The Hesley Group Limited

The Hesley Village

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

This inspection took place on 14 and 15 June 2016 and was unannounced on the first day. The home was previously inspected in November 2015 and the service was in breach of the Health and social care Act 2008 (Regulated Activities) Regulations 2014 in respect of staffing and staff deployment, review of care plans and risk assessments, management of medicine, dealing with complaints, and the monitoring the safety and quality of the service.

As a result the service was rated Requires Improvement. You can read the report from our last inspections, by selecting the 'all reports' link for 'The Hesley.Village' on our website at www.cqc.org.uk'

The Hesley Village is registered to provide accommodation for up to 80 people. The village is on the outskirts of Tickhill, near Doncaster. There are several houses and flats, set in extensive grounds, with shops, a cinema and a café. The village is for people with a learning disability and autistic spectrum disorder. Most people who live there have behaviour that can be challenging. At the time of our inspection there were 71 people using the service.

The service 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.

During this inspection we found that improvements had been made since our last inspection in November 2015. A number of new staff had been recruited and had started work. Others were awaiting recruitment checks, or undertaking induction training. There were adequate staff on duty at the time of our inspection. However, there was a need for continued improvement in recruiting and deploying staff to the core teams supporting people, and new staff needed time to settle in, in order to be able to respond well to people's needs.

The need to use agency staff had decreased, and the provider had taken steps to ensure that where they were used, this was in a more consistent way and they were better equipped to support people who used the service. Relatives we spoke with told us improvements were taking place in staffing and the use of agency staff, but there was still 'a way to go' with this. They said that, the service mostly provided good care and support and the staff were caring and kind and respected peoples choices and decisions

Medicines were managed safely and improvements had been made to ensure the management of medicines was of a consistent standard throughout the service.

People's needs were identified, and improvements had been made in the way people's plans and assessments were reviewed. This helped to protect people from risk and helped to make sure they received care and support that met their changing needs.

There was a robust recruitment system and all staff completed an induction to the service. The induction had been improved to help equip new staff for their role and to help with staff retention. Staff received formal supervision and annual appraisals of their work performance.

There were systems in place for monitoring the quality and safety of the service. These had been improved, so that they were more effective. Where they identified issues and areas of concern, these had been addressed and followed up to ensure continuous improvement.

The service had received a reduced number of complaints since our last inspection, and these had been dealt with following the company's procedures, to ensure people were listened to and their complaints acted on.

We saw that staff respected people's privacy and dignity and spoke to people with understanding, warmth and respect.

We found the service to be meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The staff we spoke with had a good understanding and knowledge of this and people who used the service had been assessed to determine if an application was required.

Staff we spoke with told us that staff worked well as a team, and things were improving They felt supported by their line managers, and felt the higher management team were more in touch with the day to day challenges, and were providing clearer leadership.

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.

There was enough staff to meet people's care needs and there was less use of agency staff. However, more recruitment was necessary, as there remained a relatively high staff turnover and new staff needed time to settle in, in order to be able to respond well to people's needs.

People's risks were identified in care plans and provided guidance on supporting people. There was good progress with the work to make sure that these were reviewed effectively.

Staff knew how to recognise and respond to abuse correctly. They had a clear understanding of the procedures in place to safeguard people.

Medicines were received and stored and administered safely.

Is the service effective?

Good

The service was effective.

Each member of staff had a good level of training, although there was an acknowledged need to continue to develop and improve the induction training, to help prepare new staff for their role, and aid in staff retention.

People were supported in line with the principles of the Mental Capacity Act 2005. Staff promoted people's ability to make decisions and acted in their best interests when necessary.

People were supported with their dietary requirements and had choice and involvement in meal planning. People were supported to have access to healthcare services

Is the service caring?

Good

The service was caring

People received kind and compassionate care. Staff

communicated with people in a friendly and warm manner that reflected their communication needs. Relatives spoke highly of the staff.
People were treated with dignity and respect and their privacy was protected.

We saw people were involved as much as possible in decisions about their care, as were those important to them, such as parents and advocates.

Is the service responsive?

Good

The service was responsive

Care plans provided staff with guidance on how to meet people's needs.

