Home from Home Care Limited

The Oaks

Inspection report

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Ratings

Overall rating for this service	Outstanding ☆

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

Summary of findings

Overall summary

We carried out our announced inspection visit on 20 and 21 September 2017.

The Oaks is registered to provide accommodation and personal care for up to six people who may have learning disabilities or autistic spectrum disorder.

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.

This was the first inspection since the service was registered.

The provider had effective systems in place to ensure that there were always the correct amount of staff with the appropriate skills and training needed to provide safe care for people. There was a structured induction program to ensure staff developed the skills needed to work for the provider and ongoing training to ensure staffs skills remained up to date. Staff were provided with support from their line manager and external consultants to ensure they were working in line with best practice. Recruitment processes ensured staff were safe to work with people at the home.

Staff had received training in how to keep people safe. Staff worked with the Positive Behavioural Support (PBS) team to help people manage their behaviours and reduce the need to restrain people for their own safety. Incidents were reviewed and changes made in care to support positive behaviour in people.

Risks to people were managed and care was planned to keep people safe. The registered manager had submitted appropriate applications under the Deprivation of Liberty Safeguards (DoLS) to ensure people's human rights were protected. People's abilities to make choices were respected and where needed decisions were made in people's best interests. Where people had the ability to make an informed choice about risk taking staff worked with people to support their choices. Other risks to people were identified and appropriate action taken to keep people safe.

People's medicines were available to them when needed and stored safely. However, we saw that the provider had not consulted with a pharmacist to ensure that there was no interaction between food and medicine when taken together. People were able to make choices about their food and their diet was individualised to meet their needs. Appropriate advice was taken to ensure that people could eat and drink safely.

Staff were kind, caring and knew how to personalise care to meet people's individual needs. They respected people's privacy and dignity and people's achievements were celebrated. Staff understood people's communication needs and supported them to make their views known. People's personal environment had

been decorated to reflect them as an individual and the care they needed.

Staff ensured that people's needs were assessed and care plans reflected their individual needs and were updated when people's needs changed. People and their relatives had been involved in planning their care. People were supported with meaningful activities which supported their well-being and encouraged them to access the local community.

People living at the home and their relatives were able to raise concerns and the provider took action to improve the care they received. People's views about the quality of care they received were gathered and used to drive improvements in care. Additionally people were involved in the running of the homes and their views were taken into account when recruiting staff or making changes.

The provider had effective systems in place to monitor the quality of care people received and took action when any concerns were identified. Staff felt supported and were encouraged to develop. The provider was working towards a no blame culture and concerns raised were used to continually improve the quality of care people received.

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.

Staff knew how to keep people safe from abuse and worked to reduce the need for restraint.

Risks to people were identified and plans put in place to keep people safe.

Systems in place ensured that there were always enough staff to meet people's needs.

Medicines were safely managed. However, advice was needed from a pharmacist regarding interactions between medicines and food when taken together.

Is the service effective?

Good

The service was effective.

Staff received effective training and support which enabled them to provide safe care.

People's rights were protected under the Mental Capacity Act 2005.

People were supported with appropriate food and drink to stay healthy.

Staff supported people to access healthcare when needed.

Is the service caring?

Good

The service was caring.

Staff were kind, caring and understood people's needs.

People's privacy and dignity were respected.

People were able to make choices about their everyday lives.

Is the service responsive?

Outstanding

The service was responsive.

People's needs were assessed before they moved into the service and their transition to the service planned to support them through the change.

Care plans reflected people's needs and described how care could be tailored to meet people's individual needs.

People were supported to access activities and to maintain hobbies and interests.

Complaints were dealt with in line with the provider's policy.

Is the service well-led?

Outstanding ☆

The service was well led.

People were supported to be involved in the development of the home and their views about the care provided were respected.

The provider had effective systems in place to monitor the quality of care provided and took proactive action to resolve issues.

There was a culture of continuous improvement and the provider engaged with external consultants to ensure they kept up to date with changes in best practice.

The Oaks

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.

