

TLC Care Homes Limited

Blamsters Farm

Inspection report

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Tel: 01787479491

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

Blamsters Farm is a residential care home that provides accommodation and support for up to 34 people who have a learning disability and or autistic spectrum disorder. The service is made up of two larger properties and five smaller houses spread across the grounds. At the time of the inspection there were 31 people living at the service. Many of the people living at the service had highly complex needs and people had a range of communication abilities and requirements. Some were able to express themselves verbally whilst others used body language and gestures to communicate their needs.

The service was last inspected on 13 October 2014 and given an overall rating of good, with requires improvement in the domain of caring. This was because it was found that whilst staff had built up good relationships with people they did not always treat them with dignity and respect.

The inspection was unannounced and took place on 11 November 2016.

The service did not have effective systems in place to assess and monitor the environment and ensure that people were kept safe from harm. Where problems had been identified it was not always clear to see the action that had been taken to rectify the issue. We were concerned that hot water temperatures posed a potential risk to people that were vulnerable and action to mitigate were not effectively in place.

There was a registered manager in post and they were present during the inspection. 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.

People were supported by staff who knew how to identify different types of abuse and who were clear about what action to take if any concerns arose. Staff treated people with kindness and respect. During our inspection we saw positive and caring interactions between people and staff.

Staff had assessed individual risks to people and had taken action to seek guidance and minimise potential risks. The service had a process in place for recording, monitoring and analysing accidents and incidents and action had been taken to mitigate the risk of recurrence.

Staff supported people to take their medicines safely and staff competencies relating to the administration of medicines were regularly checked.

People received care from suitably qualified and experienced staff who were supported to access a wide variety of training sessions which ensured that the needs of people using the service were met. Staffing levels were sufficient to keep people safe and meet their needs.

The service had a robust recruitment process in place to ensure that staff had the necessary skills and attributes to support people using the service. New members of staff were introduced to the service through

a thorough induction programme.

People were supported in line with the legislation of the Mental Capacity Act and no unnecessarily restrictive practices were in place. There were effective systems in place to ensure that people's medication, money and personal information were kept safe.

People were supported to maintain a healthy diet and to access drinks throughout the day. Mealtimes were flexible to meet individual's routines, preferences and commitments. Staff worked alongside health and social care professionals to meet people's needs and sought specialist advice and support when the need arose.

Staff were kind and respectful when providing care and people's behaviour suggested that they felt comfortable in their presence. Staff demonstrated that they knew people well and delivered care in accordance with their preferences and wishes. Staff were skilled at caring for people who had complex communication needs, offering choice and supporting them to make decisions about the care they received.

The manager was supportive and staff had confidence in their ability to deal with issues raised promptly and effectively. Notifications were sent to us as required, so that we could be aware of how any incidents had been responded to. There were systems in place to monitor the quality of service delivered.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement 

The service was not consistently safe.

Where problems had been identified during environmental checks it was not always clear to see the action that staff had been taken to rectify the issue.

Staff knew how to recognise signs of abuse and how to report any concerns.

Day to day risks to people had been assessed and measures were in place to minimise the potential for harm.

Medicines were managed safely.

Is the service effective?

Good 

The service was effective.

The service had a robust induction programme for new staff.

Staff were provided with the opportunity to access a wide range of training sessions to develop their knowledge and skills.

The service met the requirements of the Mental Capacity Act 2005.

People were supported to eat and drink sufficiently to maintain their health.

Is the service caring?

Good 

The service was caring.

Staff were kind and respectful to people and people's behaviour suggested that they felt comfortable in their presence.

Staff treated people with dignity and respect.

Is the service responsive?

Good 

The service was responsive.

On going assessment and care planning was in place so that people received support that matched their needs.

Staff demonstrated that they knew people well and delivered care in accordance with their preferences and wishes.

There was a system in place to receive and handle complaints or concerns raised.

Is the service well-led?

Good ●

The service was well led.

Staff felt well supported by the manager.

The culture and the values of the service were open and person centred.

There were reflective systems in place to assess and monitor the quality of the service.

Blamsters Farm

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 11 November 2016 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection we reviewed the information we held about the service. We reviewed notifications of incidents that the provider had sent us and previous inspection reports. A notification is information about important events, which the service is required to send us by law.

