Insight Specialist Behavioural Service Ltd

23 Oak Avenue

Inspection report

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Date of inspection visit:
31 August 2017

Date of publication:
23 November 2017

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection was carried out on 31 August 2017 and was announced.

Oak Avenue is a small care service providing personal care and accommodation for up to three adults with complex learning disabilities and mental health illness. Some people were also living with living with physical disabilities and behaviours that may cause harm to themselves or others. There were three people using the service. People living at the service were not socially excluded due to their behaviours because they were enabled to live their chosen lifestyles with intensive specialised care from staff. Oak Avenue is one of a small group of care services owned by Insight Specialist Behavioural Service Ltd and this service shares a registered manager and staff team with another Insight service nearby.

People had moved to this service within the last year from another local service also run by Insight Specialist Behavioural Service Ltd. This service had been adapted to suit the individual complex needs of the three people who lived there. The building was spacious and airy and has been designed with input from the people moving in and behaviour support specialist to meet individual needs. The service had a communal kitchen, dining/lounge room and secure garden.

A registered manager was employed at the service. 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.

Person centred care and people's safety was at the heart of the care people experienced. The two owners of the care service (The providers) shared and embedded their vision and values so that they were understood by the staff team. The providers led from the front by involving themselves in the detailed planning and daily operations of the service.

The providers had fully embraced the principals of Positive Behavioural Support (PBS). This is recognised in the UK as one of the best way of supporting people who display, or are at risk of displaying, behaviour which challenges care services. The providers had modelled the service care in accordance with current PBS best practice principles. The providers, registered manager and staff participated in research and the collection of behavioural data aimed at improving the quality of care. They recognised that harmful behaviours were also a form of communication.

The providers gave people the opportunity to share their views by training staff to understand people's communication styles, using objects of reference and collecting detailed data about people's moods, facial expressions and body language. Actions taken by the provider and planned improvements were focused on improving people's quality of life, based on the research and in partnership with external experts. People, their relatives and healthcare professionals were encouraged to share their opinions about the quality of the service, to ensure planned improvements focused on people's experiences.

Positive risk taking was promoted and safety systems were reviewed and audited to reduce the risk of harm. Risk assessments were detailed and were seen as working documents. Risk levels were reviewed and changes to interventions and staffing levels were linked to individual risk levels from hour to hour. The providers played a key role in chairing weekly clinical review and safety meetings.

The training and supervision staff received enabled them to recognise and respond to communications and behaviours to reduce the risk of violence and aggression occurring. Staff consistently implemented responses that were tailored to the individuals needs and that had been planned by behavioural analysis and specialist behavioural therapist and external health and social care professionals.

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 registered 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 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.

There was a learning culture from incidents and accidents. These were recorded and checked by the registered manager and the provider's to see what steps could be taken to prevent them happening again.

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.

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.

We observed a service that was welcoming and friendly. Staff provided friendly compassionate care and support. Staff we spoke with and observed were kind and calm at all times. We observed staff giving people choices about what activities or routines they wanted to follow. Staff were deployed to enable people to participate in community life, both within the service and in the wider community.

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

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 service was clean and odour free and staff followed infection control policies.

The providers produced information about how to complain in formats to help those with poor

communication skills to understand how to complain. This included staff understanding people's moods, behaviours and body language.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Responses to incidents reduced the risk of harm. Risk management systems covered individual and general risk.

Staff consistently worked to protect people from harming themselves or others and to minimise the risk of harm. The registered manager and staff were committed to preventing abuse.

Staff were recruited safely. People's safety was maintained through the consistent deployment of the right numbers of staff based on the levels of risk.

Thought and planning into people's needs from the environment which had been adapted minimise anxiety and challenging behaviours.

Medicines were administered safety by competent staff.

Is the service effective?

Good

The service was effective.

People were cared for by staff who understood their communication styles, moods needs.

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 were treated as individuals and able to make choices about their care.

People were involved in planning their care through a person centred approach and their views were taken into account.

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

Is the service responsive?

Good

The service was responsive.