The inspection took place on 20 and 21 September 2017 and was announced. The provider was given 48 hours notice of the inspection as we spent time at the provider's office to review the management of the homes. In addition we wanted to ensure that people would be available at the home for us to speak with.

The inspection team consisted of two inspectors and specialist advisor. In addition an expert by experience was used to contact families by telephone to gather their views of the care their relatives received. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home. This included any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the home. We also reviewed information sent to us by the local authority who commission care for some people living at the home. 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 home, what the home does well and improvements they plan to make.

During the inspection of the office we spoke with three members of the executive team, the nominated individual, the operational manager and the locality manager. We also spoke with the learning and development team, the positive behavioural support manager and the management support manager. At the home we spoke with one person who lived there, the registered manger, deputy manager, the positive behaviour support staff and a member of care staff. We also spoke by telephone to the families of three people who lived at The Oaks.

We looked at three care plans and other records related to the care people received. In addition, we examined records relating to how the home was run including staffing, training and quality assurance.

Good

Is the service safe?

Our findings

People received safe care at the Oaks. One person told us they felt safe when they were away from the house as staff escorted them. They said "I'm not on my own." They went on to tell us that they felt reassured by the night staff being available to them if they woke in the middle of the night. One person's relative told us, "When I talk to [name] they tell me they are happy and they also say they are safe, there would be behaviour issues if [name] did not feel safe."

There were enough staff to meet people's needs. A person's relative told us, "I feel there is enough staff. [Name] has a one to one staff and there is never anytime that [name] can't go out into the community if they want to." Another relative said, "I think there is an appropriate level of support." Staff told us that there were enough staff available to support people. There was a core number of staff offering support to people but support hours could be flexible to ensure that people received the support they required at the times that they wanted to. If additional support was required this could be quickly sourced from other homes in the vicinity. This meant that people received support from staff who were familiar with their needs and able to respond to keep them safe. The registered manager had identified that some people benefited from having support from a very small group of staff members who made up the person's core team of staff.

The registered manager had identified the number of care hours needed and when these should be provided. The rotas were set around meeting people's needs. For example, if a person normally chose to get up late then the staff who supported them would start later. This meant that there were more hours which were able to be provided flexibly to support people with activities and accessing the community. In the provider's weekly compliance meeting they looked at the staffing levels over the company and what risks this placed on individual homes. In addition the provider was continually recruiting new staff so there were always staff available to fill vacancies when they arose.

The provider had systems in place to ensure they checked if staff had the appropriate skills and qualifications to care for people before offering them employment at the home. For example, we saw people had completed application forms and the registered manager had completed structured interviews. The disclosure and baring checks which identify if people have any criminal convictions had been completed to ensure that staff were safe to work with people who live at the home. In addition the provider had invested in a scanner which linked to the home office. This allowed them to check that the passports and other documents used for identification were valid and that the people employed had a right to work in the UK.

Staff had received training in how to keep people safe from abuse. They were able to recognise the signs of abuse and raise concerns both within the provider's organisation and externally. One staff member said, "I'd would go straight to the registered manager, locality manager or provider." Staff also knew they could raise concerns by whistleblowing. Whistleblowing is where staff are able to raise concerns anonymously without fear of reprisal.

Some people displayed behaviour that could have caused harm to themselves and others. Staff knew how to offer safe support should this have occurred. We saw that risk assessments and support plans were in

place to support people to manage their anxieties. Staff could describe the strategies that they used. The support strategies were based on a positive behaviour support model. Positive behaviour support aims to enhance the life of people who can show challenges and looks at ways of focusing on the good things that people achieve. Staff had received positive behaviour support training. In these ways staff understood and knew how to respond to people's behaviours.

The provider had a team of six positive behavioural support (PBS) staff. These were staff who had expertise in supporting people's distressed reactions and who worked with staff to minimise the restrictions placed on people. They were able to monitor incidents in real time in each of the provider's homes and provide proactive support to the staff in the home about how to support people's behaviours to improve. They were able to spend time supporting people as part of their care team which enabled them to provide ongoing training and support to staff on how people's care could be delivered in the way in encouraged them to self-manage their behaviours and reduce the need for restraint.

