Brighton and Hove City Council

Brighton & Hove City Council - 83 Beaconsfield Villas

Inspection report

83 Beaconsfield Villas
Brighton
East Sussex
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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

This inspection took place on 9 August 2016 and was unannounced.

83 Beaconsfield Villas provides accommodation and personal care for up to five younger adults with a learning disability or autistic spectrum disorder. The service specialises in working with people whose behaviour is complex and can be challenging. The service is situated in Brighton and is in a large detached house near the town centre. People's bedrooms are located over four floors and there are two one person self-contained flats within the building. Communal areas include a kitchen/dining room and two lounges. There is a large garden for people to use. One of the self-contained flats also has its own private garden. Five people were living in the service at the time of our inspection.

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 was not present during the inspection, however we contacted them after the inspection for clarification and further information.

The last inspection was carried out on 3 and 8 July 2015. We found a breach to the Regulations. This was in relation to safe storage and recording of medicines. We also found areas which required improvement in relation to where people had 'as and when required' (PRN) medicines the guidance for care staff to follow had not been updated. The regular checks of the fire equipment in between checks made by the external contractors had not been maintained. Staff training records had been updated and this highlighted care staff had not received updates of their training to meet the timescales of the provider. Where bank staff worked in the service there was not a record of the training they had completed. So it could not be assured that they had the necessary training to meet peoples care and support needs. The hot water checks had not been maintained to ensure the delivery of hot water at a safe temperature. People were supported to eat a healthy diet. However, records of what people had eaten and fluids consumed to inform care staff had not been maintained. Recruitment documents were not fully available for senior staff to access. Feedback and quality assurance systems were not fully in place. The provider provided the CQC with an action plan as to how they would address these issues. We looked at the improvements made as part of this inspection. At this inspection we found the provider had followed their action plan, improvements had been made and the regulations were now being met.

Relatives and the visiting healthcare professional told us they felt people were safe. One relative told us, "He is very safe. We are very pleased he gets his care there." People were supported by care staff who were trained in safeguarding adults at risk procedures and knew how to recognise signs of abuse. There were systems in place that ensured this knowledge was checked and updated. Accidents and incidents had been recorded and appropriate action had been taken and recorded by the registered manager. There were systems in place to assess and manage risks and to provide safe and effective care. People were supported

through a risk management framework to access a range of activities. One member of staff told us, "We keep the guys safe. All five people are incredibly vulnerable, so we have to be vigilant as they could get into trouble. We give them a good quality of life, to be able to enjoy life and get new experiences. We are always thinking about new experiences for them all."

People were supported to eat a healthy and nutritious diet. People had access to health care professionals. All appointments with, or visits by, health care professionals were recorded in individual care plans. Medicines were managed safely and people received the support they required from care staff. There were systems in place to ensure that medicines were administered and reviewed appropriately.

The premises were well maintained. The environment was clean and spacious which allowed people to move around freely without risk of harm. Equipment and services such as gas and electric supplies and the fire alarm system had been checked by external contractors.

Consent was sought from people with regard to the care that was delivered. Staff understood the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Care and support provided was personalised and based on the identified needs of each individual. Where people were unable to make decisions for themselves staff had taken appropriate action to arrange meetings to make a decision in their best interests.

People were supported by kind and caring staff. People were treated with respect and dignity by the care staff. They were spoken with and supported in a sensitive, respectful and professional manner. There were robust recruitment procedures in place. There were sufficient numbers of suitable care staff to keep people safe and meet their care and support needs. Care staff told us they were supported to develop their skills and knowledge by receiving training which helped them to carry out their roles and responsibilities effectively.

There was a clear management structure with identified leadership roles. The registered manager told us that they operated an 'open door policy' so people, their representatives could discuss any concerns. Systems were in place to audit and quality assure the care provided. There was a detailed complaints procedure, and relatives told us they knew who to talk to if they had any concerns. Feedback was sought on how to improve the service, through the reviews of people's care, and the completion of a satisfaction questionnaire to help identify any areas for improvement. There was evidence as to how any feedback was acted upon and improvements made to the service provided. Care staff told us that communication throughout the service was good and included comprehensive handovers at the beginning of each shift and regular staff meetings. They confirmed that they felt valued and supported by the managers, who they described as very approachable. One member of staff told us, "It's a really, really good team. Everyone one is here because they want to do the job. We all pull together and help each other." Another member of staff told us, "I really love it here."

