# Insight Specialist Behavioural Service Ltd

# Insight Walderslade

## Inspection report

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Tel: 01634869273

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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 was carried out on 5 May 2017 and was announced.

The home provides care and support for up to six people with learning disabilities and/or autism. Some were at higher risk of presenting challenging behaviours which may harm themselves or others. However, staff had the skills and training to support people to participate as equals in their community, living within an ordinary home. At the time of our inspection there were six people living at the home. The accommodation was split over two floors with bedrooms on the ground floor and first floor.

A registered manager was employed at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. Restrictions imposed on people were only considered after their ability to make individual decisions had been assessed as required under the Mental Capacity Act (2005) Code of Practice. The manager understood when an application should be made. Decisions people made about their care or medical treatment were dealt with lawfully and fully recorded.

The provider's operational policy about planning for emergencies was not specific to the home. It was generic and did not ensure that managers and staff in the home would understand how to continue people's care, should the home be evacuated in an emergency. We have made a recommendation about this.

Incidents and accidents were recorded and checked by the registered manager and the provider's to see what steps could be taken to prevent these happening again. Staff were trained about the safe management of people with behaviours that may harm themselves or others. However, reportable incidents had not been appropriately reported. We have made a recommendation about this.

People were kept safe by staff who understood their responsibilities to protect people living with learning disabilities and autism. Each person had a key worker who assisted them to learn about safety issues such as how to evacuate the building in an emergency and to speak to if they felt unsafe. The registered manager had plans in place to ensure that people who may not understand what to do would be individually supported by a member of staff if there was an emergency. Staff had received training about protecting people from abuse. The management team had access to and understood the safeguarding policies of the local authority and followed the safeguarding processes.

The manager and care staff used their experience and knowledge of caring for people with learning disabilities and complex needs effectively. Staff assessed people as individuals so that they understood how

they planned people's care to maintain their safety, health and wellbeing. Risks were assessed within the home, both to individual people and for the wider risk from the environment. Staff understood the steps to be taken to minimise risk when they were identified. The provider's policies and management plans were implemented by staff to protect people from harm.

There were policies and procedures in place for the safe administration of medicines. Staff followed these policies and had been trained to administer medicines safely. Where people could retain the information, they had been supported to understand what their medicines were for and when they needed to take them. This was reinforced by staff who administered medicines.

People had access to GPs and their health and wellbeing was supported by prompt referrals and access to medical care if they became unwell. Good quality records were kept to assist people to monitor and maintain their health. Staff had been trained to assist people to manage the daily health challenges they faced from conditions such as epilepsy and diabetes. People had been supported to understand their health conditions and had been given information to help them manage their own health and wellbeing.

We observed and people described a home that was welcoming and friendly. Staff provided friendly compassionate care and support. People were encouraged to get involved in how their care was planned and delivered. Staff were deployed to enable people to participate in community life, both within the home and in the wider community.

Staff upheld people's right to choose who was involved in their care and people's right to do things for themselves was respected. We observed people being consulted about their care and staff being flexible to request made by people to change routines and activities at short notice.

The manager involved people in planning their care by assessing their needs when they first moved in and then by asking people if they were happy with the care they received. Staff knew people well and people had been asked about who they were and about their life experiences. People could involve relatives or others who were important to them when they chose the care they wanted. This helped staff deliver care to people as individuals.

Recruitment policies were in place. Safe recruitment practices had been followed before staff started working at the home. The manager recruited staff with relevant experience and the right attitude to work well with people who had learning disabilities and autism. New staff and existing staff were given extensive induction and on-going training which included information specific to learning disability services.

Staff received supervisions and training to assist them to deliver a good quality service and to further develop their skills. Staff had specialised, on-going training about managing behaviours and physical interventions to protect themselves and others from harm. Staffing levels were kept under constant review as people's needs changed. The manager ensured that they employed enough staff to meet people's assessed needs.

Staff understood the challenges people faced and supported people to maintain their health by ensuring people had enough to eat and drink. People were supported to make healthy lifestyle choices around eating and drinking.

The manager produced information about how to complain in formats to help those with poor communication skills to understand how to complain. This included people being asked frequently if they were unhappy about anything in the home. If people complained, they were listened to and the registered

manager made changes or suggested solutions that people were happy with. The actions taken were fed back to people.