Risk assessments had been completed on areas such as accessing community facilities, nutrition and epilepsy. Completion of these assessments enabled risks to be identified and guidance for staff to be put in place to minimise the impact of these risks. A staff member said, "Everything is put in place on a daily basis to keep people safe and well looked after."

Risk assessments had been reviewed regularly and staff understood their role in following them. The environment had been risk assessed and altered to maximise people's independence while remaining safe. A person's relative said, "Adaptions were fitted to make [name] safe." A staff member explained that a person's mobility had increased as a result of the environment being tailored to their needs. Specialist equipment was used and measures had been in place to prevent harm. For example, some people had sensors on their bed to alert staff if they had an epileptic seizure.

Where regular testing was required to prevent risk, such as electrical safety testing, these were recorded as having happened within the required timescales. The help that people would need if there was a fire had been formally assessed. Records reflected that fire safety checks were carried out and there were procedures in place for staff to follow. There was a business continuity plan in place to be used in the event of an emergency or an untoward event and regular servicing on equipment used was undertaken. This was to ensure that it was safe.

People received their medicines safely and as prescribed by their doctor and staff understood how people liked to receive their medicines. A person's relative said, "The medication is given on time." Another relative said, "They support [name] with medication if needed while we are out." Medicines were stored securely. Medication administration record (MAR) charts were used to inform staff which medicine was required and this was then used to check and dispense the medicines. We saw that a stock check of medicines was taken regularly.

Where people had PRN [as required] medicines there were protocols in place. This was important so that staff had clear guidance about when they should give the medicines. One person had their medicines administered with food. This had been agreed by their GP however, the registered manager had not checked with a pharmacist if any considerations needed to be taken into account. This was important as some medicines may be less effective if taken with certain foods.

Staff were trained to administer medicines. Staff received medicines training booklet for them to complete and then they were observed administering medicines on six separate occasions to check that they followed the correct processes and administered the medicines safely.

Good

Is the service effective?

Our findings

People were supported by staff who had received training and support to meet their needs. A person's relative told us, "I don't know the training staff have but I know they have training. I like the delivery of the staff, it is very personal centred and the needs of the person paramount." Another relative told us that their relative was helping to train the staff in their specific communication system.

There was a four week induction program for new staff to complete. This was a mixture of in house training at the provider's head office and shadowing experienced staff at the home. New staff were assigned a mentor on their first day working in the home and were required to complete a reflective diary after each shadow shift. The training mentor, training manager and the registered manager reviewed the diary to see if more support was needed in certain area. In addition new staff were supported to complete the care certificate. This is a national set of standards which supports care staff to provide safe care. The training manager told us how the feedback from new staff was important as they had just completed training and were a fresh pair of eyes in the service and so could identify workforce issues within the home.

In addition all staff were required to complete refresher training on core subjects on an annual basis. This ensured that they remained up to date with changes in best practice and legislations. All training was monitored on the provider's computer system so that registered managers could see in real time who had completed their training and who still needed to attend. In addition this information was also available to the resources manager who would ensure that people were not included on the rota to provide care to people unless their training was up to date.

Staff confirmed that they received training and guidance to meet people's need. One staff member said, "We have four weeks training before we start then training is on-going." A staff member explained to us that staff were 'upskilled' in areas that were identified as being important to a person. For example, staff were taught to cook meals that were relevant to people's individual diets. The provider's computer system notified staff when they needed to complete refresher training.

In addition to the mandatory training identified the provider also monitored the quality of care provided and developed training to support staff where trends identified concerns. For example, recent training had been developed around care plans and also managers had been supported to attend leadership training.

