B.L.I.S.S. Residential Care Ltd

The Brambles

Inspection report

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Date of inspection visit: 30 September and 1 October 2015
Date of publication: 14/09/2016

Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Inadequate**

Overall summary

This unannounced inspection of The Brambles took place on 30 September and 1 October 2015. The home provides accommodation and support for up to six people who may have learning disabilities or autism. The primary aim at The Brambles is to support people to lead a full and active life within their local communities and continue with life-long learning and personal development. The home is a detached house, with a substantial rear garden, within a residential area, which has been furnished to meet individual needs.

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. The registered manager told us they had begun the process to deregister as they had also assumed the responsibilities of registered manager at another home within the provider's care group. A recently appointed home manager had submitted an application to become the registered manager, who was being supported in the day to day running of the home by the registered manager and the provider.

The provider did not make sure there were sufficient numbers of suitable staff to keep people safe and meet their needs. Relatives and health professionals were

Summary of findings

concerned about the high turnover of staff and the loss of several experienced members of staff. Experienced staff who had left The Brambles had built close relationships with people who had been reassured by their presence. Their departure had left a void in some people's lives. These experienced staff had also been a point of reference for less experienced staff with regard to people's complex behaviours.

Everyone at The Brambles had been assessed as requiring one to one support whilst in the home and two to one support whilst accessing the community. The provider could not be assured that people's needs were met safely because there were not always enough suitable staff on duty to provide the required staffing ratio to meet people's assessed needs. Records showed that on numerous occasions the required number of staff were not on duty.

The provider had not completed a risk management plan to ensure people's safety where there were reduced staffing levels. When asked how the provider assured that people were safe when there was insufficient staff, demonstrated by the provider's rosters, the registered manager said , "The only answer is that there can be no reassurance of their needs being met, but knowing the staff at the Brambles they would have endeavoured to do their utmost to ensure this happened."

We observed people receiving their prescribed medicines safely, administered in a way they preferred, by trained staff who had their competencies assessed to do so.

Appropriate checks to ensure staff were recruited safely were not carried out. Staff did not always have appropriate references in relation to their previous employment and there was not always evidence supporting how the provider had assessed the applicant's suitability for the post. Where references had been requested these had not always been received or did not address the suitability of staff to support vulnerable people. Where there were identified gaps in people's employment history the provider had not ascertained the reasons for this. This meant that the provider could not be assured that staff were suitable to provide care and support for the people living at the Brambles.

The registered manager and provider did not complete regular audits to monitor the quality of the home and plan improvements. The provider did not complete audits of medicines management, staffing needs analysis or care records. They had failed to identify potential risks to people that may compromise the quality and safety of their care.

The provider was not always supportive of staff. Staff told us that the home manager was approachable and readily available but they were disillusioned with the support from the provider. This had led to staff leaving the home, which meant there were not always staff with the right mix of skills, competence or experience to meet people's needs. Health professionals told us they were concerned that whilst new staff were dedicated they may not have the required level of experience to always meet people's needs.

The provider did not promote a positive culture, where staff were supported to question practice, and be actively involved in developing the service. Where staff had raised concerns there was no evidence that any action had been taken to investigate or address the issues to improve the service.

The provider recognised that staff required training and support but did not ensure this covered the areas identified as a further requirement to meet people's needs, for example staff had not completed autism training. Staff were not always supported to provide safe and effective care for people.

Relatives told us they trusted the staff who made their family members feel safe. Staff had completed safeguarding training and had access to current guidance. They were able to recognise if people were at risk and knew what action they should take to protect them. People were safeguarded from the risk of abuse. Staff had responded appropriately to safeguarding incidents to protect people.

People's safety was promoted through individualised risk assessments. Risks had been identified, and plans were in place to manage these effectively. Staff understood the risks to people's health and welfare, and followed guidance to safely manage them.

People, or where appropriate their relatives, and care managers were actively involved in making decisions about their care and were asked for their consent before being supported. Staff had completed training on the Mental Capacity Act (MCA) 2005 and understood their responsibilities. The MCA 2005 legislation provides a legal

Summary of findings

framework that sets out how to support people who do not have capacity to make a specific decision. Where people lacked the capacity to consent to their care, legal requirements had been followed by staff when decisions were made on their behalf. People were supported by staff to make day to day decisions.

