they needed. Another person's plan had specific information about supporting them in the community as staff needed to ensure they wore specific clothing in order to maintain their privacy and dignity.

All the interactions we observed confirmed to us that relationships between staff and those they were supporting were easy going and friendly. Support was provided discretely where necessary and the general atmosphere was of an inclusive service with the people who lived there at the heart of it. One relative told us, "They are such caring people. [My relative's] lifestyle has improved since [they] came here...[They] are not able to communicate well but [staff] tend to know what [they] want. [Staff] have helped [my relative] lots with [their] confidence. [They] are much less agitated and more settled now'.

## Is the service responsive?

### Our findings

People received care that met their needs and took into account their individual choices and preferences. Staff knew the people they were supporting and caring for well and were familiar with the contents of each person's care plan. Care plans documented people's choices and preferences and made clear what people's skills and abilities were as well as the things they needed help with. One staff member told us about the six weekly multi-disciplinary meeting which were held for each person. They said, "We ensure we are promoting independence and choice and check that activities are happening for people. We review if a person's goals are being achieved and if any new interventions are required". One relative told us, "Life is 90% better now that [my relative] is here... They have taught [them] skills, like using the washing machine, that you just couldn't have asked [them] before. I would definitely recommend it to other families".

Care plans were person centred and contained information about how people's needs should be met. People's choices and preferences were clearly documented and plans were subject to ongoing review. We did find that some plans were significantly overdue for review but were assured that a process was in place to review both the format of the care plans and to request a review of people's care packages as a whole.

Plans contained very specific detail to help guide staff. For example one care plan contained clear guidelines about what to do if the person picked up an item in a shop which they had not paid for. The care plan stated staff should tell the person that they were not buying this item today, give it a kiss and then the person would understand. We found that staff knew these important details about people's care and were confidently able to tell us about each person's particular needs.

People who used the service were supported to decide how they wanted to spend their time and the service had seven vehicles for staff to use to take people out. One person told us, "I go out every day". They told us they regularly visited their mum, sometimes popped down to the pub for a shandy and went bowling every Friday. We also observed people enjoying the facilities the large grounds provided. One person was cutting the grass, others were sitting on the patios outside their bungalows enjoying the sun, another was hanging out their washing and one person was playing with a bat and ball. Seven people went out into the community on the morning of the inspection and two people went on a trip to the seaside. One person said, "I did my food shopping today and I am going to the seaside this afternoon". A pottery session took place in a craft room and several people took part and were proud of their creations.

A relative commented, "The team are so accommodating. We wanted our [relative] to be at a family wedding but we all knew it would be too much for [them]. The staff brought [them] and they were able to bring [my relative] back when [they] had had enough. We are very lucky."

We saw that the individual approach to people's care and 'progressive behaviour monitoring' had enabled some people to make progress. One person went out to lunch with two care staff where previously this person had needed five staff to do this safely. Another person had successfully undergone a train journey which had been one of their goals, and another was working towards being able to clean their teeth and make drinks independently. A person whose anxiety could make their life difficult had a weekly talk time set

aside so that they could talk their feelings through with staff. Two people had volunteer jobs.

There was a complaints procedure in place and people knew how to make a complaint if they needed to, although some people would need support or advocates to help them with this. We saw that one member of staff had used the service's own whistleblowing procedures to raise an issue. The matter had been fully investigated and was not substantiated. There were no other formal complaints and the service did not have an effective complaints log. This had already been identified by the new manager as part of their service improvement plan and we saw evidence that they had begun to put a clear system in place for any future issues.

The service routinely consulted people, and their relatives, on the way the service was delivered. Formal meetings did not work successfully with this client group and so people had regular meetings with their keyworkers and multi-disciplinary meetings. One relative told us, "I attended the last care planning meeting. [My relative's] keyworker makes lots of suggestions about how to make things better for [my relative], to make [their] environment better. There was some light in [their] room that made it difficult for [them] to sleep, it was too direct, in [their] face. The keyworker made some adaptations. [My relative] sleeps much better now". Another relative commented, "At the multi-disciplinary meeting we talked about lots of new ideas about how to help [my relative] with their emotions. They are trying them now".

## Is the service well-led?

### Our findings

Before the current registered manager came into post the service had not had a stable management team in place and a high level of safeguarding referrals had caused concern both at the local authority and CQC. The new manager had taken over and had been required to address a number of issues across the service. We found the manager to be providing strong leadership to the service and to have a clear idea of the priorities for the service and strategies to take it forward. We have identified some issues for improvement or consideration in this report but the vast majority had already been identified by the manager and plans were already underway to tackle them.

The service had a very positive and open culture. The new manager was known to residents, relatives and staff and all spoke very positively about the contribution he had already made to improving the service. One member of staff said, "The manager is really good. I definitely feel supported in my role. He has an open door policy so you can just go to him. One person that I support always wants to see the manager and he is very accommodating". Staff told us they felt more settled since the manager had been in post. One person said, "He's like a breath of fresh air. He's really supportive and encouraging. If you do something well he tells you or if you don't know something he will help you. It's never a problem". Another member of staff also told us that the manager had shared positive feedback about their participation in a recent care review. This clearly meant a lot to them.

The manager had instigated an open forum staff listening group and had invited all 102 staff to attend. Attendance had been poor and the manager was planning to increase the opportunities for staff to meet with him, including arranging monthly manager's surgeries. The manager demonstrated commitment to improving communication and support for staff. This was certainly appreciated by staff with one saying, "He is addressing issues that need to be addressed and moving in the right direction. I believe that he is a no nonsense manager which is what is needed. He is a boundary setter". Another stated, "We air our gripes and Andrew will sort things out". The manager also felt well supported by their line manager and director who visited regularly and were available to support and guide them if needed.

Relatives also commented on the positive changes the manager was overseeing, saying, "I have noticed changes since the new manager came. I think they are raising the bar, taking it to a different level".

The culture of the service was based on a set of values which related to promoting people's independence and achieving personal goals. Staff we spoke with were clear about how they provided support which met people's needs and maintained their independence and we observed this during our inspection.

The registered manager understood their responsibilities and had sent us the statutory notifications that were required to be submitted to the Care Quality Commission for any incidents or changes that affected the service.

There were systems in place to monitor the quality of the service and we found that the regular quality assurance audits were thorough and issues raised at one audit were given a 'red flag' and followed up at the

next and improvements were evident. The manager had a service improvement plan in place which was a live document which was kept updated. Incidents of physical intervention, where staff had been required to restrain someone in order to protect them and others, were monitored by the manager and had reduced. The manager had identified a number of issues to take forward, some previously documented in this report. A review of people's care packages was a priority as it was acknowledged that staffing levels could be improved and staffing hours be more clearly identified. The environment was also a priority given that some of the bungalows were not ideally suited to the people who were living in them. We were reassured that the issues that concerned us were also the main issues the manager had independently identified.

We saw that recruitment was also a clear priority and innovations such as rostering staff on shift together so that they could car share had been trialled, as well as a consideration of an enhanced wage compared to similar local services.

Records for the people who used the service and staff were well organised, which meant that important information could be located easily and quickly.