Many of the people using the service had complex needs which meant that they could not easily give their views and opinions about care. To help us gain a better understanding of people's experiences of using the service we observed the interactions between people and staff and saw care and support being provided. We looked at two care plans and associated care documentation and at how medicine was managed. We also looked at documentation relating to the management of the service including policies and procedures, staffing rotas covering the last six weeks, staff training records, a range of audits and the results of quality assurance surveys.

We spoke with six people using the service, eleven members of staff and the training manager. We spent time with the registered manager and the Head of Operations discussing the service. We also looked at five staff files to see whether staff had been recruited safely and looked at complaints and compliments received by the service.

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.

Is the service safe?

Our findings

The service had a range of environmental checks in place to access and monitor the environment. However, where problems had been identified it was not always clear what action that had been taken to rectify the issue.

We had some concerns about how the service monitored hot water temperature to ensure that it was maintained at a safe level for people living at the service. Following the inspection the registered manager provided evidence to demonstrate that thermostatic mixing valves (TMV) were in place throughout the service. A TMV is a valve that blends hot water with cold water to ensure a constant and safe water temperature, The Health and Safety Executive (HSE) recommendation for a safe hot water temperature in care settings is between 41°C and not to exceed 44°C. The manager informed us that when it was identified that the hot water temperature exceeded 44°C, the contractor was informed, this was because the TMV may need adjusting or replacing. However, records observed during the inspection showed that this did not consistently happen. We saw that on several occasions' staff had recorded the hot water as being above a safe recommended limit but there was no indication of what action had been taken to address the problem. For example, we looked at the hot water temperatures in other units and found that on 1 November 2016 one person's sink was recorded as being 49°C. There was a note stating that this had been reported but there was no evidence to support that this had been done or that the problem had been resolved. Another person's kitchen sink was recorded as being over 50°C on 28 September 2016, 5 October 2016 and 12 October 2016, there was no record to show that staff had reported this. Although we were informed that this kitchen was out of use and permanently locked so the person living in the service was placed at direct harm there was no evidence that the high water temperature had been highlighted to the contractor as per the service guidelines.

In addition to this we found that there were gaps in the recording of some of the environmental safety checks and when a problem had been identified there was not always evidence that action had been taken to rectify the issue. In most of the units records confirmed that equipment and the environment including the fire alarm, emergency lighting and moving and handling equipment were regularly monitored and serviced. However, in Lodge there was a six week gap during which there was no record of the emergency lighting being tested. Records showed that whilst regular environmental audits were undertaken and action plans were in place to identify the problems raised there was no evidence to confirm when, or if, these issues had been resolved. For example, we saw that on one occasion an audit on Oak had identified that the fire blanket in the kitchen was out of date and on another occasion that the kitchen fire door was not working, however there was no record that the fire blanket had been replaced or that the fire door was now working correctly. We spoke with the manager about this who confirmed that both of these issues had now been resolved. In order to have a clear oversight of the service a clear record of the response to issues raised in action plans needs to be maintained. Without this we could not be assured that people were being kept safe from harm.

Staff understood their responsibilities to keep people safe and protect them from abuse. All the staff that we spoke with told us that they had received safeguarding training. Staff understood how to recognise different

signs of abuse and were clear about the action that they would take should any concerns arise. Staff were aware of the whistle blowing policy and knew which external agencies to contact in order to safeguard people from harm and we saw guidance on display around the service to advise staff about how to respond to safeguarding concerns. Both the director of operations and the registered manager had backgrounds in working across different sectors of care and managing safeguarding concerns. Records showed that the director of operations had completed internal investigations into safeguarding alerts that had been raised within the service. They explained to us how they felt that open communication was the key to ensure that concerns were flagged up and responded to appropriately and promptly. They also told us they were meeting quarterly with the Local Authority to discuss any concerns within the service.

Risk assessments were in place and we saw that the assessments promoted people's liberty and independence and staff told us that they encouraged people to be as independent as possible. Restrictions were minimised so that people felt safe, but also had the freedom to access and participate in their choice of daily life skills.

Alongside risk assessments support and behavioural care plans were in place to provide staff with guidance about how to meet the needs of the person that they were supporting. Where people had behaviours that challenged these had been clearly documented and included any possible triggers and the strategies of how to support the person and keep them and others safe from harm when these events occurred. This level of consistency was imperative to provide staff with the skills to anticipate, identify and meet the needs of people that they are supporting.