The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide a lawful way to deprive someone of their liberty, where it is in their best interests or is necessary to protect them from harm. The registered manager had completed the required training and was aware of relevant case law. The registered manager had made DoLS applications for each individual which had been authorised, which demonstrated they had taken the necessary action to ensure people's rights were recognised and maintained.

People were provided with nutritious food and drink, which met their dietary preferences and requirements. People were supported to eat a healthy diet of their choice.

There was a friendly and relaxed atmosphere within the home, where people were encouraged by staff to express their feelings, whilst respecting others. Whenever relatives had raised concerns or issues prompt action had been taken by the registered manager to address them.

People's dignity and privacy were respected and supported by staff, who were skilled in using individual's specific communication methods. Staff were aware of changes in people's needs. Referrals to relevant healthcare services were made promptly when required.

People's needs were accurately reflected in detailed plans of care and risk assessments, which were up to date. These plans contained appropriate levels of information for staff to provide individualised support.

Staff did not all know the provider's motto, 'Creating changes, changes lives.' However during the inspection we observed staff demonstrate values in their care practice which included compassion, dignity, respect, equality and safety.

People's and staff records were stored securely, protecting their confidential information from unauthorised persons, whilst remaining accessible to authorised staff.

During the inspection we identified a number of serious concerns about the care, safety and welfare of people who received care from the provider. We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking further action in relation to this provider and will report on this when it is completed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

The provider did not ensure there were sufficient numbers of suitable staff deployed at all times to keep people safe and meet their assessed needs.

Appropriate recruitment checks were not always undertaken to ensure suitable staff were employed to support people safely.

We observed people receiving their prescribed medicines safely, administered in a way they preferred, by trained staff who had their competencies assessed to do so.

Staff had received safeguarding training and had access to relevant guidance. When safeguarding incidents had occurred they had been correctly identified, reported and acted upon by staff to ensure people were safe and protected from harm.

Is the service effective?

Requires improvement

The service was not always effective.

The provider recognised that staff required training and support but did not ensure it covered the areas identified as a requirement to meet people's needs. Staff did not always receive effective support and supervision to fulfil their roles and responsibilities.

People were supported to make their own decisions and choices by staff who demonstrated an understanding of consent, mental capacity and deprivation of liberty safeguards (DoLS).

People were provided with nutritious food and drink, which met their dietary preferences and requirements. People were supported to eat a healthy diet of their choice.

Staff supported people to maintain good health and have access to healthcare services promptly when required.

Is the service caring?

Good

The service was caring.

People had positive and caring relationships with the staff who treated them with kindness and showed compassion and concern for their welfare.

Staff supported people to be actively involved in making decisions about their care and day to day lives.

Staff promoted people's independence and ensured their privacy and dignity were respected in the way their care was provided.

Summary of findings

Is the service responsive?

Good 

The service was responsive.

People's care was personalised and based on their wishes and preferences. Staff understood people's specific needs and provided care in accordance with their wishes.

Staff listened to people's views and responded to them on a daily basis.

People were provided with information about how to complain, which was accessible and in a format of their choice. Relatives told us they knew how to make a complaint and would feel comfortable doing so if required.

Is the service well-led?

Inadequate 

The service was not well-led.

The provider did not promote a positive culture, where staff were supported to question practice, and be actively involved in developing the service.

Staff told us there was a good team spirit amongst the staff and people living at the Brambles but felt the provider did not value or support them.

Quality assurance systems to monitor the service provided to people were not effective. As a result the provider could not be assured of the quality and safety of service provision.

The Brambles

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 checked 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 of The Brambles took place on 30 September and 1 October 2015 and was unannounced. When planning the inspection we took into account the size of the service and the fact that some people could find unfamiliar visitors unsettling. As a result this inspection was carried out by one inspector.