The registered manager and the deputy manager had demonstrated a desire to deliver a good quality service to people by constantly listening to people and improving how the service was delivered. People and staff felt that the home was well led. They told us that managers were approachable and listened to their views. The registered manager of the home and other senior managers provided good leadership. The provider and registered manager developed business plans to improve 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.

People's risks assessments were relevant to their current needs, but emergency plans needed to be in place.

The process for reporting incidents to external bodies needed to be clearer.

The registered manager and staff were committed to preventing abuse.

Medicines were administered by competent staff.

Recruitment processes for new staff were robust.

### Is the service effective?

**Good**

The service was effective.

People were cared for by staff who knew their needs well.

Staff met with their managers to discuss their work performance and staff had attained the skills they required to carry out their role.

The registered manager and staff had completed training in respect of the Mental Capacity Act 2005 and understood their responsibilities under the Act.

Staff understood their responsibly to help people maintain their health and wellbeing.

### Is the service caring?

**Good**

The service was caring.

People could forge good relationships with staff so that they were comfortable and felt well treated. People were treated as individuals, able to make choices about their care.

People had been involved in planning their care and their views

were taken into account. If people wanted to, they could involve others in their care planning such as their relatives.

People experienced care from staff who respected their privacy and dignity.

## Is the service responsive?

Good

The service was responsive.

People were provided with care when they needed it based on assessments and the development of a care plan about them.

Information about people was updated often and with their involvement so that staff only provided care that was up to date.

People were consistently asked what they thought of the care provided and had been encouraged to raise any issues they were unhappy about.

## Is the service well-led?

Good

The service was well led.

The home had benefited from consistent and stable management so that systems were effective.

Development plans included more services to assist people to gain more skills and independence.

Staff were informed and enthusiastic about delivering person centred care.

There were clear structures in place to monitor and review the risks.

# Insight Walderslade

**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 5 May 2017 and was announced. We gave short notice of the inspection so that people may be less anxious by our presence in their home. The inspection team consisted of one inspector.

Prior to the inspection we also looked at previous inspection reports and notifications about important events that had taken place at the service. A notification is information about important events which the home is required to send us by law.

We spoke with two people about their experience of the home. We spoke with four staff including the registered manager, deputy manager and two support workers. We observed the care provided. We asked the local authority contracts team for their views about the home.

We spent time looking at general records, policies and procedures, complaint and incident and accident monitoring systems. We looked at two people's care files, three staff record files, the staff training programme, the staff rota and medicine records.

At the previous inspection on 25 May 2015, the home had met the standards of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

# Is the service safe?

## Our findings

Some people in the home could speak to us about their experiences. Other people were less able or had less confidence to express their views directly to us. However, people communicated with us, either by us observing how they responded to staff when care was delivered or by talking to us about things that were important to them. People could go to staff who would listen to them if they were unhappy about something. People told us they felt safe.

One person was proud of their bedroom and they were happy to show us and tell us about the things that they liked. They told us that the staff treated them well and that they were happy living in their home.

Relatives commented. 'The staff are very much in tune with my son and his needs.' And, 'This is the very best care.'

The registered manager had carried out assessments to identify and address any risks posed to people by the environment. These had included fire risk assessments and the checking of portable electrical equipment. The provider also had a 'business continuity' policy in case of an emergency, which included information of the arrangements that had been made disruption to staffing levels during periods of severe weather. However, the policy did not state how safe care would continue for people in the event of a major incident in the home such as fire, flood, loss of all power or water supply. We discussed this with the registered manager and they told us that all of the people in the home could evacuate in emergencies. They were not clear about what would happen next if it was not safe for people to re-enter the home. The providers policy and local arrangements did not enable staff to respond and manage major incidents and emergency situations.

We recommended that the registered manager seeks advice and guidance from a specialist in relation the levels of information their emergency policies should contain and how this should be presented in the home.

Staff were made aware of the identified risks for each person and how these should be managed by a variety of means. These included looking at people's risk assessments, their daily records and by talking about people's experiences, moods and behaviours at shift handovers. Staff signed care plans and risks assessments to acknowledge they understood them. Records detailed the information shared between staff about risks within the service. Incidents and accidents were recorded and checked by the manager for any learning. Steps were taken to reduce incidents and accidents from happening again. We saw that people's health and safety had been discussed at team meetings to inform and reinforce staff knowledge of the steps that were to be taken to minimise the risk after incidents.