Staff supported people to be involved in activities that reflected their preferences; and the opportunities for this were increasing as core staff teams were established.

There was a complaints system in place and this was being followed to ensure people were listened to.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in place who had developed a good understanding of their role and responsibilities.

People's voices were listened to. Meetings were held with people who used the service, with their relatives and with staff. The meetings gave people opportunities to raise any issues.

There were systems in place for monitoring quality of the service provided. These were effective and any shortfalls identified were effectively addressed.

The Hesley Village

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 14 and 15 June 2016 and was unannounced on the first day. The inspection was undertaken by three adult social care inspectors.

Prior to the inspection visit we gathered information from a number of sources and looked at the information received about the service. This included feedback we had received from people's relatives and notifications the service had sent us about incidents that affected people's care. The provider completed a Provider Information Record (PIR).This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We also contacted the local authority safeguarding team, three social care professional who were involved in and monitored the care of three people, and two health care professionals before our visit.

As part of this inspection we spent some time with people who used the service observing support, this helped us understand people's experience of the service. We looked at documents and records that related to people's care, including three people's support plans.

We spoke with 17 staff members, these included care managers, deputy care managers, team leaders, the rota manager, a workplace mentor, a practice lead nurse, psychologists, speech and language therapists, occupational therapists, the deputy manager, the registered manager and the provider's nominated individual. After the inspection we contacted six people's relatives to seek their views on the service.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found that there was high staff turnover and high use of agency staff, and this had a negative effect on the service received by some people. Additionally, the feedback we received from health and social care professionals before this inspection indicated the service was having some success in addressing the issues we identified at the last inspection, although some remained critical of the service in respect of turnover of staff and the use of agency support staff, which they felt affected the consistency of the service for some people.

At this inspection we looked at the area of staffing in some detail and found that the provider had taken action to address the issues identified, and continued to make improvements. We found there was a need for continued improvement in recruiting and deploying staff to the core teams supporting people, in order to make sure all people's needs were met.

Relatives we spoke with thought enough staff were provided. They said the service had been through a difficult period with staffing and the use of agency staff, which had caused concern for some relatives. However, things were improving in recent months.

New staff had been recruited and had started work, or were awaiting recruitment checks, or undertaking induction training. The use of agency staff had reduced, although several agency staff were still used.

A post of rota manager had been created in order to improve the way staff were deployed. The rota manager told us that a number of actions had been taken to make sure the agency staff who worked at the service had the correct skills and knowledge. Additionally, they had undertaken further work with the main agency provider to make sure there was clarity about the skills agency staff needed.

They told us that where possible, the agency staff worked at the service on a regular basis, to ensure there was as much consistency as possible. For instance, where possible agency staff were booked for 16 week periods. Where this was not possible, as staff were required to cover at short notice, there was a list of preferred workers who had proved themselves to have the necessary skills and knowledge. When first introduced to the service, agency workers had a three day trial period, and an induction that was a shortened version of that undertaken by newly appointed staff. This helped to make sure they were better equipped with information and knowledge to be able to support people appropriately. Some agency staff had also successfully applied for permanent posts.

The management team told us they were using a range of methods to improve staff retention of permanent staff. For instance, the induction training that new staff received had been improved to help prepare them for their role, the pay and conditions improved and more support was available for staff, for instance, through the employment of workplace mentors.

At this inspection we received feedback from people's relatives and visiting health and social care professionals, which indicated that the service had made improvements. For instance, work had been done

to make sure stable, consistent core teams were built up to support people who used the service, and in most cases, core team members had been assigned to people.

Several people's relatives said that where people had new members of staff in their core teams, they were consistently part of the core team and people were getting used to their new staff. One person's relative said they were aware that a lot of work had been done to improve the staff interview and selection process, the staff induction training and staff retention, with positive results for people who used the service.

All the staff we spoke with at the time of the inspection said staffing had improved at the service, although agency staff were still being used. This improvement was due to regular agency staff being booked and some agency staff becoming permanent care workers at the service. One support worker said they had one staff vacancy in the core team they worked in, and added that they felt this had not had a detrimental effect on the way care and support had been delivered. However, we received some anonymous comments soon after our inspection to say that there was still disruption to some people's service, due to lack of staff available to cover absences and the need to use agency staff.