Before the inspection we examined previous CQC inspection reports. At our last inspection on 10 January 2014 we did not identify any concerns about the support being provided. We read all of the notifications received about the service. Providers have to tell us about important and significant events relating to the service they provide using a notification. We also reviewed the Provider Information Return (PIR) from the service. 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. Information from the PIR is used to help us decide the issues we need to focus on during the inspection. We also looked at the provider's website to identify their published values and details of the care they provided.

During our inspection we spoke with the five people who use the service. We also spoke with the staff including the registered manager, the home manager, three senior staff and 11 staff.

We used a range of different methods to help us understand the experiences of people using the service who had limited verbal communication and were not able to tell us about their experience. These included observations and pathway tracking of five people. Pathway tracking is a process which enables us to look in detail at the care received by an individual in the service.

During our inspection we observed how staff interacted and cared for people across the course of the day, including mealtimes, activities and when medicines were administered.

We reviewed each person's care records, which included their daily notes, care plans and medicine administration records (MARs). We looked at ten staff recruitment, supervision and training files of current staff and five of those staff who had recently left the service. We also looked at records relating to the management of the service, such as health and safety audits, emergency contingency plans, minutes of staff meetings and provider quality assurance reports.

Following the visit we spoke with the relatives of four people, five health and social care professionals and two advocates. The health and social care professionals were involved in the support of people living at the home. We also spoke with three commissioners of the service.

Requires improvement

Is the service safe?

Our findings

The provider did not make sure that there were sufficient numbers of suitable staff on duty at all times to keep people safe and meet their needs.

All people had been assessed as requiring one to one support from staff whilst awake in the home during the day. Four people had been assessed as requiring two to one support whilst accessing the community. People's needs during the night time when people were asleep had been assessed as requiring two staff. The assessed and funded hours were used by the provider as a guide to ensure sufficient staff were deployed to keep people safe and meet their needs.

On our arrival at 0700 am Wednesday 30 September 2015 there were two night staff supporting three people who were already up and dressed. Two people were walking to and from the garden to use a trampoline which left two people in the house being supported by one member of staff. This meant on this occasion the provider had not ensured there were sufficient staff to keep people safe and meet their assessed needs.

Relatives and health professionals were concerned about the high turnover of staff and the loss of several experienced members of staff, which was demonstrated in the staff rosters. Relatives told us that experienced staff who had left The Brambles had built close relationships with people who had been reassured by their presence and their departure had left a void in some people's lives. These experienced staff had also been a point of reference for less experienced staff with regard to supporting people's whose behaviours may challenge.

The rosters from 27 July to 1st October 2015 showed that for 51 out of a total of 66 days the required number of staff to meet people's assessed needs and to keep them safe during the day were not on duty. For example during the week 14 to 20 September 2015 every day there was a shortage of staff between 8 am and 8 pm. During this period 15 shifts had not been covered.

Rosters demonstrated that between 8 am and 8 pm on Saturday 8 August 2015 the provider had not deployed four of the rostered seven staff to cover hours funded, required to meet people's assessed needs. On Sunday 9 August 2015 between 8 am and 8 pm the provider had not deployed five of the rostered seven staff to cover hours funded, required to meet people's assessed needs. On Saturday 19 September 2015 the provider had not deployed five of the rostered 9 staff to cover hours funded required to meet people's assessed needs. On Sunday 20 September 2015 rosters demonstrated the provider had not deployed three of the rostered seven staff to cover people's assessed needs. This meant the provider had failed to ensure that people were protected from harm by deploying enough suitably qualified staff to meet their identified needs through required staffing ratios.

There had been no actual harm caused to people due to insufficient staff. However, staff told us that when their were insufficient staff they had not always been able to provide activities within the community because they did not always have sufficient staff to meet the assessed staffing ratios to keep people safe. Staff told us that there had been a weekly activity schedule for each person which could not be adhered to due to insufficient staff.

The provider had not completed a risk management plan to ensure people's safety where there were reduced staffing levels. When asked how the provider assured that people were safe when there was insufficient staff, demonstrated by the provider's rosters, the registered manager said , "The only answer is that there can be no reassurance of their needs being met, but knowing the staff at the Brambles they would have endeavoured to do their utmost to ensure this happened."