There was a confused picture when it came to discussions with managers in the home about reporting incidents that affected the health, safety and welfare of people. Incidents of challenging behaviour had been discussed with people's care managers and a decision was made during these discussions about whether the incident should be referred as a safeguarding incident. These discussions with care managers meant

that the registered manager had not always considered if the incidents were still notifiable to the Care Quality Commission (CQC). For example, records showed that there had been a recent incident where the police had been involved and also incidents of verbal aggression by one person that had affected other people.

We recommended that the registered manager seeks guidance about the appropriate reporting of incidents to external bodies.

People were protected from the risk of receiving care from unsuitable staff. Staff had been through an interview and selection process. The manager followed a policy, which addressed all of the things they needed to consider when recruiting a new employee. Applicants for jobs had completed applications and been interviewed for roles within the service. New staff could not be offered positions unless they had proof of identity, written references, and confirmation of previous training and qualifications. All new staff had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with people who needed safeguarding.

Recruitment files for staff evidenced that before staff started working at the home robust recruitment procedures took place. Relevant checks had been completed to ensure that the applicant was suitable for the role to which they had been appointed before they had started work. Staff we spoke with confirmed they had been through full application, interview and selection process.

There was enough skilled and experienced staff to meet people's needs. The registered manager had to ensure that the staff had the correct skills, training and experience. We looked at the rotas and saw that staff were deployed in line with people's choices around activities and in response to challenging behaviours. Staffing levels were increased when people needed additional staff assistance or monitoring to keep them and others safe. For example, in some situations two staff supported one person when in the community.

People had practiced evacuating the service, for example when the fire alarm sounded. Emergency drills and tests were recorded. People had an personal emergency evacuation plan written to meet their needs. Staff and people living in the home received training in how to respond to emergencies. The registered manager had an out of hours on call system, which enabled serious incidents affecting peoples care to be dealt with at any time. Staff understood people's individual communication styles, like body language or behavioural changes which may indicate people were unhappy or distressed.

There was a current safeguarding policy, and information about safeguarding. Staff told us that they had received training on safeguarding procedures and were able to explain these to us, as well as describe the types of concerns they would report. This training was also recorded on the staff training plan. Staff were also aware of reporting to safeguarding teams and raising concerns using the provider's whistle-blowers' policy. Staff talked us through the correct actions they would take if they suspected or witnessed abuse happening.

There were personalised risk assessments and behaviour intervention plans in place for each person who used the home. The actions that staff should take to reduce the risk of harm to people were included in the detailed care plans. Positive behaviour care plans were in place for people and used to identify triggers for behaviours that had a negative impact on themselves or others or put others at risk. The steps and early interventions staff should take to defuse these situations and keep people safe was fully recorded. Staff understood their roles in assisting people to understand and manage their behaviours. Risk assessments were reviewed regularly to ensure that the level of risk to people was still appropriate for them. Records

evidenced staff implementing their skills to manage verbal and physical aggression safely.

There were safe processes in place for the management and administration of people's medicines. The current medicines policy available for staff to refer to should the need arise. Access to medicines was restricted to trained staff, but people had been given information about what medicines were for and when they should be taken. People had been assessed individually about their abilities to understand information about medicines. We reviewed the records relating to how people's medicines were managed and they had been completed properly. Medicines were stored securely and audits were in place to ensure medicines were in date and stored according to the manufacturers guidelines. The registered manager ensured that regular audits of medicines happened and that all medicines were accounted for. Staff were encouraged to report errors in a supportive way. These processes helped to ensure that medicine errors were minimised, and that people received their medicines safely as prescribed and at the right time.

Good

# Is the service effective?

## Our findings

Some people in the home could speak to us about their experiences. Other people were less able or had less confidence to express their views directly to us. However, people communicated with us, either by us observing how they responded to staff when care was delivered or by talking to us about things that were important to them. Staff had the skills required to care and support the people who lived at the service. All of the people we spoke with told us they liked the staff and they got on with them.