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.

People's care records included support plans, and risk assessments.

People were supported by care staff who understood their responsibilities in relation to safeguarding. Staff knew what action to take if abuse was suspected. All new staff were vetted and checks undertaken to ensure they were safe to support adults.

Medicines were managed, stored and administered safely and regular audits were undertaken by staff in the service.

Is the service effective?

Good

The service was effective.

Care staff had an understanding around obtaining consent from people, and had attended training on the Mental Capacity Act 2005 (MCA).

There was a comprehensive training plan in place. Care staff had the skills and knowledge to meet people's needs. They had a good understanding of peoples care and support needs.

People were supported to maintain good health and had access to a range of healthcare professionals. Food and nutrition was monitored by care staff and people's likes and dislikes were taken into account.

Is the service caring?

Good

The service was responsive.

People had been assessed and their care and support needs identified. These had been regularly reviewed and any changing needs were responded to. People had been consulted with as to the activities they would like to do.

The views of people and their representatives were sought and

informed changes and improvements to service provision.

A complaints procedure was in place. Relatives were comfortable talking with the staff, and told us they knew who to speak to if they had any concerns.

Is the service responsive?

Good

The service was well led.

Quality assurance was used to monitor and help improve standards of service delivery.

The leadership and management promoted a caring and inclusive culture. Care staff told us the management was approachable and very supportive.

Is the service well-led?

Good

The service was well led.

Quality assurance was used to monitor and help improve standards of service delivery.

The leadership and management promoted a caring and inclusive culture. Care staff told us the management was approachable and very supportive.

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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 took place on 9 August 2016 and was unannounced and undertaken by one inspector.

Before the inspection, we reviewed information we held about the service. This included previous inspection reports, and any notifications, (A notification is information about important events which the service is required to send us by law) and complaints we have received. Before the inspection the provider completed 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. This helped us with the planning of the inspection. From this information, following our inspection, we received feedback from a health care professional about their experiences of the service provided.

We used a number of different methods to help us understand the views and experiences of people, as they were not all able to tell us all about their experiences due to their learning disability. We observed people's care and support in communal areas throughout our inspection to help us understand the experiences people had. We spoke with two senior care officers, and four care staff. After the inspection we also spoke with two relatives.

We looked around the service in general, including the communal areas. As part of our inspection we looked in detail at the care provided for two people, and we reviewed their care and support plans. We

looked at menus and records of meals provided, medicines policies and procedures and administration records, the compliments and complaints log, incident and accidents records, records for the maintenance and testing of the building and equipment, policies and procedures, meeting minutes, staff training records and two staff recruitment records. We also looked at the service's own improvement plan and quality assurance audits.

The service was last inspected on 3 and 8 July 2015.

Good

Is the service safe?

Our findings

People appeared relaxed, happy with staff and very comfortable in their surroundings. Feedback from relatives and the health care professional was that people were safe in the service. One relative told us, "The care he gets there is what we would expect to be given .He is very safe. We are all very pleased he gets care there. They help him to be secure in his world." Another relative told us, "Very much so. They seem to understand (Person's name) He is very content with the environment and there is usually enough staff." Comments from the recent quality assurance questionnaires completed in the service included, 'It's safe clean and very supportive.'

At the last inspection on 3 and 8 July 2015, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because not all medicines had been stored or administration recorded to meet the requirements of the law. At this inspection we found all medicines were stored appropriately and care staff had recorded any administration. Medicines policies and procedures were in place. These had been reviewed since the last inspection to ensure current guidance had been considered. Where people took medicines on an 'as and when' basis (PRN) there was guidance in place for staff to follow to ensure this was administered correctly. The information was up-to-date so care staff had the latest guidance to follow. Systems were in place to order repeat medicines in a timely way. We completed a spot check of three people's medicines, which were the same as the records indicated they should be. An audit and stock check had been completed to ensure people received their medicines as prescribed. This was to help identify any discrepancies or errors and ensure they were investigated accordingly.