Staff told us they were tired due to working excessive hours to cover other shifts. One staff member said, "I am really tired but I would never forgive myself if anything happened to anyone. They are the reason I come to work and I won't let them down." Staff rosters confirmed that some staff worked over their contracted hours. For example one staff member contracted to work 160 hours per month in August actually worked 232 hours. This staff member worked ten 12 hours shifts in a row, including a night shift, between 10 and 19 August 2015 without a break.

The registered manager told us there had been two medicine errors since our last inspection. We reviewed one of these incidents and identified that one person had not received their night time medicine because neither of the two staff on the night shift were qualified to administer medicines.

In isolation this missed medicine did not cause the person harm but if repeated had the potential to increase their risk

Is the service safe?

of experiencing a seizure. This meant on this occasion the provider had not deployed sufficient numbers of suitably qualified, competent staff trained to administer medicines when required to keep people safe. We did not identify any other occasions where this had occurred. When we informed the home manager about this they immediately took action to ensure there was always one member of staff qualified to administer medicines on future night shifts.

Health professionals raised concerns that there had been a rapid turnover of staff and recently several senior staff had left, which was confirmed by staff rosters. This meant that a relatively inexperienced staff team were supporting people with complex needs. Concerns raised in interviews by staff leaving the service had not been considered by the provider who had not taken appropriate action to ensure staff retention.

The failure to ensure there were sufficient numbers of suitable staff to keep people safe and meet their needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed people receiving their prescribed medicines safely, administered in a way they preferred, by trained staff who had their competencies assessed to do so. The provider ensured people's behaviour was not controlled by excessive use of medicines by conducting regular reviews with relevant health professionals and their representatives.

During our inspection we observed one person supported on an activity in the community. Records confirmed this occurred daily. Staff supporting the person ensured they took the person's prescribed emergency medicine in case they experienced a seizure. However we noted there was no booking in and out procedure in place in relation to these medicines. This meant the provider could not be assured that these medicines were always taken when the person accessed the community.

We recommend the provider refers to National Institute for Health and Care Excellence guidance for Managing Medicines in Care Homes, in relation to recording medicines taken with people when they are temporarily away from the home.

The provider had not ensured they only employed 'fit and proper' staff who were able to provide care and support appropriate to their role. Where references from previous employers had been requested these had not always been received or did not address suitability of staff to support vulnerable people. The provider had completed Disclosure and Barring Service (DBS) checks on prospective staff as part of their recruitment process. The DBS helps employers make safer recruitment decisions to prevent unsuitable people from working with people who use care. However, where DBS checks had raised concerns about staff suitability the provider had not completed risk assessments as to how people would be protected from harm if these staff were employed. Staff and the home manager told us applicants attended an interview to determine their suitability. However, interview records were not always available to evidence how the provider had assessed applicants suitability to meet the requirements of the role. The provider had not ensured people were protected from the risk of receiving their care from staff who were unsuitable to deliver support to people with learning disabilities and complex needs.

The provider had not protected people by ensuring that the information required in relation to each person employed was available. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had completed safeguarding training and they were able to demonstrate their understanding of their role and responsibility to protect people. Staff described how they would deal with a safeguarding issue, including reporting issues outside of the organisation if necessary. Relatives and health and social care professionals told us about an incident which had been referred to the local safeguarding authority since our last inspection. They told us they had been impressed with the openness of the registered manager and staff to investigate and learn from the incident. We looked at records which showed that the safeguarding incidents had been reported, recorded and investigated in accordance with the provider's safeguarding policies and local authority guidance. The provider safeguarded people against the risk of abuse and took the correct actions if they suspected people were at risk of harm.

Risk assessments and risk management plans were completed with the aim of keeping people safe yet supporting them to be as independent as possible. These were detailed and gave staff clear guidance to follow in order to provide the required support to keep people safe.

Requires improvement

Is the service safe?

These included managing their finances and supporting people safely on external activities such as attending a local swimming pool, bowling, visiting the cinema and attending college. One person was being supported with epilepsy and had an epilepsy risk assessment and protocol unique to their individual needs. Two health and social care professionals told us the registered manager and staff proactively managed people's health needs and promoted their independence, whilst keeping them safe. Staff demonstrated their knowledge of people's needs and risk assessments, which was consistent with the guidance contained within people's care plans. People were protected from the risks associated with their care and support because these risks had been identified and managed effectively.