People were supported with their agreed and recorded daily routines by staff. People's health needs were monitored by staff and comprehensive information was provided about people's conditions. For example, people with epilepsy had treatment guidelines in place which staff knew how to follow.

People were assisted to access other healthcare services to maintain their health and well-being, if needed. People told us about going to the GP and getting help from other health and social care professionals like dieticians. Records confirmed that people had been seen by a variety of healthcare professionals, including a GP, nurse and dentist. Referrals had also been made to other healthcare professionals, such as psychiatrists and the relevant learning disability team.

People we spoke to about the food were happy with the choices they got. People said, "I like the food and can get involved in cooking." And, "I get support from staff to cook and make my own drinks." People had choices about the menus and could change their minds about what they ate and drank. The way eating and drinking was managed enabled independence and worked well for people.

There was lots of flexibility for people around eating, drinking and meals. People had access to their kitchen and could make drinks and chosen foods independently or with support. This helped people maintain their independence and created a person centred culture around meals. People had been asked for their likes and dislikes in respect of food and drink. Staff supported people to avoid foods that contained known allergens people needed to avoid. Food preparation areas were well presented and clean. They were accessible to people at any time. Members of staff were made aware of people's dietary needs and food intolerances.

Staff told us that there was a training programme in place and that they had the training they required for their roles. This included specialised training to a recognised national standard in the management of challenging behaviours. It was clear that new and existing staff had a good level of skill and training to manage people with challenging behaviours. Staff told us, "The training is run effectively so that we get updates." And, "The training and induction we get has given me the confidence to support people well." Records demonstrated staff had used safe distraction techniques. Staff understood how and when to escalate their interventions if needed and which ensured that everyone was kept safe. Staff learning was provided in a number of ways, including by e-learning, distance learning courses and face to face training and this was supported by records we checked. Additional training was provided in relation to person centred care planning and its delivery for people with learning disabilities, autism and epilepsy.

Staff also told us that they received supervision and felt supported in their roles. As soon as new staff started working at the home they began training and induction. New staff had to meet competency standards within the providers performance and behaviours policies to progress from their probationary period. Staff received additional training and support to achieve the standards if needed. Supervision meetings with staff were held with senior members of staff and showed that staff had an annual appraisal. Supervision and appraisal assisted staff to maintain, improve and develop their work practice and skills to benefit people in the home. Staff said, "I have just had my appraisal, we discuss any training we need to help us develop." Staff also had meetings during their probationary period to discuss their progress and any developmental needs required. This meant that staff were supported to enable them to provide care to a good standard.

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.

There was good communication between staff and people living at the home, staff were friendly and caring. Best interest meetings about important decisions were recorded. People with changing capacity to make day-to-day decisions about their care were still offered choice and provided with information to help them decide what they wanted to do.

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. Care plans for people who lacked capacity, showed that decisions had been made in their best interests. For example, some people had been supported in making best interest decisions about DoLS by an independent mental capacity advocate (IMCA). IMCA's are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. These decisions included the use of physical interventions, and showed that other relevant people, such as GP's, Community Mental Health Nurses and people's relatives had been involved.

The registered manager understood when an application should be made and how to submit them. Care plan records demonstrated DoLS applications had been made to the local authority supervisory body in line with agreed processes. This ensured that people were not unlawfully restricted.

Good

# Is the service caring?

## Our findings

Some people in the home could speak to us about their experiences. Other people were less able or had less confidence to express their views directly to us. However, people communicated with us, either by us observing how they responded to staff when care was delivered or by talking to us about things that were important to them. People were positive about staff and living at Insight.

Positive relationships had developed between people who used the service and the staff. People stated that the staff were kind and helpful and were approachable to ask for help and assistance. One person said, "I like my room, I've got the things I like in it, the staff are nice and caring." Another said, "I can do the things I like and can move around freely."

Relatives commented, 'Insight provides good care'. And, 'My sons care is excellent, we are lucky he is placed here.'

The staff we spoke with were aware of what was important to people and were knowledgeable about their preferences, hobbies and interests. They had been able to gain information on these from the 'Person centred care plans', which had been developed through talking with people and their relatives. This information enabled staff to provide care in a way that was appropriate to the person.