Staff felt supported and their knowledge of their role was checked regularly. One staff member told us, "Supervisions we have one a month. It's a good opportunity to bring up any concerns." At the end of the induction process staff received a telephone call from an external company who asked them about their experience and this information was used to improve the induction process and the information from this call was used to inform their next supervision with their manager. In addition, care support staff continued to receive calls on a two monthly basis but the information from these calls was anonymised. Any urgent concerns raised, for example, equipment not working was raised with the provider immediately. Other information was collated to give an overall picture of each home. This information was reviewed by the locality manager and the operations manager.

People were supported to have enough to eat and maintain a healthy diet. Comments from people's relatives included. "[Name] goes to slimming world and has lost a lot of weight." "As far as I can see there is a good diet the staff work around her needs and make a healthy diet." "I am delighted with the choice of food, it is a family meal with residents and staff eating together. Staff make an effort with [name's] food. If [name] throws away their meal they are offered an alternative and there is opportunity to eat out."

One relative told us that the provider had installed a kitchen in a person's room so that they could manage their concerns around meal times. Staff explained that another person was being supported to reach their goal of losing weight. They had been supported through healthy options and encouragement. The person was described as having increased in confidence and felt better as a result of their weight loss.

Where people needed specialist diets or equipment to be able to eat their meals independently this was provided. One person required staff to thicken their drinks to prevent them choking. The guidance around how thick the drinks should be was not readily available. The registered manager agreed to make the guidance clearer to all staff.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the Act. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and we found that it was.

Where people were suspected to not have the capacity to make decisions with regard to their care needs an assessment had been completed. The relevant people had been consulted and best interest decisions had been made on behalf of people in line with the requirements of the MCA. One relative said, "There has to be best interest decisions in everything." Best interest decisions were based on the least restrictive intervention. A staff member told us, "We have risk assessments and best interest decisions to see if they can take risks but still be safe."

The registered manager was aware of the legislation and had considered these requirements during care planning. Where restrictions to people's liberty had been required the DoLS applications had been submitted. Staff had received training about the MCA and understood how it affected their role and the people they were supporting. A staff member said, "It's something you use on a daily basis."

People were supported to maintain good health and had access to healthcare services. A person's relative said, "[Name] is registered with the village GP, and the staff organise that for them. [Name] has been taken to the dentist." Another relative told us, "The key worker was on leave when a major hospital appointment was being held for [Name], I felt this key worker should be there but as they were on leave I felt this would not be possible. However, the key worker spoke to me and said – I will be there, I will come in, it is not a problem." They went on to tell us that the person had been experiencing a deterioration in their physical health and staff had supported the person to access appointments and undergo tests. Records showed that people had access to a variety of health care professionals for routine check-ups as well as emergency appointments.

Good

Is the service caring?

Our findings

People were treated with dignity and respect. A person's relative told us, "There are no safe guarding concerns, [name] is treated with dignity." Another person's relative said, "I find the staff to be very respectful and they treat everyone as an individual within the setting." We observed staff knocking on doors and asking permission before entering people's rooms. A staff member said, "Just treat people how you would want to be treated." Throughout our visit we saw staff interacting with people. It was clear that they were familiar with each other and that people were comfortable in staff's presence. Staff demonstrated a caring nature and a passion for providing good quality care. One staff member said, "We want people to be safe and have fulfilled lives and enjoy living here."

People were supported by staff who understood their needs and what was important to them. One relative said, "The staff understand [name]." Another relative told us, "I was very concerned about a change in night staff and [name] waking up and not knowing the staff." They told us how day staff had changed their shift and worked at night until the person got used to the new members of staff.

The home environment was comfortable and suited to people's needs. Each person had their own private study/sitting area and bedroom. There were communal spaces so that people could spend time with staff and other people if they wished to. People's bedrooms were personalised to them and they each had their own private garden. We could see that these had been designed to people's individual taste. One person showed us around their study, bedroom and en-suite bathroom. They were proud of the rooms and told us that they enjoyed spending time in them. A staff member said, "They are so personalised."

People were empowered to make decisions for themselves and make meaningful choices. A staff member told us, "We don't ever say [name] can't do that. Why shouldn't she?" Staff explained how people were able to opt in or out of activities as they wished. Staff offered guidance and alternatives if people needed help in making choices. Aids were used to support people to make choices such as objects of reference.