Records and staff comments indicated that a satisfactory recruitment and selection process was in place. The six staff personnel files we checked included all the essential pre-employment checks required. This included at least two written references and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. We spoke with two recently recruited workers who described their recruitment and told us they had not been allowed to start working with people until all their checks had been completed.

Policies and procedures were available regarding keeping people safe from abuse and reporting any incidents appropriately. The registered manager was aware of the local authority's safeguarding adult's procedures, which aimed to make sure incidents were reported and investigated appropriately. They understood their responsibilities in promptly reporting concerns and taking action to keep people safe. We saw there was a paper file, which contained all the notifications sent to CQC and Doncaster Council, as well as a computerised spreadsheet, which contained a detailed log of all safeguarding concerns reported and the outcomes. The service has also provided CQC with regular updates on the outcomes of safeguarding concerns.

Staff we spoke with could identify the types and signs of abuse, as well as knowing what to do if they had any concerns. They told us they had received yearly training in this subject to keep their knowledge up to date. This was confirmed in the training records we saw. Staff also told us there was a whistleblowing policy available, which told staff how they could report concerns. One staff member told us they had successfully used the whistleblowing policy in the past.

Feedback from other professionals was that there were areas within the village where people gathered, which could be a source of anxiety for some people and resulted in incidents. Messages were given to care managers by senior managers about these concerns, but the same themes and mistakes continued. We discussed the way people were supported to mix in communal areas. We were told that after any incidents debriefing sessions were held, lessons were learned and alterations made to people's risk management plans to decrease the likelihood of incidents being repeated. For instance, people were allocated time slots and this was coordinated so that people who had not previously got on could avoid spending too much time together.

We spent time observing the support provided to people at the bistro, and saw that people were supported

appropriately. The records we saw indicated that people's care and support was delivered in a way that promoted their safety and welfare. The four care files we looked at showed records were in place to monitor any specific areas where people were more at risk, and explained what action staff needed to take to protect them. These had been reviewed appropriately.

All the staff we spoke with demonstrated a good understanding of people's needs and how to keep them safe. They discussed how areas of risk were assessed and planned for and told us how they encouraged people to be as independent as they could be, while monitoring their safety.

Staff said they had completed training on how to manage behaviour that may challenge others and described how they had put this into use. One staff member told us, "We do a lot of training in this area and it is updated regularly. We often use redirection techniques such as an activity to take [the person's] mind off what is upsetting them and we remove anything that will trigger events."

Staff told us they rarely had to restrain anyone, but said they had undertaken training in minimal intervention techniques, which they found very useful. One staff member told us about one person who they had needed to restrain in the past. They said, "It is in their care plan, but now they have a regular core team working with them incidents of restraint are rare."

Another staff member described how if someone might need to be physically restrained, a care plan and risk assessment would be put in place to provide detailed guidance for staff. They said sometimes in an emergency, staff may have to restrain someone without a plan being in place. They said if this happened an incident report would be completed and a plan would be put in place as soon as possible.

One staff member told us that the provider took people's safety seriously and made adjustments to help ensure this. They described the actions taken to move someone using the service to single accommodation premises within a short period of time, so that other people using the service were kept safe. Another staff member said that although they are they worked in was safe they felt other areas could be more challenging. They gave an example of staff being hurt on occasions but said, "I definitely feel safe and supported."

One staff member we spoke with at the time of the inspection had been subject to injury as a result of an incident. They said they had been supported well after the incident, and that the members of the management team had listened, been responsive and provided the resources they said were necessary to help them get back to work confidently.

We looked at medication administration systems and records in Lockett Gardens, as we had identified concerns at the last inspection in November 2015. We found that improvements had been made and people were receiving their medication safely and as prescribed. People's files included information about the medication they were taking. We saw 'How I take my medication' forms, which included information about how best to support each person to take their medication. Staff told us they had received training in the safe administration of medication.

One team leader described the process followed should someone needed to receive their medication covertly [disguised in food or drink]. They explained how the person's capacity to make decisions was assessed and a best interest meeting held to look at all the options available. They said all discussions would be documented and included in the person's care plan.