The rooms within the service were personalised to a high degree to people's choice and lifestyle. This was a positive aspect of the service during the inspection. We saw examples of how people had negotiated things like the décor. Staff had been mindful and respectful of people's dignity and self-expression and managing the complexity of people's needs. Staff were able to describe ways in which people's dignity was preserved, such as making sure people's doors were closed when they provided care. Staff explained that all information held about the people who lived at the service was confidential and would not be discussed to protect people's privacy.

People were encouraged to be as independent as possible. There was one staff member who had allocated time to support a person using the service to facilitate their development and community participation. People gave us examples of things they liked to do, for example going to clubs or making drinks. Records showed that people were supported to maintain family relationships. People often went out into their local community and the people we spoke with expressed how important this was for them.

People and their relatives were asked for feedback about the service. People set their own care goals. Decisions about household routines were taken collectively by people at their house meetings or at one to one time meetings. There were a number of information leaflets on the notice boards around the home which included information about the service, safeguarding, the complaints policy and activities. These had been provided in accessible formats.

Good

# Is the service responsive?

## Our findings

Some people in the home could speak to us about their experiences. Other people were less able or had less confidence to express their views directly to us. However, people communicated with us, either by us observing how they responded to staff when care was delivered or by talking to us about things that were important to them. People were encouraged to discuss issues they may have about their care.

People told us that staff were responsive to their choice and individual expression and how people could access community activities which were personalised to their interests. One person spoke to us about how they liked the colour of their bedroom, [which they had chosen] after it had been repainted.

Staff were responsive and flexible to people's choices and needs. People were encouraged to participate in activities such as weight loss groups, theatre trips and attending local events. There was evidenced with gender sensitive staffing being offered for assisting with personal care. Positive behaviour support plans encouraged participation in the wider community.

People spoke to us about how they had discussed areas with staff about access to community activities and the personalisation of their rooms. We observed that people's choice of individuality was respected. For example, if people had chosen themed décor for their bedroom this was respected. People were either getting ready to out or were supported to go a participate in their chosen activities. Activities included learning such as developing social skills and involvement in household tasks. People could change their minds and told us they did not have to do their chosen activity. Other people had a routine for one to one staff support in the community. This included participating in leisure activities, going to the pub for lunch and personal shopping. Staff were allocated to people's activities based on their skills and experience.

People were encouraged to participate in the recruitment process for new staff. Applicants for roles in the home were asked questions set by people who lived at the home. People met new staff before they were offered a full position. People's views about potential staff were considered a key part of the applicants suitability to work with people in the home. This meant that people had a hand in choosing the staff they felt displayed the right attitude to work with them.

People's needs had been fully assessed and care plans had been developed on an individual basis. The provider employed their own clinical psychologist and therapist. This meant that people and staff could access professional support, assessment, review and care planning advice easily and quickly. Assessments were completed and reviewed with people, their care manager from the learning disability team or their relatives whenever possible. Before people moved into the service an assessment of their needs had been completed to confirm that the service was suited to the person's needs. After people moved into the service they and their families where appropriate, were involved in discussing and planning the care and support they received.

Assessments and care plans reflected people's needs and were well written. Care planning happened as a priority when someone moved in. The provider had some good examples of personalised care planning

formats in their policies files and the registered manager of the home had maintained the personalisation of care plans and records. People's involvement in their care planning was fully recorded.

The care people received was person centred and met their most up to date needs. People's life histories and likes and dislikes had been recorded in their care plans. Staff encouraged people to advocate for themselves when possible. This assisted staff with the planning of activities for people. Each person had a named key worker or they had access to an external mentor. This was a member of the staff team who worked with individual people, built up trust with the person and met with people to discuss their dreams and aspirations. We saw from care plans that when people had met and chosen activities these had been organised by their key worker or mentor and they recorded when they had taken place.

Behavioural support care plans detailed early interventions based on people's individual needs. This enabled staff to intervene early if they saw people becoming upset or agitated. Staff understood the recorded behavioural triggers for each person. If people's needs could no longer be met at the service, the manager worked with the local care management team to enable people to move to more appropriate services. This had happened when people's behaviours had become distressing to others living in the service.