People's achievements were celebrated. Staff had supported people to track their progress in ways that were meaningful to them. For one person we saw photographs of the activities that they had been engaged in along with comments from themselves or staff expressing things they had achieved. For example, eating with their peers, which they had previously not done or accessing community activities. A staff member said, "There are no boundaries here except for the ones they set for themselves."

Staff understood the ways that people communicated and supported them to make themselves understood. A person's relative told us, "[Name] needs total communication approach, they need to use speech and to sign too. They also have symbol boards." A staff member told us "We all have different ways of communicating." People's specific communication needs had been considered and support strategies implemented to help people express themselves and make choices about their lives. For example, staff used picture communication tools to let people know what activities were on offer for the day. One person showed us how they used technology to help them sequence their day and time. Staff understood people's specific communication needs and adapted their style to suit people.

People were supported to maintain and develop independence skills. One person we spoke with told us, "I cook dinner." They showed us the recipe book that they used to choose meals and cook them with staff support. Staff explained that the person choose the meals that they wanted to cook for the week and was then supported to put together a shopping list and go and purchase the items they needed. We observed other people making themselves hot drinks and completing laundry tasks with staff support. One person was being supported to be involved in managing their medication. This was a skill that had been identified as important to the person and enabled them to have some control over the medicines that they took.

The provider had systems in place to support staff to be caring and at their best when at work. Rotas were managed by the resource manager at head office to remove the task from the registered manager's workload and to remove any bias from the system. The resource manager worked to rules which support the wellbeing of the staff in that they ensure that everyone was scheduled to have five days off in a two week period and that staff have every other weekend off. If staff do pick up extra shifts this is monitored by the registered manager to ensure that they are not overworking as this may impact on their health and stress levels and the support they provide to people living at the home.

Outstanding ☆

Is the service responsive?

Our findings

Relatives were happy with the care their family member received. A person's relative told us, "I am very happy with the care and I feel there are no concerns." Another relative said, "There have been no concerns at all it is superb, [name] is not expected to fit in the home, the home is made to fit their needs."

People were happy with the care and support that they received. One person's relative said, "I know [name] is happy because she tells me to go home." Another relative said, "It is humbling to see the relationships that have developed between [name] and staff." Staff were matched to people so that they were supported by staff with characteristics or skills set that were identified as being important to people's support. Where people had moved from one service run by the provider to another staff had moved with them to help them settle. A staff member told us, "She can only succeed because the staff team is so tailored to her."

The transition into the service was planned and support put in place to help people's move be as smooth as possible. One person's relative told us that they were not allowed to visit with the person during a 'settling in period'. They said, "It was hard when [name] first joined the home, we could only face time for the first six weeks, we were not allowed to visit. We could see the logic but it was very abrupt. [Name] is very settled and happy now." Another relative told us, "[Name] transferred straight from school with their care plan."

People and their relatives were involved in planning and reviewing the care that they received. One person's relative said, "Staff are always asking me how I would do things for [name]." Another person's relative said, "We have challenged about a lot of things, the staff put up with us challenging them about why they do such and such. [Name] needs structure and boundaries in place we have to work as a team." A third relative told us, "We have supported [the staff] in every aspect of writing the care plan." Staff told us that people were invited to attend review meetings but most choose not to. They told us that staff observed people's interactions and engagement and feed these back at meetings to reflect what people had seemed to enjoy and what they did not.

People were supported to maintain relationships with people who are important to them. People's relatives were kept informed and involved in events that occurred. One person's relative said, "When [name] went into hospital we were informed straight away, this has happened three times since moving to the home, we are happy with the way this was dealt with. Another relative said, "I can call anytime and the staff keep me up to date by email." Staff supported people to meet with their relatives and take part in activities in the community together. We saw that people had access to computer based communications systems so that they could chat with relatives and maintain contact. People's relatives could visits without undue restriction. One relative said, "As family we can turn up at any time, but we must be respectful of others as it is their home too." Another relative told us, "We ring up to arrange, and visit anytime, friends and extended family have also visited."