At the last inspection on 3 and 8 July 2015 we found that checks of the temperature to ensure that the hot water was being delivered to ensure people's safety had not been maintained. Equipment had been regularly checked and serviced for essential safety equipment such as emergency lighting, the fire alarm system and fire extinguishers. However, regular checks of the fire safety equipment in between these external checks had not been consistently completed. At this inspection we found there were records the hot water and the fire system had been regularly checked. We found the premises was well maintained. The environment was clean and spacious, which allowed people to move around freely without risk of harm. Staff told us about the regular checks and audits which had been completed in relation to fire, health and safety and infection control. Contingency plans were in place to respond to any emergencies, such as flood or fire. Staff told us they had completed health and safety training. There was an emergency on call rota of senior staff available for help and support, and care staff told us they knew who to contact if they needed any advice or guidance. Where care staff had used this they told us it had worked well.

People were cared for by staff who had been recruited through a safe recruitment procedure. Senior staff had the support of the provider's human resources department when recruiting staff. New staff had completed an application form, two references and a criminal records check had been sought. Where new staff had been recruited internally from within the organisation, and had previously been through the recruitment process. Staff had completed a further application form and attended an interview. Each member of staff had a criminal records check completed and a further written reference was requested to

support the application.We spoke with one new member of staff who was able to confirm the recruitment process had been followed.

The provider had a number of policies and procedures to ensure care staff had clear guidance about how to respect people's rights and keep them safe from harm. This included systems on protecting people from abuse. Senior staff told us they were aware of and followed the local multi-agency policies and procedures for the protection of adults. Care staff told us they were aware of these policies and procedures and knew where they could read the safeguarding procedures. They demonstrated a good understanding about what constituted abuse and how they would raise concerns of any risks to people and poor practice in the service. They told us they had received safeguarding training and were clear about their role and responsibilities and how to identify, prevent and report abuse.

There were arrangements to help protect people from the risk of financial abuse. Care staff were able to tell us about the procedures to be followed and records to be completed to protect people. One member of staff then showed us how they monitored that the procedures were being followed and records completed correctly as part of the regular review process.

There was a whistle blowing policy in place. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. The care staff we spoke with had a clear understanding of their responsibility around reporting poor practice, for example where abuse was suspected. They also knew about the whistle blowing process and that they could contact senior managers or outside agencies if they had any concerns.
To support people to be independent, risk assessments were undertaken to assess any risks for individual activities people were involved in to protect them from harm. Each person's care and support plan had an assessment of the environmental risks and any risks due to their health and support needs, and these where possible had been discussed with them. The assessments detailed what the activity was and the associated risk and guidance for staff to take. For example, supporting people to use transport to get to and from an activity. There was a regular review of the risk assessments, and staff told us if they noticed changes in people's care needs, they would report these to one of the managers and a risk assessment would be reviewed or completed.

Staff had completed training in managing people's behaviours that challenged others. Care staff were able to tell us what was in place to support people and could talk about individual situations, and what they should do to diffuse a situation. When asked what the service did well one member of staff told us, "We take the challenging, make it acceptable and change perceptions for people who do not know the service well." Additionally staff from the behavioural support team had been contacted for support and advice. Care staff told us reviews of peoples care and support were important as it enabled senior staff to have feedback from the care staff as to what had worked well and not worked well. From this they could look at the approach staff had taken and identify any training issues. One member of staff told us, "If used we sit down and talk about it, and fill out an incident form." They also told us of further refresher training planned in the next month, and said this was as, "It's been used and to make sure it has been used correctly and appropriately."

On the day of our inspection there was sufficient staff on duty to meet people's needs. One relative told us, "They have an experienced staff team. The care he gets is very good." We looked at the staff duty rota, and staff told us how staffing was managed to make sure people were kept safe. A formal tool was not used to calculate the level of staff needed, but guidance was in place as to the minimum staffing levels which the service could operate. The senior staff told us they looked at the staff skills mix needed on each shift, for example to ensure that there was always experienced care staff on duty with new care staff or agency/bank care staff. Also what activities were planned, whether people needed one to one, or two to one support for

specific activities, and anything else such as appointments people had to attend each day to determine the level of staff needed to be on each shift. The registered manager and senior staff regularly worked in the service and so were able to monitor that the planned staffing level was adequate.