During our inspection we observed several incidents where staff responded appropriately to behaviours which may challenge. We observed sensitive interventions by staff, which ensured that people's dignity and human rights were protected.

Each person had a 'hospital passport' which detailed key information about them in the event of an emergency. Information included their means of communication, medicines, known allergies and the support they required. People were kept safe as staff had access to relevant information which they could act upon in an emergency.

Requires improvement

Is the service effective?

Our findings

Relatives were mainly complimentary about the effectiveness of the service. One relative told us they were impressed by the way staff always offered reassurance in a calm unhurried manner and were able to recognise when people were worried. Another relative told us, "The staff are quick to get help from experts when they need it." One relative told us they were concerned that the recent high turnover of experienced staff may have an adverse impact on the quality of care and how effective the service was.

Records showed that the provider's required staff training was up to date. Support workers had received further training specific to some needs of the people they supported, including epilepsy, diabetes, moving and positioning and dementia. However, the provider had also identified that staff required further training in relation to autism, intensive interaction and Makaton language. Makaton is an interactive language which uses signs and symbols to help people communicate. Intensive Interaction is an approach for teaching communication skills to people who have autism or learning disabilities. Staff told us they had not received this training, which was confirmed by the provider's training schedule. During the inspection we observed the home manager support an inexperienced member of staff who was supporting a person with their anxiety. The home manager told us their priority was to ensure all staff completed the intensive interaction training so all staff had an understanding of different approaches to meet people's different needs. People may not always be supported by staff who had completed specific training in relation to autism, intensive interaction and Makaton language, to meet their needs. The provider had recognised that staff required training and support but did not ensure it always covered further training required to meet people's specific needs.

Newly recruited staff completed an induction course based on nationally recognised standards and spent time working with experienced staff. This ensured they had the appropriate knowledge and skills to support people effectively. Staff told us they had received a thorough induction that gave them the skills and confidence to carry out their role. There was a record of the induction process and training for the use of specific aids and equipment to ensure that staff knew how to use them safely. A new member of staff told us they had received good training which they felt had prepared them to support people's needs.

Staff told us they were encouraged to obtain further qualifications relevant to their role, which certificates and the provider's training schedule confirmed. This meant that people received care from staff who were supported in their professional development.

The provider had a supervision policy which specified that staff should receive planned regular one to one supervision meetings. The home manager and staff told us this should be every six to eight weeks, although this was not specified in the policy. The provider's schedule of supervisions indicated that no staff had had a supervision during the previous three months. We noted the home manager had made entries in their diary to complete these within the next two months. Staff who had worked at The Brambles for over a year had received an annual appraisal. Staff told us they felt supported by the home manager and the deputy manager who had recently left, but did not feel supported by the provider. This meant the provider could not be assured that people had received care from staff who had been supported through an effective system of supervision to carry out their roles and responsibilities.

We observed staff communicated with people using the methods detailed in their support plans to make day to day decisions using pictures and their knowledge of the individual concerned. People were given choices and asked for their permission before staff undertook any care or other activities.

Staff had completed training on the Mental Capacity Act (MCA) 2005 and understood their responsibilities. The Mental Capacity Act 2005 legislation provides a legal framework that sets out how to support people who do not have capacity to make a specific decision. Where people lacked the capacity to consent to their care, guidance had been followed to make best interest decisions on their behalf. Such decisions included the benefits to a person of taking a particular medicine and provision of sedation before undergoing medical and dental procedures. Records detailed the person's capacity to make the decision, the decision, the reason for it and who was involved in making it. This meant that people's mental capacity was assessed and decisions were made in their best interest involving relevant people.

Requires improvement

Is the service effective?

The provider used positive behaviour support methods to avoid triggers that may result a in a person presenting with behaviours that may challenge. We observed sensitive staff interventions using verbal and non-verbal calming techniques. The provider ensured that when people displayed behaviours which may challenge they were treated in a manner which protected their human rights.