Each person living at the service had a missing person's profile in place and we saw that equipment such as sensor mats and specialist pressure care mattresses were in place to meet people's needs and reduce the risk of harm. Personal emergency evacuation plans (PEEP) were also in place for all people using the service. These plans provided staff with guidance on how to support people to evacuate the premises in the event of an emergency.

Each unit kept a record of the accidents and incidents that occurred. The registered manager reviewed each unit's records to ensure the implementation of action plans to mitigate the risk of reoccurrence. After any incident staff met as a team to reflect upon the situation and to discuss how the incident was managed, what had worked well and what had not and a review of the points of the action plan that had been implemented following the incident. Staff told us that they found the evaluation of incidents particularly beneficial because it provided them with the opportunity to reflect upon their practice.

In addition to the registered manager who was responsible for the overall management of the service, each unit had a manager in post who took responsibility for the day to day management of the house and the staff allocated to it. During the inspection we found that staffing levels were appropriate to meet the needs of people living in each house and to enable people to go out if they chose to. However, it was clear that historically there had been times when an unplanned reduction in staffing levels, due to sickness and difficulties in the retention of staff, had compromised the safety and suitability of the service. One staff member told us, "There's quite a high staff turnover. This can be difficult as people take time to trust staff." The PIR form completed by the provider and reviewed prior to the inspection also confirmed a high staff turnover within the service. The manager confirmed that at the time of the inspection the service was carrying some staff vacancies and that bank and agency staff were being used to cover the shortfall in staffing. Due to the complex needs of people using the service it took time for people to get to know and establish relationships with the staff supporting them. In order to manage this the manager told us, and rotas confirmed, that regular agency staff were used to cover vacant shifts. The service was in the process of addressing the issues of staff retention by introducing measures such as; incentives for new staff, increasing

the support available to new employees and the recruitment of staff through an agency. The manager told us that the recruitment process was thorough to try and attract the right staff and staff confirmed that things had improved in the last six months and there was now an increased stability at the service.

Staff carried alarms which enabled them to support and respond to any urgent situation that occurred across the service. For example on the morning of inspection one person had a seizure and another person in a different house had become very distressed. Staff dealing with the situation called for assistance from other staff members. This ensured other people's needs were met when some staff were dealing with urgent situations.

Safe recruitment and selection processes were followed when new staff were employed. We reviewed five staff files and saw that they contained the relevant documentation to enable the provider to make safe recruitment choices. Each file contained job descriptions and offer letters clearly stating the terms and conditions of employment, references and proof of identity. Prior to starting employment, new employees were also required to undergo a DBS (Disclosure and Barring Service) check, which would show if they had any criminal convictions or had ever been barred from working with vulnerable people.

There were systems in place to ensure that medicines were administered safely. Staff told us that they completed medication training at three levels; introduction, intermediate and advanced depending on their level of responsibility. They were required to complete annual refresher training and their medicine competencies were assessed. In each house medicines were securely stored, individually prescribed and dated when opened. Staff supported people to take their medication in a variety of ways. Some people were supervised to take their own medicines and we saw that risk assessments had been completed to ensure people could undertake this safely. Other people required covert medication and we saw evidence in their care plans that this had been supported by their GP. One person had recently started refusing their medicines and this was being monitored by staff and the GP had been contacted for advice. We reviewed the administration of controlled drugs and saw that specialist medicines such as midazolam, which is used for the control of epilepsy, was administered by staff who had received the specific training and had been assessed as competent. However, only four staff had been deemed to be competent to do this which was a low number given staffs shift patterns. This could not ensure a trained staff member was on each shift and available given this medicine needed to be administered promptly and without notice.

We looked at medication records and policies. People had medication profiles in place which outlined what medication they were taking and why and when the medication should be administered. We also saw that there were clear guidelines for staff about how to administer the medication in accordance with the person's preference. The service had processes in place to order medication and return unwanted medications and for recording medication errors. We saw a recent external audit had been completed by the supplying pharmacist and any remedial actions were being addressed. The service conducted weekly audits where they sampled 10 percent cent of medication records to ensure their accuracy and checked these alongside the stock. In addition to this full monthly audits were also completed.