There were weekly staff meetings where staff were able to discuss how things were going in the service, what had worked well and not worked so well, and this could include the staffing levels. Staff told us there was adequate staff on duty to meet people's care needs. Minimum staffing levels were maintained, but staffing was usually above this to ensure people could be supported to attend their chosen activities. One member of staff told us, "That's where our staff team shines they get out and do what they need to do." There had been a number of care staff vacancies, which had led to a high use of agency and bank staff, but this had improved as new care staff had been recruited.

Good

Is the service effective?

Our findings

Relatives and the health care professional told us that the staff were knowledgeable and kept them in touch with what was happening for people. One relative told us, "They have an experienced staff team. They all provide good care." Comments from the recent quality assurance questionnaires completed in the service included, 'Permanent staff understand (Person's name) and their complex needs very well.'

At the last inspection on 3 and 8 July 2015 an audit undertaken in the service had identified not all care staff had received the training updates required. There was not a record that it had been checked that bank staff who worked in the service had also completed the required training and updates. At this inspection we found there were systems in place to monitor staff attendance at training and to highlight to staff when refresher training was due. One member of staff told us, "Through supervision the training records come out and we discuss what needs to be refreshed." There was now a record that it had been checked that bank staff who worked in the service had completed the required training and updates.

People were supported by care staff who had the knowledge and skills to carry out their role and meet individual peoples care and support needs. Induction training had been reviewed to incorporate the requirements of the new care certificate. This is a set of standards for health and social care professionals, which gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. The new care staff had also completed an induction specific to working at 83 Beaconsfield Villas. There was a period of shadowing a more experienced staff member before new care staff started to support people. The length of time new care staff shadowed was based on their previous experience, whether they felt they were ready, and a review of their performance. One new member of the care staff told us, "I was very impressed. I had a full induction. It was thorough and in depth. I shadowed for two weeks. You don't get pressured into doing things you don't feel able to do." They said the induction had provided them with all the information and support they needed when moving into a new job role.

Care staff received training that was specific to the needs of people using the service, which included training in moving and handling, medicines, first aid, safeguarding, health and safety, food hygiene, equality and diversity, and infection control. Care staff also completed training to help them understand learning disabilities, behavioural support and their role in supporting people to increase their independence. Care staff told us this had given them information and a greater understanding of how to support people with a learning disability. They told us they felt they had received the training they needed to meet peoples care needs. They had received regular updates of training as required. One member of staff told us, "Access to training has improved. It's a much better system. It helps us keep track of our training." Senior staff were continually updating the recording systems in place to ensure they were alerted to when care staff required any training updates. Senior staff were able to show us that requests for training had been made.

At the last inspection on 3 and 8 July 2015 records of what people had eaten were not accurately maintained. This did not fully support care staff to give them a clear and full picture of whether people had received adequate food and fluids during the day to maintain their health. At this inspection we found

records were more fully completed. There were systems in place to check the completion of records and highlight any omissions in recording. People were supported to eat a balanced diet and drink enough fluids. People's nutritional needs were assessed and recorded, and people's likes and dislikes had been discussed as part of the admissions and review process. People's weight was monitored regularly with people's permission. There were clear procedures in place regarding the actions to be taken if there were concerns about a person's weight. For example, if people were putting on weight. The menu was set up to provide meals that people liked to eat. People were encouraged and supported to follow a healthy eating plan. Some people had specific dietary requirements either related to their health needs or their preference and these were detailed in their care plans. One relative told us, "(Person's name) used to have a very restricted diet by choice. They have done a good job in expanding the choices in his diet."

Staff demonstrated an understanding and there were clear policies around the Mental Capacity Act 2005 (MCA). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. One member of staff was able to tell us about a meeting held in one person's best interest when they needed to have dental work completed. Senior staff told us they were aware how to make an application, and about the DoLS applications that had already been made. Care staff told us they had completed this training and all had a good understanding of what this meant for people to have a DoLS application agreed, or any actions they had to follow to support people where a restriction would be place on a person's freedom in order to keep them safe had been applied for.