The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide a lawful way to deprive someone of their liberty, where it is in their best interests or is necessary to protect them from harm. At the time of inspection all of the people living at The Brambles were subject to DoLS authorisations. This demonstrated the registered manager had taken the necessary action to ensure people's rights were recognised and maintained.

Where people had been identified to be at risk of choking we observed staff provide the necessary support, in a way that maintained their dignity. At mealtimes we saw people were actively encouraged and supported by staff in the preparation of meals. Pictorial menus were created of people's likes, which were used to support people making a choice. Each person had a nutritional care plan which outlined their dietary needs, likes and dislikes. Staff we spoke with told us about each person's dietary needs and their preferences. People were able to access and request drinks at any time. We also heard staff offering people drinks at regular intervals. People were supported to have enough suitable and nutritious food and drink to meet their needs and provide a healthy balanced diet.

People were supported to stay healthy. Records showed that people had access to healthcare professionals such as community learning disability nurses, speech and language therapists (SALT), occupational therapists, physiotherapists, GP's, Consultants, psychiatrists, opticians, and dentists. when their needs changed. We observed the guidance provided from such healthcare professionals demonstrated by staff during the provision of their support for people.

Good

Is the service caring?

Our findings

We observed there was a homely atmosphere at The Brambles, where interactions between people and staff were friendly and respectful. Relatives told us staff were caring and dedicated to the people they supported. One relative said, "The staff are always kind and treat everyone with compassion and respect, as if they were part of their own family." Another relative told us, "The Brambles is the best place for her because the staff really care and are always looking to improve the quality of her life."

The home manager told us it was important to make sure that people feel they are special and that staff listen and talk to them appropriately to understand their needs. One relative told us their family member had really enjoyed a summer garden party, where the staff were so "kind and attentive to everyone". Another relative told us how staff had supported their loved one to buy a smart suit so they could attend their school leaver's ball.

We observed meaningful interactions between people and staff, whilst people made caring gestures and showed mutual respect towards one another. A staff member completing their induction at the time of our inspection told us that they were encouraged to speak with people to get to know them and their preferences, which we observed in practice whilst they shadowed other staff. We saw this enabled people to build trust and confidence in the new staff.

We observed one person who began smiling broadly upon the arrival of the home manager, whilst another excitedly greeted a member of staff and rushed to give them a big hug. People were observed to be experiencing positive relationships with staff.

People were supported to express their views by staff who were skilled at giving people explanations they needed, which we observed. Staff demonstrated detailed knowledge about individual's diverse needs and were able to tell us about their personal histories and preferences. Staff were knowledgeable about people's support plans and the events that had informed them. People listened and communicated with staff in a manner which demonstrated had developed mutual trust and understanding.

People and, where appropriate, their relatives were involved in making decisions about their own care, which was recorded in their care plans and risk assessments. Families attended formal review meetings where appropriate. Monthly reviews were completed by staff and reviewed quarterly by the registered manager, which records confirmed.

Staff were sensitive to people's wishes. During our inspection we saw people became anxious and staff immediately provided reassurance in accordance with their support plans. The staff spoke fondly and passionately about the development of people's life skills and the promotion of their independence. A relative confirmed the positive impact of the caring support provided by staff which had lessened their loved one's anxieties and behaviours which may challenge.

We observed interventions by staff which ensured that people's dignity and human rights were protected. One person chose to remove their clothes when they were anxious and staff reassured and supported them, whilst maintaining their dignity and mental well-being. People were supported by staff who were sensitive to their needs and knew how to support them.

People were able to exercise choice over all aspects of their lives. For example, in terms of where and how they spent their time, including what time they got up and went to bed. On the day of our inspection some people chose to get up early, whilst others preferred to stay in bed. Staff understood some people required more support than others to make choices and tailored their interactions accordingly, which we observed in practice.