Positive behavioural therapist worked with people and staff to achieve positive outcomes. People's care was clinically reviewed at least weekly.

People's preferences, likes and dislikes were understood by the staff from the person's point of view.

People were supported to maintain relationships that were important to them and to engage within their local community.

There were appropriate systems in place to deal with complaints.

Is the service well-led?

Good

The service was well led.

The provider's worked closely with the registered manager and staff at Oak Avenue and other specialist services to promote inclusion, person centred care and positive risk taking.

Innovative solutions were in use to involve people in sharing their opinions about the quality of the service.

Before changes were made, the providers and staff took time to process analysed data and used professional planning to consider what the impact might be on people.

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

23 Oak Avenue

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 31 August 2017 and was announced. We gave short notice of the inspection so that people may be less anxious by our presence in their service. The inspection was carried out by one inspector.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at notifications about important events that had taken place at the service, which the provider is required to tell us by law. We used this information to decide which areas to look at during our inspection.

People did not engage verbally with their experiences of the service. People used a range of communication styles including behaviours and body language. We gathered information about the care people received by observing how people responded to staff when care was delivered. We spoke with three staff including the registered manager and two care workers.

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

The service had been registered with us since 05 September 2016. This was the first inspection carried out on the service to check that it was safe, effective, caring, responsive and well led.

Good

Is the service safe?

Our findings

People were protected by staff who understood how each person communicated if they were in pain, anxious, upset or unhappy. We observed how this happened by witnessing two members of staff minimising the risks of harm through their understanding of and responses to individual instances of potentially harmful behaviours.

Staff said, "To keep people calm we understand their verbal or physical gestures, we remain positive and try to engage with people."

Enough staff were deployed to enable people's individual needs to be met and for care to be delivered safely. People benefited from 1-1 staffing input and additional staff were made available so that people could remain safe when accessing their local community safety. On the day of the inspection two staff had been allocated to accompany a person out on a community activity. Staff had specialised behaviour intervention training to maintain people's safety. To maintain another person's safety at night a member of staff stayed awake as the person's one to one support. Only appropriately trained regular agency staff were used to cover staff absences. This minimised the risks of harm.

The providers employed mentors to assist with activities and positive behaviour therapist worked closely with people and their support staff to minimise risk levels. Each person had personalised risk assessments and behaviour intervention plans in place. The actions that staff should take to reduce the risk of harm to people were included in the behaviour intervention 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.

Information about safety was analysed for trends to reduce risk and was communicated to the staff. Staff signed care plans and risks assessments to acknowledge they understood them. Records detailed the information shared between staff about risks within the service. Staff confirmed they understood potential risks and how these were minimised. Staff said, "We feedback our observations though team meetings and clinical meetings to reduce behaviours." Incidents and accidents were recorded and checked by the registered 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. For example, a person who had previously injured themselves wore a foot protector to reduce the risk of the injury happening again.

The registered manager understood how to protect people by reporting concerns they had to the local authority and protecting people from harm. Staff had access to the providers safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers

within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse.

Staff understood how they reported concerns in line with the providers safeguarding policy if they suspected or saw abuse taking place. Staff gave us examples of the tell-tale signs they would look out for that would cause them concern. For example, bruising or mood changes. Staff understood that they could blow-the-whistle to care managers or others about their concerns if they needed to. (Blowing the whistle enables employees to contact people with their concerns outside of the organisation they work for, like social services.)

The registered manager protected people's health and safety. Safe working practices and the risks of delivering the care were assessed and recorded to keep people safe. Environmental risks and potential hazards were assessed and equipment was checked by staff before they used it. There was guidance and procedures for staff about what actions to take in relation to health and safety. For example this was recorded in team meetings. Fire systems were maintained and tested. Each person had a personal emergency evacuation plan (PEEP) with detailed information about their ability to escape fire and the support they needed from staff to do this safely.

The provider had a 'business continuity' policy which was being reviewed. This gave information to staff about how people's care should continue safely immediately after an emergency, and the arrangements that had been made disruption to staffing levels during periods of severe weather.