Care staff told us that the team worked well together and that communication was good. They were involved with any review of the care and support plans. They used shift handovers, shift debriefs to give staff structured peer to peer support in order to improve practice and the support that is provided and a communications book to share and update themselves of any changes in people's care. They received supervision though one to one meetings and observations whilst they were at work and an annual appraisal from their manager. These processes gave care staff an opportunity to discuss their performance and for senior staff to identify any further training or support they required. Additionally there were regular weekly staff meetings to keep staff up-to-date and discuss any issues within the service. One member of staff told us, "Every week there is a staff meeting. We discuss what has worked well. Especially with (Person's name) having moved in."

People were supported to maintain good health and received ongoing healthcare support. People's physical and general health needs were monitored by staff and advice was sought promptly for any health care concerns. Care and support plans contained multi-disciplinary notes which recorded contact with healthcare professionals such as GPs, nurses or dieticians and when referrals had been made. Feedback from the healthcare professional we spoke with supported this. Care staff told us that they knew the people well and if they found a person was unwell they would report this to a manager.

Good

Is the service caring?

Our findings

We observed care being given during the inspection. People benefited from staff who were kind and caring in their approach. People were treated with kindness and compassion. Feedback from the relatives and the social care professional was that staff were very kind and caring. People were listened to and enabled to make choices about their care and treatment. Comments from the recent quality assurance questionnaires completed in the service included, '(Person's name) is very happy in his home. 'One member of staff told us, "The only gripe I hear is what's the best way to do the job." Everyone one is focused on doing the best job that they can."

Care provided was personal and met peoples individual needs. People were addressed according to their preference and this was by their first name. A key worker system was in place, which enabled people to have a named member of the care staff to take a lead and special interest in their care and support. The relatives were aware of the keyworker for their relative and commented the keyworkers and staff were excellent. Staff spoke about the people they supported fondly and with interest. People's personal histories were recorded in their care files to help staff gain an understanding of them, and staff were knowledgeable about their likes, dislikes and the type of activities they enjoyed. Staff spoke positively about the standard of care provided and the approach of the staff working in the service. People had a care and support plan in place which detailed their goals, such as working towards being more independent and improving their quality of life. These had been discussed where possible with people and their family, and their progress towards their goals was discussed as part of their reviews of care.

People were treated with dignity and respect. Staff responded to people when spoken to and listened to what people had to say. We noted staff showed patience and understanding when communicating with and supporting people. People were not rushed and were given the time they needed to complete tasks themselves without being put under pressure, for example to eat their food. Care staff had received training on privacy and dignity and had a good understanding of how this was embedded within their daily interactions with people. They were aware of the importance of maintaining people's privacy and dignity, and were able to give us examples of how they did this. One member of staff told us when they provided personal care they ensured the , "Blinds are down in (Person's name) room as they would be changing their clothes several times during the day. We are mindful of how people are dressed when they go out."

The atmosphere in the service was calm and relaxed, but there was also a general hum of activity. People had their own bedroom and ensuite facility for comfort and privacy. This ensured they had an area where they could meet any visitors privately. Where possible they had been able to bring in personal items to make their stay more comfortable. People had been supported to keep in contact with their family and friends. One relative we spoke with told us they and their wife visited daily and joined in one of the daily activities their relative participated in. People all had the support of their family, and had not had the need for additional support when making decisions about their care from an advocacy service. Comments from the recent quality assurance questionnaires completed in the service included, 'Staff are always very accommodating and encourage family contact, even at short notice. 'Senior staff were able to confirm advocacy services had been used previously to support people and they had information on how to access

an advocacy service should people require this service again.

Care records were stored securely. Information was kept confidentially and there were policies and procedures to protect people's personal information. There was a confidentiality policy which was accessible to all staff. Staff demonstrated they were aware of the importance of protecting people's private information.

Good

Is the service responsive?

Our findings

Care staff understood people's individual needs and there was the opportunity to build positive and supportive relationships. People also enjoyed a range of leisure activities, for example listening to music or going out for a drive or a walk. Relatives and the health care professional confirmed people had been supported to attend a range of activities and they had been involved in any review of the care and support provided. One relative told us, "They really do try to think things out. They try very hard to think outside of the box to resolve problems." Another relative told us, "They understand (Person's name) very well. They try hard to keep him happy. They understand how he reacts and how to respond. They give him choices as much as they can."