People's care needs had been assessed. Care plans were in place and these guided staff to provide personalised care to people. Care plans reflected people likes, dislikes and preferences. They detailed their preferred routines and things that were important to them. For example, one person required staff to

understand their specific sensory needs and how the environment impacted on them. An assessment and strategies to support the person were developed taking these considerations into account. Where people were able to have input their care and support was planned in partnership with them and their views were asked for regarding their needs and how they would like their care to be delivered. Care plans took into account all areas of people's lives including their mobility, nutrition, physical needs, social needs and their cultural and emotional needs.

The provider employed positive behaviour support staff with specialisms in supporting people with complex needs and behaviour that puts either themselves or others at risk of harm. They supported care staff in devising and implementing strategies to support people in the least restrictive way possible and enhancing people's quality of life.

The positive behaviour support team met weekly to discuss any concerns that had been raised by staff or observed in people's behaviours. They reviewed the support and made recommendations for changes or additional measures to help people remain safe and manage their anxieties. Along with a consistent staff support team this had meant that people were experiencing a decreased level of anxiety and risky behaviour. This had resulted in people having greater access to the community and vocational and social activities. Staff were required to use less physical intervention to keep people safe and some people were taking less medication as a result. One staff member said, "[Name] gets so much more out of life."

People were supported to pursue activities that they enjoyed, where meaningful to them and promoted their wellbeing. One person's relative told us, "[Name] has activities to attend and having a peer group gives natural opportunity to go out with them. There are times when they want 'a not going anywhere week." Another person's relative said, "[Name] goes to a club one night a week, they work in a canteen, go to slimming world, they like to shop." A third relative told us, "[Name] has a better quality of life at the home, they are taken into the community to shop and eat out, which [name] loves, the staff understand [name] and take her out and about." We saw that people had access to a variety of in house and community activities including a work placement for one person. One person's relative said, "I understand there is good transport for [name] to use when accessing the community."

People were able to decide when they wanted to take part in activities. One person using the service met with their core staff team weekly to plan their week ahead. The staff that they needed to support them with their chosen activities were then rotated on at the times that they wanted them to be available. Staff recognised that people's engagement and enjoyment in activities was based on their mood, circumstances and their ability to engage. For example, for one person watching a TV programme might be relaxing while for another person this might be an intense activity that required them to maintain a level of focus. Activities were offered to people based on an assessment of their engagement in an activity.

People's relatives felt able to raise a concern if they had one. One relative said, "There is a person who works for the company but not in the home that I can contact if I have any concerns and do not wish to discuss them with a home staff member."

The provider had a complaints policy in place and we saw that they responded to complaints appropriately. The provider offered to contact the relatives of people living at the home on a regular basis to discuss the care their family member was receiving and any concerns that they had. When concerns were raised appropriate action was taken.

Outstanding ☆

Is the service well-led?

Our findings

People's relatives felt the service was well-led. One person's relative said, "There has been a change of manager, the assistant manager is approachable." Staff felt the service was well led. One staff member said, "I would have any of my relatives living here." They went on to say, "This home is pretty amazing."

The provider had restructured their workforce to introduce more stability to each home and to support person centred care. They had introduced specialised support teams structured around people's needs. The teams were there to support people's day to day needs and worked with people providing care for a large part of the week so that they understood people's needs. They were responsible for ensuring people's care plans reflected the care they needed. Each team was led by an assistant manager, but other members of the team were also given key roles in which they supported the person. For example, with activities or their general wellbeing. This gave the provider a line of accountability to follow if something was not done correctly and ensured that they could take prompt action to resolve issues.

Staff felt supported. One staff member said, "We have a high class team." They went on to say, "If I need anything from [registered manager] I get it. They check with me regularly." Another staff member said, "The communication is good." Staff surveys had been completed and the results analysed. The changes made from the staff survey had been fed back to staff in a newsletter. This showed that the provider had reviewed the induction process for people and developed a framework to ensure all staff were able to access coaching and mentoring to help with career progression as part of the actions from last year's survey.