The manager sought advice from health and social care professionals when people's needs changed. Records of multi-disciplinary team input had been documented in care plans for Speech and Language Therapist, Continence Nurses and District Nurses. These gave guidance to staff in response to changes in people's health or treatment plans. This meant that there was continuity in the way people's health and wellbeing were managed.

The manager and staff responded quickly to maintain people's health and wellbeing. Staff had arranged appointment's with GP's when people were unwell. This showed that staff were responsive to maintain people's health and wellbeing.

There was a policy about dealing with complaints that the staff and manager followed. This ensured that complaints were responded to. There were no formal complaints recorded. People had one to one meetings with staff and the provider facilitated six weekly group meetings. At these meetings people were encouraged to talk about any concerns or complaints they had about the service. Staff understood that people with learning disabilities, autism or mental health issues may not always be able to verbally complain. Staff compensated for this by being aware of any changes in people's mood, routines, behaviours or health.

Good

# Is the service well-led?

## Our findings

Some people in the home could speak to us about their experiences. Other people were less able or had less confidence to express their views directly to us. However, people communicated with us, either by us observing how they responded to staff when care was delivered or by talking to us about things that were important to them.

The registered manager had been in post since March 2013. They had extensive experience of working and managing services for people living with learning disabilities and autism. They had demonstrated to us they had the skills to consistently deliver good outcomes for people and support the staff team.

The registered manager had carried out quality audits of the service on a monthly basis. Audits enabled them to identify areas of the service that needed improvement which they recorded and took the actions required. Over time there had been continuous improvement in the quality of the service which included the development of person centred care plans and health action plans. These developments supported people to make individualised life choices and participate in the life of their community.

People and their relatives had been asked about their views and experiences of using the home. We found that the registered manager used a range of methods to collect feedback from people. There were regular individual or group meetings for people and their relatives at which people had been kept updated about their care.

We found that the results of the surveys/questionnaires were analysed by the provider. These had been sent to twenty six people, including relatives, advocates, and care manager. The feedback from the surveys was positive. Anonymised information about people's comments and opinions of the home, plus the providers responses were made available to people and their relatives.

The aims and objectives of the service were set out and the registered manager of the service was able to follow these. For example, to provide the best individualised support to people. Staff received training and development to enable this to be achieved. The manager had a clear understanding of what the service could provide to people in the way of care and meeting their learning disabilities needs. This was an important consideration and demonstrated the people were respected by the registered manager and provider.

The registered manager and their staff team were well known by people. The values of the organisation were clearly noted and identified within the policies observed and displayed within the service. Staff were committed and passionate about delivering high quality, person centred care to people living with learning disabilities and autism. We observed them being greeted with smiles and staff knew the names of people when they spoke to them.

Staff told us they enjoyed their jobs. The provider asked staff their views about the service. Staff felt they were listened to as part of a team, they were positive about the management team in the service. Staff spoke

about the importance of the support they got from senior staff, especially when they needed to respond to incidents in the service. They told us that the manager was approachable. One member of staff said, "The team culture is good, the team is well rounded and we support each other." "I always read the team meeting minutes if I could not attend the team meeting." And, "We get the opportunity for reflective learning." Good communication and support within the staff team led to the promotion of good working practices within the service.

There were a range of policies and procedures governing how the service needed to be run. They were kept up to date with new developments in social care. The policies protected staff who wanted to raise concerns about practice within the service. Staff had signed to say they understood the policies. Staff understanding of the policy's they should follow was checked by the manager at supervisions and during team meetings.

Senior staff carried out routine health and safety checks in the service and these were recorded. This showed that audits were effective and covered every aspect of the service.

Managers reviewed the quality and performance of the service's staff. They checked that risk assessments, care plans and other systems in the service were reviewed and up to date. All of the areas of risk in the service were covered; staff told us they practiced fire evacuations.

Maintenance repairs were carried out quickly and safely and these were signed off as completed. Other environmental matters were monitored to protect people's health and wellbeing. These included legionella risk assessments and water temperatures checks, ensuring that people were protected from water borne illnesses. This ensured that people were protected from environmental risks and faulty equipment.

Senior managers at head office were kept informed of issues that related to people's health and welfare and they checked to make sure that these issues were being addressed. There were systems in place to escalate serious complaints or incidents to the highest levels with the organisation so that they were dealt with to people's satisfaction.