Senior staff were able to tell us about the pre-admission assessment that took place. One member of staff told us for the last admission to the service they had, "As much information as they could give us at the time. There was also an assessment completed by staff from the service." This enabled senior staff to identify if people's individual care and support needs could be met in the service, and that people were happy to move in. The healthcare professional told us, "The transition planning for the new service user started many months before they moved in. The service met with the community learning disability team (CLDT) clinicians several times in order to plan the transition and gather key information to ensure risk assessments and guidelines were in place and all staff supporting them were as prepared as possible for their arrival. As with other CLDT clinicians supporting the service user we met with members of the team several times before and soon after they moved in to closely monitor how they were settling in and receive feedback from the team to ensure we could update risk assessments and guidelines etc. Communication with the service has remained very good." One member of staff told us that during the transition period, "There were short visits with mum and dad. They looked around their room and the place. It seemed to work really well. They came three to four times with mum and dad."

Staff and relatives told us that care and support was personalised and confirmed that, where possible, people and their relatives were directly involved in care planning and goal setting and any review of their care and support needs. One relative told us, "I feel if I say something they will take it on board." People had clear and detailed care and support plans in place which reflected their individual needs and preferences. These described a range of people's needs including personal care, communication, eating and drinking and support required with medicines. This information would ensure that care staff understood how to support the person in a consistent way and to feel settled and secure. These had been reviewed and audits were completed to monitor the quality of the completed care and support plans and progress towards the development of people's life skills and independence.

We asked care staff how relevant information about people's care was communicated to staff coming on duty. Staff told us they knew what people's current care needs were and received verbal updates from each other when people's needs changed and read about them in people's daily records. We were told a handover took place between every shift to ensure continuity of care. There was a shift plan in place which described tasks that needed to be undertaken either 'am' or' pm' and also recorded the staff member allocated to complete it.

Information was provided to people in a way they could understand. We spoke with one member of staff who took the lead for communication in the service. They told us communication was discussed at each team meeting. There was an opportunity discuss what had worked well or had not worked so well. They had also spent time to 'sign' together to help keep people's signing skills up-to-date. Scare staff demonstrated an understanding of non-verbal communication needs and how to interact with people who could not verbally communicate. They told us, when offering choice to people who could not verbally communicate; they used facial expression, body language and gestures to communicate which staff used to understand peoples likes and dislikes. They could also tell when a person was not happy with the care being provided. We saw symbols (a visual support to written communication) and objects of reference were used to support people, communication boards and staff were also available who could use Makaton (a language system of hand signs and symbols) to communicate with people. This showed us that people's communication needs were met.

People were actively encouraged to take part in daily activities around the service such as meal and snack preparation. Each person had a weekly timetable of activities they participated in. They detailed activities such as, going out for a walk, playing with a ball in the park, a car drive, going for a swim, eating out in a restaurant, or going out to the local shops. Comments from the recent quality assurance questionnaires completed in the service when asked about activities included, '(Person's name) is offered opportunities to listen to music, favourite DVD's, cooking and physio ball within the home. Staff encourage (Person's name) to do long walks, visit parks and swimming.'

The compliments and complaints system detailed how staff would deal with any complaints and the timescales for a response. It also gave details of external agencies that people could complain too such as the Care Quality Commission and Local Government Ombudsman. We asked care staff how they ascertained if people were unhappy with any aspect of the care and support provided. They told us, they knew the people well, and they used either facial expression or body language to tell care staff they were unhappy. Relatives told us they felt listened to and that if they were not happy about something they would feel comfortable raising the issue. We looked to see how complaints had been dealt with. However, no formal complaints had been received this year.

Good

Is the service well-led?

Our findings

Care staff and relatives told us they thought the service was well led. They told us they felt included and listened to, heard and respected. One relative told us, "They do very well. The care is good. The carers do what they can." When asked what had improved since the last inspection one member of staff told us, "We are a lot more organised." Another member of staff told us, "We are in a good place at the moment."