The service had a protocol in place for offering and administering medicines given to the person as required (PRN). Each prescribed PRN medication had information for staff about what it had been prescribed for and when to administer it. For example, some people were administered zopiclone. There was information for staff that this medication was prescribed for insomnia and is likely to cause drowsiness. There were further guidelines for staff informing them that it should only be administered if a person was unable to sleep and all other methods to calm and relax the person have failed.

Where appropriate the company used external contractors to audit and ensure they met the legal

requirements to keep people safe. We saw a recent fire safety audit had been undertaken and that personal electrical appliance (PAT) testing had been carried out to ensure that electronic equipment was in safe working order. The service had plans in place for staff to follow in the event of an emergency and we saw that in addition to the telephone numbers for the on call managers contact details were also available for a heating engineer, a plumber and general maintenance person.

Is the service effective?

Our findings

During the inspection we saw staff supporting people to make choices in their daily lives. We also observed positive interactions between staff and people who used the service and saw that people appeared comfortable in the presence of staff and that staff were confident and competent as they went about their daily support tasks.

A robust induction programme was in place to support new staff members when they joined the service. Staff explained to us that in their first week they were introduced to the company and all the core areas of practice in adult social care such as safeguarding adults, health and safety and mental capacity. Staff said they also completed training around mental health, learning disability and autism. Following this staff were supported on shift for a minimum of a week, this could be extended at their request or if their mentor felt that they required additional support. Staff confirmed they had time to read people's care and support plans and this was helpful in getting to know people's needs. One member of staff who had recently been employed by the service told us, "It's one of the best inductions I've ever had." Another staff member explained to us that having completed the induction training and the shadow shifts they felt confident to start in their new role. The service had introduced a buddying and mentoring system. This involved new staff meeting regularly with more experienced staff to ensure they received support and guidance and provided them with the opportunity to raise and address any concerns that they had about their new role. One new staff member told us, "Training has really helped, support plans are really helpful and the staff are really nice."

The organisation had a training manager in post who was responsible for ensuring that staff completed the necessary training during the induction process and for organising on-going training for staff. All the staff that we spoke with were very complimentary about the training, support and supervision that they received. Staff told us that during supervision session they were able to identify any additional training needs that they had and that training was then organised to ensure that these needs were met. One staff member told us, "They love their training, there's lots of it." Another said, "We are constantly learning." We saw that staff had completed training sessions in areas including, personality disorder causes, positive behavioural training, sensory training and autism training. This additional training reflected some of the needs of the people living at the service.

Staff received training and support around understanding and managing behaviour. Some staff were trained in the use of physical intervention. Staff explained to us that this option was only used as a last resort if they were unable to de-escalate a person's behaviour through positive behavioural support and they were posing a threat of harm to themselves or others. Incidents of escalated behaviour were recorded and these were evaluated by the registered manager to ensure that the appropriate action had been taken. These records were also used to identify possible avoidable triggers and the successful management of unwanted behaviours. The service was supported by having access to a range of health care professionals and their own behavioural specialist.

Staff told us they felt well supported both by colleagues, the managers on their units and the registered

manager. Records showed that staff had monthly supervisions and annual appraisals of their performance. The manager told us that in order to support staff to further develop their skills and knowledge they were given the opportunity to spend time with other health and social care professionals. This enabled staff to gain a better understanding of the role of the other professionals and helped to develop improved working relationships.

Most of the people living in the service were not able to make important decisions about their care and how they lived their daily lives. The manager understood her responsibilities under the Mental Capacity Act 2005, (MCA) and around protecting people's rights. The 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. The application procedures for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

Staff received training in the MCA and DoLS and had access to policies should they need them. Staff told us there were a number of restrictions in place and no one currently using the service went out without staff support and supervision. We saw that this was clearly documented in people's care plans along with the rationale as to why supervision was necessary and how staff should support people in the least restrictive way possible. Individual decisions were documented when actions had been taken in the person's best interest. This ensured people's rights were upheld and there were clearly recorded decisions showing who had been involved. Where people were subject to deprivation of liberty safeguards this was clearly documented and authorised by the Local Authority giving a clear rationale as to why people were not able to leave the service unsupervised.

People with specific health issues, such as diabetes, had their needs assessed and their care plans contained clear guidelines for staff which ensured that staff were able to effectively monitor and manage their condition. Staff supported people to access health care professionals and when the need was identified staff referred people for specialist advice and support. The service had established a good relationship with their local GP practice and we saw that people had regular medication reviews and their health care needs were clearly documented in their care plans. Everyone had a health action plan and hospital passport giving clear information about their needs. If people required a hospital appointment or admission staff accompanied and, if necessary stayed with them to support them and to ensure continuity of care.