Another member of staff told us PRN protocols were in place in medication files. They said these covered

what staff should see and when to give the medication. They added that if they administered any PRN medicines this would be reported to the manager on duty.

Staff we spoke with confirmed that the service had a medication policy which outlined the safe storage and handling of medicines. The care manager for Lockett Gardens described the process and showed us how the system worked. We saw there was a system in place to record all medicines going into and out of the service. This included a safe way of disposing medication no longer needed. Medication administration records [MAR] we saw had been completed appropriately with no gaps. Where medication had not been given the reason was recorded on the back of the MAR.

There was an audit system in place to make sure staff had followed the home's medication procedure. We were shown stock sheets that we were completed at the start of each four week cycle to determine the amount of medicines in stock and that the correct amount had been received from the pharmacy. The records we saw had been completed appropriately.

We also looked at the record kept by the provider of medication errors. The summary of the 'medication errors' file identified that 24 errors had been reported over a four month period in 2016. These were mainly with regards to staff not completing medication records correctly. We saw more serious errors had been appropriately reported to DMBC safeguarding team. In all cases appropriate action had been taken. For instance, staff had received additional training or supervision sessions. We did see that in some cases, the monitoring forms had not been fully completed and signed off by the care managers. This was discussed with the manager, so that any gaps could be addressed.

We spoke with one of the two practise leads employed by the service, both of whom were qualified nurses. They described how they met on a monthly basis to discuss the development of an infection control management pack for the service. From this they had developed an 'outbreak pack' which provided information about what to do if there was a suspected outbreak of an infectious disease. They said they also carried out workshops for staff, which included correct hand washing procedures.

Good

Is the service effective?

Our findings

Staff described how they ensured people ate nutritious and healthy meals that met their needs. Care files included information about people's nutritional needs, their likes and dislikes. They told us each person had an individual diet and nutritional plan to ensure their needs were met. Staff said set menus were usually planned, which included foods the person liked and journals were used to record exactly what the person had eaten. They told us people had good choices of meals.

We spent time observing people using the bistro at lunchtime. During our observations we saw staff listened to what people wanted and took time to make sure their needs and preferences were met. We saw some people collected pre-ordered meals and took them to their own house to eat them, while other people sat in the bistro to eat, supported by staff. Staff told us some people also shopped for and cooked their own meals with staff support.

Staff said a doctor held a clinic at the service each week so people could visit them with regards to health issues. People also had access to a variety of other health care services, as needed. Staff said key information about changes in people's health needs and wellbeing were discussed at a verbal handover between shifts. They said there was also a handover book used as well as emails between key staff and managers and this helped to make sure any health related needs were responded to in a timely way.

We spoke with one of the two practice leads who were employed by the provider and who came from a nursing background. They told us they were liaising with surgeries and district nurses regarding taking blood samples from people who were particularly nervous. They said this had produced good results with people who had always had a problem having blood tests to happily having blood samples taken.

They also told us that they were liaising with the local accident and emergency department [A & E] with regards providing people with a better experience when they visited the department. This had included each person having a rucksack containing information about them. For instance, what was likely to happen if they were admitted and their hospital passport [information about the person's personal details and medical history] This also included the use of 'pain symbols' used in the A & E, on a key ring. The practice lead said they had met with the A & E coordinator and nurse to look at using a bleep system to tell them someone was being transported to the hospital and if they were anxious, so they could make sure the person's arrival and treatment was given in the best way possible.

Relatives we spoke with felt the staff were very good, understood their relative's needs, and that the previous lack of consistency with staff supporting people was being effectively addressed by the provider. The staff we spoke with were very knowledgeable about the needs of the people they supported. From our observations it was clear staff responded appropriately to people and communicated effectively.

A team leader told us that new staff completed a thorough induction, which included three weeks of 'classroom' training. They said this was followed by shadowing the team leader or experienced support worker until they had completed the care certificate booklet and were assessed as competent to work

alone. The Care Certificate is a nationally recognised programme of training for care workers.

Staff told us initial training included topics such as; health and safety, food hygiene, manual handling people safely, Mental Capacity Act and first aid. They also said they had completed HELP training, which they described as 'learning about technique's to use to manage certain behaviours people may exhibit.' They said regular refresher training in these subjects was completed.