At the last inspection on 3 and 8 July 2015 there was not a registered manager in place. Robust quality assurance processes were not in place, and had not identified issues to be addressed. At this inspection the service had a registered manager. The registered manager and the senior staff had undertaken audits on a number of aspects of the service, for example completion of care records, health and safety and medicine administration records. We found these had been fully maintained. Relatives confirmed they or their family were involved in the review of their care and support. Relatives and the health care professional told us they were able to comment on the service through these reviews. However, at the last inspection there were no other formal systems to receive feedback and help inform the quality assurance processes in the service, such as regular quality assurance questionnaires or relatives meetings. At this inspection we found quality assurance questionnaires were being used to help gain feedback on the care and support being provided from people's relatives. Comments received included, '(Person's name) behaviour management is excellent and he has conscientious and caring key workers,' 'Excellent keyworkers and staff, ' and 'It's safe, clean and very supportive.' When asked what relatives liked about the service one person commented, 'Commitment of the staff who provide a high standard of care for (Person's name). warm and caring people and environment.'

There was a clear management structure with identified leadership roles. The registered manager was supported by two senior care staff. The registered manager and senior staff promoted an open and inclusive culture. When asked why the service was well led, one member of staff told us, "It's having respect for the manager. He works on the shop floor. He is very good with boundaries. He has got very good people skills." Care staff told us the management team were approachable, knew the service well and would act on any issues raised with them. They told us they were being supported by their line manager and they were receiving the support they needed to undertake the role. One member of staff told us, "We would not be able to work here if we weren't 100% supported." Another member of staff told us, "It's one of the best teams I have worked with. Our manager is on the floor most of the time and knows what's going on. He is accessible. We have a laugh which is a major, major bonus."

Where appropriate, specialist advice and support had been sought and this advice was included in care plans. For example, staff confirmed that advice and support had been sought from the community learning disability team (CDLT). Feedback from the health care professional was that there was good interactions with staff who contacted them appropriately and followed guidance given. They told us, "It's not an easy service to work in but the team remain highly motivated to provide the best possible support to all of the service users. This has been evidenced recently with the latest service user who recently moved in who has displayed very high risk challenging behaviours, some predicted and some not predicted. The team have communicated with me excellently in order to monitor the behaviours, update the behaviour support plan

and feedback re staff confidence, resilience and wellbeing."

The provider's representatives had also undertaken periodic quality assurance visits to look at the quality of the care provided. We looked at their last report following their visit in 2016 to review actions taken to address issues highlighted. This detailed where it had been found the service was working well and where it was felt further improvements could be made, and the timescale for this to be implemented. Work had been completed within the identified timescales.

Care staff told us they were asked for their views about the service. Staff meetings were held each week throughout the year. These were used as an opportunity to both discuss problems arising within the service, as well as to reflect on any incidents that had occurred. These had been used for updates on people's care and support needs, and to discuss people's progress towards their agreed goals. We looked at staff meeting minutes which recorded where issues had been identified, these had been discussed with the wider staff group and how improvements could be made. An action plan detailing work to be completed was then used to inform the next staff meeting of actions taken.

The aim of staff was based on everyone having, their rights as citizens, inclusion in their local community, choice in their daily life, real chances to be independent, and control over choices and decisions made about their lives. Staff demonstrated an understanding of the purpose of the service, with the promotion and support to develop people's life skills, the importance of people's rights, respect, and diversity and understood the important of respecting people's privacy and dignity.

The manager had regularly sent statistical information to the provider to keep them up-to-date with the service delivery. We looked at the last report which gave the
provider information on staffing, incident and accidents, complaints and the maintenance of the premises. This enabled the provider to monitor or analyse information over time to determine trends, create learning and to make changes to the way the service was run. The registered manager told us that where actions had been highlighted these had been included in the annual development plan for the service, and worked on to ensure the necessary improvements. They were aware they needed to submit notifications to us, in a timely manner, about all events or incidents they were required by law to tell us about. Policies and procedures were in place for staff to follow. There was a policy and procedure on people's responsibility under the Duty of Candour. This is where providers are required to ensure the there is an open and honest culture within the service, with people and other 'relevant persons' (people acting lawfully on behalf of people) when things go wrong with care and treatment. The registered manager confirmed an understanding of their responsibilities. The registered manager was able to attend regular management meetings with other managers of the provider's services. This was an opportunity to discuss changes to be implemented and share practice issues and discuss improvements within the service.