The service was clean and free from odours. The risks of infection and cross contamination were minimised by health and safety control measures based on an up to date infection control policy. These controls included the testing of water systems for legionella bacteria, water outlet flushing and temperature monitoring, infection control training for staff, safe systems of cleaning, and the provision of personal protective equipment. For example, daily, weekly and monthly cleaning schedules were followed by staff. A member of staff said, "We get infection control training and we pride ourselves on our cleanliness." These safe systems of work protected people from potential infection.

The registered manager checked that staff followed the providers' medicines policy and that staff remained competent when they administered medicines. Staff administering medicines were provided with training so that they understood the broader principals of medicine safety and record keeping. Staff we talked with and observed administering medicines demonstrated how they administered medicines safety.

People were protected by staff who understood their responsibility to record the administration of medicines. The medicine administration record (MAR) sheets showed that people received their medicines at the right times and as prescribed. The system of MAR records allowed for the checking and recording of medicines, which showed that the medicine had been administered and signed for by the staff. We sampled recent MAR sheets and these were being completed correctly by staff. The registered manager confirmed there was a policy regarding the safe management of 'As and When Required Medicines' (PRN), for example paracetamol. Medicines were audited monthly by the registered manager.

People were protected by safe recruitment practices, minimising the risk of receiving care from unsuitable staff. The registered 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 relevant to the role. Gaps in employment were explored to provide a consistent record of work history. 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.

Good

Is the service effective?

Our findings

We carried out observations of people's care in the kitchen and lounge. 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.

We observed that staff had the skills required to care and support the people who lived at the service. People were supported with their agreed and recorded daily routines by staff. People's health needs were monitored by staff and staff had been given information about people's conditions, which they were able to talk to us about. For example, people wore head guards to protect their safety during epileptic seizures or if they were at risk of head injury from negative behaviours.

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. On the day of our inspection, staff supported one person to a dental appointment. Referrals had also been made to other healthcare professionals, such as psychologist and the local learning disability team. Emergency medical assistance was sought in a timely manner. For example, an ambulance had been called when a person fell and hit their head during an epileptic seizure. Additional monitoring of the personal health and wellbeing after the accident was recorded.

Risk to people from choking or swallowing difficulties had been minimised through assessment and dietary adjustments. For example, eating a soft diet. People were involved in the preparation of their meals and menu choices. They could help choose the menu for the week and people got involved in step by step food preparation. People's likes and dislikes in respect of food and drink and the menus had been planned taking their preferences into account. Staff recorded if certain foods were eaten or rejected as an indicator of food preferences. A range of diet choices were catered for. One person had chosen a different menu. Members of staff were aware of people's dietary needs and food intolerances. Information about food was displayed using pictures and documented in the care plans. Staff recorded what people ate and drank in the daily records. This meant that key areas of people's health and wellbeing could be monitored as an indicator of their health.

A training programme was in place and staff told us 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. We observed them patiently implementing safe distraction techniques, they understood how and when to escalate their interventions if needed and they ensured that everyone was kept safe. Additional training and guidance was provided for staff in relation to person centred care planning for people with learning disabilities and for specific health conditions people may have, for example epilepsy or asthma.

The registered manager implemented regular meetings for staff called supervisions. These meeting gave

staff and their manager time to discuss the service and their work performance and training needs. A programme of staff development meetings called appraisals was in place. These were used to assists staff to develop more skills and experience and to talk about the quality of their work. Staff also told us that they received supervision and felt supported in their roles. Records of staff appraisal and supervisions were up to date. Records showed that when new staff started they would begin training using the Care Certificate Standards. These are nationally recognised training and competency standards for adult social care services. This meant that staff were supported to enable them to provide care to a good standard.

To assist people in making choices about consent, staff respected and empowered people to make decisions before care and support was delivered. We saw records of relatives taking part in the planning of care and best interest decision making. Staff told us of ways in which they gained consent from people, demonstrating how they communicated with people who could not verbalise their wishes. Staff explained that if needed, they used non-verbal methods of communication using gestures, signs and showing people items to enable them to give consent and make choices. Our observations confirmed that these methods were used effectively to gain consent and understand people's needs.