Most staff were positive about the range of training opportunities available to them. One member of staff said to us, "The training is very good, I need to train to keep up my registration, I have only been here a couple of months and have already more than doubled what is expected in training for this year." Staff stated that the service was now concentrating on 'a more person centred approach to training'.

At this inspection we found that overall, the provider had continued to improve the training provided to staff. However, managers and members of the clinical acknowledge that there was still room to improve, and that this would contribute to improving staff retention. Members of support staff we spoke with said good work continued in this area.

Staff we spoke with told us they felt supported in their job. They said they received regular support sessions and each member of staff received an annual appraisal of their work performance. A team leader said they found supervision sessions "Valuable" and felt it was, "A good time to talk and get things off your chest." They also said, "I find it rewarding doing supervision with staff in my team and seeing how they progress." A support worker commented, "I like the one to one interaction [of supervision sessions]."

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). The DoLS requires providers to submit applications to a 'Supervisory Body' for authority to do so.

The care files we saw showed that people had given consent to their care, and where people did not have the capacity to consent the requirements of the Mental Capacity Act had been followed. Care staff we spoke with had a general awareness of the Mental Capacity Act 2005. They told us they had received training in this subject during their induction to help them understand how to protect people's rights and this was confirmed in the records we checked.

Senior staff understood their responsibilities under the Mental Capacity Act 2005 and were aware of the Deprivation of Liberty Safeguards. We found that the necessary consideration and consultation had taken place. Approximately 95% of the people that used the service were affected by Deprivation of Liberty Safeguards. We looked at the DoLS information for twelve of the people that used the service. These were all up to date and had been regularly reviewed to assess their need and effectiveness. The assessments were mostly made in terms of the use of support for people whose physical and mental capacity conditions prevented them from providing informed consent. This included going out in the community, medication and interactions with other people.

Staff we spoke with stated that they all worked together in the best interests of the people that used the service. The psychology department are, in future, planning to become part of the pre-admission assessment team, this would help to make sure that the person being assessed would have received a more comprehensive assessment of their needs before they are offered a place at the service.

Most of the people that used the service had a diagnosis of diagnosis of learning disability and autistic spectrum disorder. A small number also had mental health issues. A psychiatrist visited the service every week to speak to individuals that required their support, to liaise with the staff group and help to support care plans and risk assessments. The people that used the service also had access to other health and social care professionals. A specialist healthcare team supported some people when they had health requirements and this had proved to be less challenging for them and was more supportive of their individual needs.

Good

Is the service caring?

Our findings

We saw staff supported people in a caring and responsive manner while assisting them to go about their daily lives and take part in social activities. We saw staff were consistently allocated to the person they were supporting, so were available to provide hands on care and support as required.

The staff we spoke with demonstrated a good knowledge of the people they supported, their care needs and their wishes. People were given choice about where and how they spent their time. We saw staff enabled people to be as independent as possible while providing support and assistance where required. Staff we spoke with gave clear examples of how they would offer people choice and respect their privacy and dignity. Staff comments included: "I treat everyone as an equal." and "We use to take one person to church even though they weren't a regular churchgoer, as they liked to go at Easter and Christmas."

A support worker gave an example of how two people living at the service had become friends while going food shopping and now they took it in turns to cook meals and eat with one another, building a good relationship between them.

Staff told us they offered people choice in things like what they ate, what they wear, what activities they wanted to participate in, and how they spent their day. One staff member told us, "For example, if someone can't tell me verbally I would show them two outfits and ask which they prefer to wear. You can also use pictures and symbols to help people choose or just offer them a choice, such as which one they want to drink."

Staff discussed closing doors and blinds, wrapping people up when they are moving from bathrooms to bedrooms and preserving their dignity if they try to remove their clothes in public.

We saw an independent advocacy service was based at the service several days a week, so people had good access to advocacy when needed. Advocates can represent the views of people who are unable to express their wishes.

We observed positive relationships between staff and people they supported that were based upon mutual respect. We also observed that people's privacy and dignity was considered and respected by the staff team.