Where people had limited capacity to make choices staff offered them a range of their preferred options, such as their daily activities or particular drinks and snacks they enjoyed. Where people required support with more complex decisions the provider had arranged for advocates to speak on their behalf. We spoke with an advocate of one person who supported them with financial decisions. They told us that the staff always consulted them in relation to more complicated financial decisions. Another professional had been appointed by the DoLS authority as the 'Resident Person's Representative'. They told us they had been impressed with the proactive approach of the new home manager who had made staff interaction with people and their involvement in decisions a priority. People were constantly being given choices, consulted and involved in decisions about their daily lives.

Good

Is the service responsive?

Our findings

One person's care manager told, "We are very pleased with the care provision, especially the way staff support people living with autism. " A relative told us, "Staff are always thinking about different ways to help people do what they want to do and are committed to supporting them to live life to the full."

People were supported to follow their interests and take part in social activities and education opportunities . On the day of our inspection one person was supported to attend college, another person was supported to go for a walk in the countryside, whilst another was supported to go shopping in the town centre. Another person attended a dental appointment. Records demonstrated that people had been supported to take part in social activities such as trips to a bird sanctuary, a small airport and on a train journey to the seaside.

The provider reviewed people's support plans regularly to ensure that their changing needs were met. Each support plan contained a record of any changes to the person's health or behaviour and the resulting changes to their risk assessments. This ensured staff provided care that was in response to people's changing needs.

Each person had an activity schedule with activities they enjoyed or would like to try, including swimming, horse riding and trampolining. Staff told us that taking measured risks meant that people were able to achieve more and experience a quality of life which was enjoyable and meaningful to them.

People were supported by staff to develop and maintain relationships with those who were important to them to avoid social isolation. One person had their own transport and staff supported them to visit their family on a weekly basis. We spoke with a relative of one person who was unable to visit the Brambles. They told us, "The staff are very good at keeping me informed and always make sure they come and visit me at least once a week." They also said, "Sometimes it is difficult to know what she is feeling, but I can tell she is really happy. When she comes here it means the world to her." Relatives told us they were always welcomed into the home and there were no restrictions on times or lengths of visits.

Care managers, relatives, health professionals and staff told us people received person centred care that was responsive to their diverse needs. They told us that they had been involved in the assessment and planning of people's care. In conversations supported by staff people told us they were happy with their care. Relatives told us the registered manager and staff were committed to ensuring people had care plans that reflected how they would like to receive their care and support. People or, where appropriate, those acting on their behalf, contributed to the assessment and planning of their care.

People, their relatives and health professionals told us staff consistently responded to people's needs and wishes in a prompt manner. For example a relative praised staff for their swift action recently when they supported their loved one to attend hospital with an injury and for keeping them informed.

Each person had a support plan to set their own goals and record how they wanted to be supported. People's care plan included a 'What's important to me' record. This documented the person's life history, including significant events, what was important to them at the moment and their future ambitions. This meant staff had access to information which enabled them to provide support in accordance with the individual's wishes and preferences.

All staff had been taught a recognised system for supporting people to manage behaviour which may challenge others. A health professional told us "Staff know people and are quick to respond when they see signs that they are becoming anxious to reassure and comfort them." People were supported by staff who understood their individual needs.

Each person had a communication plan. This provided staff with detailed information about how people communicated and their level of understanding. For example one person's communication plan emphasised that staff must 'maintain eye contact and remain positive and upbeat.' One person's communication plan stated what signs they used to communicate different messages. We observed staff implement this information when communicating with people. People's communication methods were understood and implemented in practice by staff.

Where people had more complex health needs, we saw there were specific plans which detailed the care required and how to deliver it. We saw that one person had an epilepsy care plan. We reviewed their daily records and

Good

Is the service responsive?

found that care had been delivered in line with their epilepsy plan and that monitoring had been appropriately recorded. Staff we spoke with knew the immediate action required to ensure the person's safety if they had a seizure whilst engaged in activities within the community.

People had access to information on how to make a complaint, which was provided in an accessible format to meet their needs. Since our last inspection there had been no complaints about the service. People and relatives were also able to raise issues in their quarterly reviews with the registered manager. Relatives told us they knew how to make a complaint and would feel comfortable doing so if required. One relative told us they had raised concerns to the registered manager who had responded promptly and taken steps to address the issues raised. Staff knew the complaints procedure but told us they dealt with small concerns as soon as they arose to prevent them escalating.