The Mental Capacity Act 2005 (MCA 2005) 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.

We checked whether the service was working within the principles of the MCA 2005 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. The best interest meetings and subsequent decisions taking place in the service were fully recorded and documented in compliance with guidance. We found that this process protected the person's rights.

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 2005. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The resisted 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

Staff saw their roles as enablers for people. We observed staff were assisting and encouraging independence rather than just doing things for people. For example, we saw a member of staff gently encouraging a person to wipe off the table after lunch. We observed them using hand on hand positive engagement.

Care plans included information about people's wishes for end of life care and their religious and cultural beliefs. For example, one person had made a choice about their preferred funeral arrangements in line with their chosen religious beliefs.

Staff treated people well. When they spoke to us they displayed the right attitude, they told us they gave people time to do things, they tried not to rush people. Staff calmly asked a person to get changed ready to go out. Staff told us about using objects of reference to communicate with people to help their understanding of what choices people wanted to make.

We observed good communication between staff and people living at Oak Avenue, and found staff to be 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.

Positive relationships had developed between people who used the service and the staff. We observed all staff to be calm, reassuring and individually responsive to people at all times. Staff also described to us the signs they could recognise if people were in pain. Staff were often observed to be chatting with people, using eye contact and appropriate language. Staff understood how to maintain a mostly calm and relaxed atmosphere, and at times people were laughing with staff.

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.

We viewed two people's bedrooms. The rooms within the service were homely and personalised to a high degree to people's choice and lifestyle. This was a positive aspect of the service for people during the inspection.

Staff understood that all information held about the people who lived at the service was confidential and would not be discussed to protect people's privacy. Information about people was kept securely in the office and the access was restricted to staff. Staff understood their responsibility to maintain people's confidentiality. We observed they were careful when discussing personal information.

Good

Is the service responsive?

Our findings

People's needs had been fully assessed and care plans had been developed on an individual basis. The provider employed their own Positive Behavioural Support (PBS) staff and person centred care planning (PCP) co-ordinators. PBS is a nationally recognised model of care and is seen as one of the best way of supporting people who display, or are at risk of displaying behaviour which may cause harm to themselves or others. PCP is a way of thinking and doing things that sees the people in the service as equal partners in planning, developing and monitoring care to make sure their needs and preferences were met.

We observed that staff were responsive and flexible to people's choices and needs. PBS care plans were comprehensive, with every area of the person's life is broken down into sections, for example, activities, independence participation, personal care etc. Within each section each area was broken down further with realistic personalised targets. For example, stripping and making their bed. The step by step care plan included what people could do for themselves and how much support they need from staff. Very small steps of progression were used to encourage development. The person's care and development were monitored daily and weekly and the care plans were adjusted accordingly. Where appropriate assistive technology was in place. (Assistive technology is a system of non-intrusive equipment used to assist people to maintain their safety or independence.) For example, one person used an assistive technology to alert staff if they had an epileptic seizure when in bed.

Staff told us that the information gained from these records were used to gauge people's contentment. For example, how were their independence and participation targets affecting instances and regularity of behaviour that challenge staff or the service. If behaviours that challenged were increasing, staff met at a weekly clinical group meeting and reviewed people's needs and environment and made adjustments accordingly. This was enabling for people who communicated using behaviours and body language as staff understood the decisions and choices people preferred to make.

The provider used appropriate personalised care planning formats for people with a learning disability. For example, one person had covered their care plan with pictures of characters from their favourite television program. People also used lots of photographic and pictorial information in their care plans to assist their understanding. For example, keeping safe from abuse or places they liked to visit. This gave people some interest and ownership of the information about them.

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. Activities were recorded. This meant staff could understand and meet this person's individual needs.

The activities people were involved in were tailored to their choice and lifestyle to encourage participation and reduce social isolation. The provider's hired an external venue on a weekly basis to provide access to people for group activities. Some people had one to one singing sessions, others made use of sensory equipment to stimulate touch, sight and smell. Others had routinely been for lunch out, attended social

events and visited places that may interest them. For example, beaches and woodland walks. Staffing was provided based on the assessment of risks the activity to be undertaken may have. Activities were introduced to people slowly so that staff learn by the person behaviours if they were comfortable with the activity.