We also spoke to relatives on the phone to gain their views. Most said staff were caring, well trained and worked hard to give people good life experiences. For instance, one relative said they were very happy with all aspects of the service, including the way that staff cared for their family member. They said the staff were, "Very caring", and were "Working hard to get [my family member] out into the community despite the challenges to this. They are going swimming next week." Another relative said the staff were, "Brilliant" and they considered their family member and themselves very lucky to have found the service. Another relative said the service to their family member had been, "Excellent and Exemplary", that they were Highly delighted with the care their family member has received in over the 10 years that they had lived at Hesley Village and that staff had a real vocation for the job.

One person's relative told us there was still some disruption to their family member's service, due to staff turnover, but this was improving. One social care professional said, "The staff on the ground listen and try their best."

Good

Is the service responsive?

Our findings

During our visit we observed staff providing care and support to people who used the service. We observed this was personalised and responsive to their needs. Relatives we spoke with told us most staff responded appropriately to people's needs.

Staff told us the service offered a wide range of social and learning activities within the Hesley Village. The site included a bistro, beauty and hair salons, a supermarket, a post office, a bank, cinema, bar and a 'village hall', where communal activities took place. There was a 'field study centre' and horticulture area, where people could go fishing, garden or grow vegetables. Staff also told us about a vocational centre which included a training kitchen and a music room. On site dances and discos are also held.

We saw there was a wide choice of activities people were involved in, this included days out with their allocated staff member or in small groups. Records and staff's comments showed they had participated in activities in the local community. Staff said activities people had taken part in included, attending football matches, playing football, trips to the park, trampoline, shopping for food or generally, trips to the coast, swimming, bowling, arts and crafts, use of the sensory room and music room. We also saw that some people were involved in cleaning their accommodation and cooking their meals.
While walking to the bistro we heard the choir rehearsing for a planned concert. The deputy manager told us a people also took part in a 'signing choir'.

One team leader described how a team of people went out to assess prospective service users. They said this usually included the care manager, SALT and other health and social care professionals. They said discussions were then held with the team leaders to assess if the person would fit into the available vacancy. They confirmed the management team had responded positively to their comments.

Relatives told us they were able to visit anytime unannounced. There were overnight rooms available for use by relatives who lived a long way from Hesley Village, this meant they could come and visit and not have to travel back the same day.

Care records we looked at showed that needs assessments had been carried out before people moved into the service and the person and their relatives had been part of that assessment. Staff told us that care managers completed initial assessments and information was gathered from families and the person's last placement. Multidisciplinary meetings were also held involving all grades of staff and the professionals involved in the person's care.

Each person had two care files, one that contained care plans and risk assessments, and a second file about their health care needs. In both files we found there was repetition, which made it difficult to find information quickly. We were told there was a project in progress to make people's written information easier for staff to access.

The files we checked contained in-depth information about the areas the person needed support with and

risks associated with their care. We found where intervention by staff was needed, a support plan was in place, along with details about how staff could minimise any identified risks. Care plans and risk assessments had been reviewed and evaluated.

Care files included information about people's preferences, and about what was important to them. There was 'pen picture' information, to tell staff about the person, their main needs and their preferred routines, although this was not always at the beginning of the file. This meant that new staff and agency staff did not have easy access to information they needed to know about straightaway.

We saw a journal was completed daily by staff which outlined which staff had supported the person over a 24 hour period and how the person had spent their day.

The service had a clinical team including psychology and speech and language departments. Each morning the service had a meeting and this was attended by members of the clinical team. This helped to ensure that the staff team were working closely together and all understood the individual needs of the people they were supporting.

The provider had a complaints procedure which was available to person who lived and visited the service. We saw that since our last inspection the improvements had been made to how concerns were recorded so there was robust documentation of all concerns received and the outcome. For example we saw the complaints file had a log which showed that 13 complaints had been received in 2016. We looked at the progress of two of the complaints we were aware of and found they had been investigated, and the complainant had received a letter outlining the outcome of their concern. In one case we saw that where the complainant was not happy with the outcome, and a further meeting had been arranged to further try to address their concerns.

A team leader told us how lessons were learned from complaints. They said meetings were held with the core staff involved, to look at what could be done to work round concerns.

Good

Is the service well-led?