Staff were encouraged to develop within their role. A staff member explained the management support focus system. They had met with their manager and devised a continual development plan. This had identified their strengths and weaknesses within their role and put in place strategies to develop and increase their confidence in weaker areas. The provider had put in place supervision meetings for key members of staff with external experts including clinical consultants to ensure that staff stayed up to date with changes in best practice.

The provider was working to develop a no blame culture which supported staff to identify issues with the systems and raise concerns in a non confrontational way. They used data collated on the computer system to show why they were concerned. This removed the subjective element of the challenge and allowed staff to focus on what needed to change as opposed to the personalities raising concerns. This resulted in a framework of continuous improvement. One staff member told us, "We have de-briefs, we reflect on what we could do better."

Where people were able they were encouraged to engage with the running of the home. The Positive Behavioural Support (PBS) team had developed training and processes for some people who lived at the provider's homes to become recruitment partners. This had included working with the people to identify what they wanted from staff and mock interviews to help people understand if they wanted to be part of the interview process. At the end of the six week program people had been provided with awards to show that they had completed the training and were offered the opportunity to sit in on interviews when recruiting

staff. They had developed 10 qualities that they wanted to see in staff employed to support them. These included someone who makes me feel safe, someone who talks to me and listens and someone who doesn't sit on their bum. In addition these outcomes had been developed onto easy read questions so that people who chose to take part in the interviews had their own questions and were able to record their thoughts.

People were also supported to input into the development of the service through residents' meetings called our voice. These were held at provider and home level. During these meetings people were able to offer suggestions and comment on aspects of the service. A staff member told us, "We take into account what service users have said." They gave an example of a person requesting a trip out which had taken place on the day of our inspection. The provider held 'our voice' meetings where people using the services could meet and feedback to the provider about the services as a whole.

The provider had just started to develop the provider level meetings using the positive outcomes from the recruitment partners initiative as a format for the meetings. The meetings were now being led by the PBS manager and they told us, "The people we support are the experts. We need to provide a forum for them to be heard and use the 10 qualities identified at recruitment to look at how we are doing and what we can do better." They were looking at identifying our voice partners to work alongside the recruitment partners. In addition they had scheduled the our voice meetings the day before the senior staff meetings so that the outcomes could be included in the overall monitoring of the homes.

People living at the home had a survey to complete. The provider had produced this in a format which was accessible to them. In addition families were also contacted to gather their views about the care provided. All the information was analysed and used to drive improvements in the quality of care provided.

The registered manager completed a weekly walk around the home to monitor the quality of the environment and identify any areas where action was needed. In addition there was a weekly medicines audit and a compliance audit to be completed. The registered manager was able to access all the information needed to monitor the quality of care and staffing in their home on the provider's computer system. For example, they registered manager was able to see how many staff had received supervisions in line with the provider's policy.

Once a month the nominated individual visited each home to complete an audit and compare their findings with that of the registered manager. Any differences were discussed and this process was used to develop the skills of the registered manager to identify areas which needed action. In addition there was a planned audit process for the year around infection control, health and safety, fire and medicines. There were completed on a rolling cycle throughout the year and so improvements in each area could be noted.

We saw that all issues identified in audits had been included on an action plan along with timescales for when the action needed to be completed. Records showed that appropriate actions had been completed within identified timescales. The provider also took proactive action when needed, for example, some fire reports had shown similar issues at some of the provider's homes and so instead of waiting for the reports for all the homes the provider arranged for the same issues to be fixed in all their homes.

There was also two incident monitoring group meetings a month to discuss the incidents reported, any trends within or between homes and any actions needed at home or provider level to improve the quality of support people received.

The provider had recently been awarded an Investors in People Gold award and were looking at ways they

could share best practice with other Gold award winners. They were also working towards the platinum award. The provider was also looking at other ways they could share best practice with other providers. They were working to create an academy of care excellence and an internet resource of planned activities and how they could be broken down into steps people living at the home could engage with.