Person centred reviews took place with health action plans and communication passports in place. Health action plans are recommended for people with learning disabilities by the department of health to promote people's health and their access to health services. Communication passports are easy to follow person-centred booklets for those who cannot easily speak for themselves when they need to use other services. For example, if they were admitted to a hospital.

There was a general policy about dealing with complaints that the staff and registered manager followed. The complaints procedure was made available in the service. For people living in the service the staff used analysis of behaviours and reactions within the PBS model to gain information about people to gauge what had made them unhappy and why. Any concerns were recorded in people's care plans and discussed within the weekly clinical meetings.

Good

Is the service well-led?

Our findings

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 registered manager had a clear understanding of what the service could provide to people in the way of care and meeting their learning disabilities needs.

The registered manager and their staff team were well known by people. We observed staff being greeted with smiles by people. The registered manager had extensive experience of delivering person centred care to people with learning disabilities and complex needs. It was clear from our discussions with them that they had the skills and motivation to lead the staff team in the delivery positive outcomes for people.

The values of the organisation were clearly noted and identified within organisational policies and provider statement of purpose. The providers vision was based on enabling people with learning disabilities to take control of their lives and be less isolated in their communities and to live in a homely environment. Staff told us that they learnt about the values of the organisation from day one of their employment. Staff were committed and passionate about delivering high quality, person centred care to people living with learning disabilities and autism.

Learning and practice development were supported by the providers. The registered manager attended networking events such as the learning disability practice forums. A member of the team currently holds a certificate in person centred support and a diploma in positive behavioural support awarded by the Tizard and is currently working towards a BSc (hons) in Intellectual and developmental disabilities. Their learning was disseminated down to staff and staff approaches adapted for people when staff provided support. (The Tizard Centre is the leading UK academic group working in learning disability and community care, is widely known world-wide and has an international reputation and works to advance knowledge about the relationship between care services and their outcomes for people with learning disabilities.)

The provider's quality assurance system were based on a person centred culture, putting people who lived in the service at the centre of everything they did. People's wider circles of support were included such as staff, relatives and health and social care professionals. The provider's and staff demonstrated their commitment to a lifestyle approach model of care that fostered a proactive, positive value led approach to the management of challenging behaviours. The providers visited the people in the service on a weekly basis. They attended the weekly clinical meetings where discussions took place about people's progress and wellbeing. One member of staff said, "The providers are here weekly, they are very approachable, all of the management are very open." The providers contributed to finding solutions to the challenges or barriers people faced in living fulfilled lives. They had invested in the service to make it a homely place that people felt comfortable in. The service has been adapted to suit people's needs. For example, all of the accommodation is accessible to people with physical disabilities. One person had been provided with an on-suite shower room. Staff said, "This service is now a lot better for people, they are a lot calmer."

People were protected by consistent and comprehensive quality audits. The registered manager had carried

out 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. They completed audits of all aspects of the service, such as medicines, kitchen hygiene, infection control, care plans, staff training and staff health and wellbeing.

Actions taken as a result of analysis included changing behavioural management guidance for staff referring individuals to mental health professionals, refresher or additional training for staff and sharing information with relatives, the local safeguarding team and CQC. For example, the providers had organised additional training for staff around caring for a person at Oak Avenue with a bi-polar disorder.

The providers and the registered manager sought to protect the health and emotional wellbeing of staff who often worked intensely in stressful situations. Key staff received training about stress management to enable them to understand and support the management of stress within the team. Staff meetings and staff surveys were carried out and we saw that the providers responded to any issues by offering additional support to staff. For example, by staff attended reflective discussion groups.

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.

The registered manager was proactive in keeping people safe. They discussed safeguarding issues with the local authority safeguarding team. The manager understood their responsibilities around meeting their legal obligations. For example, by sending notifications to CQC about events within the service. This ensured that people could raise issues about their safety and the right actions would be taken.