Our findings

At the time of our inspection the service had a manager in post who was registered with the Care Quality Commission. The people we spoke with said they were happy with the overall care provided and how the service was run. Throughout the visit it was noted that the registered manager had a better overview of how the service was operating than at the last inspection.

Following concerns highlighted at the last inspection we found improvements had been made to how the quality and safety of the service was monitored. We saw effective systems were now in place, with any shortfalls or issues of concern being identified and followed up in a timely manner.

The registered manager showed us a new compliance system, which had been strengthened to help them monitor the service to each person using the service and the members of the core team who supported them. Actions plans were included in the system. The registered manager told us that other information was to be included as the system was developed, such as team meeting minutes, so that all information would be more accessible to those who needed it.

The registered manager said other audits included care files, medication and infection control. We looked at some of these audits and found appropriate action had been taken in a timely manner to address any shortfalls highlighted. Staff we spoke with confirmed regular audits took place for topics such as medication and care plans. We also saw that there was an operations director, who carried out a three monthly audit looking at topics such as finance, recruitment, staffing and staff turnover.

One of the practice leads said care managers carried out infection control audits for each house, which was then shared with the registered manager. They described how they then offered staff advice about how to address issues. They also said they were currently auditing every person's care file to make sure they contained all the required information, and that all out of date information was archived. They said this would make sure staff had easier access to the information they needed.

Following the last inspection the registered manager said they had set up small meetings where they and the operations director met with as many staff as possible, to get their opinion of how the home was operating and any concerns. They said this had brought about improvements. For instance, staff told them that they did not always know which managers were on call. Therefore, a list was made available in each area, so all staff had easier access to this information.

Staff spoke in a positive manner about the registered manager and deputy manager. One staff member told us, "It seems okay now. There have been a lot of changes. It's better since the new manager came, it's more organised so we know we have certain things we have to do, but they are approachable." Another staff member commented, "Its good [the management of the home]. I get on with them all. I know I can go and talk to them." A support worker said, "It couldn't be much better, they are approachable." However, one support worker told us, "I would like more thanks for what we do, such as coming in on our days off to do trips. Not all the time, just some of the time."

When we asked staff if they felt there was anything the service could do better two staff members said they could not think of anything they would like to change. However, one staff member spoke about retaining staff, while another said they would like to see more one to one activities taking place for some people who used the service.

Staff told us, and minutes of meetings demonstrated that staff meetings took place and at the time of our visit we saw a staff survey was being used to gain their opinions. This was completed online with a box being placed in reception for staff to drop their completed forms in.

An analysis of accidents and incidents had been carried out on a monthly basis. There was a health and safety committee which held periodic meetings. Due to the difficulties faced by people who used the service, there were risks that staff, or other people who used the service could be injured. The registered manager told us of a range of ways to support people that have suffered an assault at the service and the staff we spoke with said the management team were responsive and supportive when incidents had taken place.

We were told the service was actively involved in external groups, such as the Autism show being held in London the day after the inspection, as well as various conferences. The registered manager said members of the training department also delivered external training to other providers, professional groups, and parents.

We found morning meetings took place on week days which involved the management team and other key staff such as care managers, practice leads, psychologists, speech and language therapist and occupational therapist. The registered manager told us this helped the team to stay up to date with what was happening in the service.

The registered manager told us that to make sure staff had regular contact with the care managers they visited each house to speak to staff and sign the care journals. They said this was checked by the senior management team, to ensure all documents were signed. The registered manager said that Thursday mornings were 'protected time' so they could go around the service and chat with people, as well as checking the properties. They said they also had an 'open door' policy, so staff could speak with them whenever they wanted to.

The SALT had organised 'people's choice' meetings where people met to discuss choices and ideas. This was regularly attended by around 12 people who use the service. There was also quarterly family forum that took place, which was led by relatives. Minutes were brief, as they were produced by the relatives, but showed they openly shared their opinions on how the service operated and improvements that could be made.

Stakeholder surveys were conducted annually and the last one was in November 2015. A parents' forum and surveys were also used to gain people's opinion of the service.

The clinicians we spoke with told us the service continued to make improvements, including an improved assessment processes. The executive team had a clear action plan and continued to creatively address the issues of staffing, staff support and retention, and recruitment.