When people moved between different services, for example whilst attending hospital, the home manager ensured they received consistent personalised care because they were accompanied by staff and had 'hospital passports' already prepared. These 'passports' contained all the relevant information required by health professionals to support people's needs. One person had recently transferred from their old school to a new college. We reviewed their comprehensive transition plan, which ensured they received the required support to provide reassurance whilst they settled in. A relative told us they were pleased with the care and planning by staff and health professionals which had made this transition as smooth as possible. People's needs, wishes and choices were recognised and shared with relevant professionals when they moved between services.

Inadequate

Is the service well-led?

Our findings

Quality assurance systems to monitor the service provided to people were not effective. As a result the provider could not be assured of the quality and safety of service provision. The provider had not established and operated robust processes effectively to ensure compliance with the legal requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulations 4 to 20A).

The registered manager and provider did not complete regular audits to monitor the quality of the home and plan improvements. Audits of medicines management, staffing needs analysis, accidents and incidents or care records had not been completed. Neither the registered manager or home manager had audited the staff recruitment and selection files to assure the relevant security checks had been completed to ensure staff employed were suitable to provide care and support appropriate to their role.

Although Staff had completed 48 accident and incident records in 2015 only two of these had been fully completed with regard to recommendations to prevent future recurrence. The provider had not analysed these records to identify any trends or themes to drive service improvements and keep people safe.

The failure of the provider to have systems and processes that enable them to identify and assess risks to the health, safety and welfare of people who use the service and to ensure compliance with requirements was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A person living with epilepsy had an increase in their prescribed medicine, which was accurately recorded within their health professional notes. However, staff failed to increase the dosage when ordering the next prescription and did not update the person's medicine administration record (MAR) to show the increase. This error was eventually identified by a visiting Learning Disability Nurse eight weeks later and immediately addressed. The impact of this error potentially exposed the person to a greater risk of experiencing a seizure. The provider had not established and operated effective systems to identify this error promptly, which could have led to the prescription being increased further due to a lack of response to the initial increase. The provider had not maintained an accurate record of the decisions taken in relation to this person's care and treatment.

Medicines administration recording was not always effective. During our inspection we identified recording errors in relation to two people's medicines administration records. The provider had no checks in place to ensure these errors were identified, which meant they could not take necessary action to address either a systemic failure or staff competency. There were daily temperatures recorded in relation to the medicines cabinet and fridge. However there was no audit of these temperatures to ensure they remained within required tolerances. This meant the provider could not be assured that people always had their medicines as prescribed. The provider had not maintained accurate records of the care and treatment provided to people.

The failure of the provider to maintain, accurate, complete records in relation to people, including a record of the care and treatment provided and decisions taken in relation to their care and treatment was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us the home manager was approachable and readily available but they were disillusioned with the support from the provider. This had led to staff leaving the home, which was confirmed in exit appraisals we reviewed. During recent months the Deputy Manager and two experienced senior staff had left the Brambles. Comments made in staff exit interviews included, "There is a lot of room for improvement but Bliss (the provider) doesn't try to improve" and "Bliss should pay more attention to the views and opinions of support staff as they are the ones doing work of a high expectation with little to no acknowledgement of their efforts. They are the ones we rely on to provide quality care but this won't happen if they feel devalued." The provider had archived these exit interviews and there was no evidence to demonstrate that the concerns raised had been investigated or considered with a view to drive improvement.

The provider not seeking and acting on feedback from staff to continually assess and improve the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Staff did not all know the provider's motto, 'Creating changes, changes lives.' However during the inspection we observed staff demonstrate values in their care practice which included compassion, dignity, respect, equality and safety.

Staff and relatives told us told us they felt they could raise concerns with the home manager and registered manager and that they would be supported. However, the home manager and registered manager told us they had not been supported by the provider in relation to the staffing shortage. We spoke with a staff member who had raised concerns as a whistleblower. They told us they had been well supported by the registered manager who took prompt action to deal with the concerns raised.

People's and staff records were stored securely, protecting their confidential information from unauthorised persons, whilst remaining accessible to authorised staff.