People's meal times were flexible to enable them to participate in activities during the day and in the evening. During the inspection some people choose to go out to eat their lunch, or where already out attending activities, and staff supported them to do so. We also heard staff discussing with people what they wanted to eat at lunch time and where necessary supporting people to make an appropriate decision. Staff supported people to have a balanced diet. A four week menu plan was in place which enabled people to choose from a number of different options and included the occasional take away meal. Where appropriate, staff supported people to prepare their own meals. Records showed that staff monitored people's weights and where concerns were identified about people's nutritional status specialist advice and support was sought from healthcare professionals such as the dietician and speech and language therapist.

Is the service caring?

Our findings

Due to their complex need many of the people living in the service were unable to verbalise their opinions to us. We therefore spent time observing the interactions between staff and the people that they cared for. We saw that people appeared settled and comfortable in the company of staff. We observed staff treating people with respect and supporting them to be as independent as possible whilst recognising the impact their disability had upon them.

In our last inspection we felt that staff had not consistently been treating people with dignity and respect. At this visit, we found staff providing care which was respectful and that people's dignity was maintained at all times.

Staff were skilled at meeting people's needs. They knew people well, including their likes and dislikes and how they wished their care to be provided. Staff demonstrated an understanding of people's behaviours and gestures which enabled them to provide effective care and support. One staff member told us, "Behaviour is their way of expressing themselves. When you know people you get to know and understand what each little thing means." All the staff that we spoke with were positive about their roles and took pride in the relationships they had built with the people they were supporting and caring for. One staff member said, "I really enjoy it here. Initially, never in a million years would I have thought it but I love it here."

We observed staff knocking before entering a person's personal space and saw that staff were aware of the interpersonal relationships and needs of people sharing the same living space. Some people required support in social situations and to develop and maintain personal relationships. People's care plans contained clear guidelines for staff about how to support them in this area and ensured that staff were consistent in their approach. One person showed us around their house. Another showed us their bedroom which was personalised and an area which they took pride in. One person was repetitive in their questioning and we heard staff responding consistently and appropriately which helped them manage their anxieties. The manager told us that, as far as possible, they tried to keep staff static within one unit. This meant that people were able to develop relationships and have confidence in the staff supporting them.

Staff were observed treating people with dignity and respect. We saw staff communicating with people at a pace which was appropriate to their needs. Staff gave them time to process what was being discussed and time to respond appropriately to ensure people were engaged and understood what was happening. Some people required one to one support in certain situations, such as mealtimes and in communal areas, due to risks arising from their needs. We observed this one to one support was provided in a non-intrusive and respectful way. People were enabled to move freely and were not restricted by the staff who supported them. As far as possible staff supported people to make decisions about their daily lives including, what they wanted to do and where they wanted to go.

Some houses held residents meetings but these were not in place in every unit. We saw no evidence that information was available for people in an easy read format. Most of the information around the service was published in written format and therefore, was not accessible to some people using the service.

Is the service responsive?

Our findings

People received personalised care from staff who understood their needs. We spoke with one person about who supported them. They told us, "Mainly three people, I have a key worker. " They went on to tell us that they liked the staff and explained how they were involved in their care reviews and in deciding how staff supported them with things they liked to do.

Care plans were personalised and outlined people's needs. They included information about how people wished to be supported and about people's life history, which helped staff to understand their main life experiences and the importance of connections with family and friends. The care plans that we reviewed provided staff with clear guidelines about how to support the person and enable them to remain as independent as possible.

All of the staff that we spoke with were familiar with the needs of the people that they were supporting and had an awareness of what was in their support plan. It was clear from a number of incidents we were told about that consistent and cohesive support was pivotal to the success and well-being of each person. There had been times when this had been compromised by staff supporting people who were not sufficiently familiar with their needs or where staff had not followed specific guidance put in place to support and protect both people and staff.

People's needs were regularly reviewed. The manager told us that where possible families were involved in the transition period when people moved into the service and in reviewing care plans. Staff members who directly supported people attended professional meetings and reviews. This ensured that people's current needs were represented and that staff were kept up to date with any change in their medication and psychology reviews.

Behavioural plans outlined different levels of staff response. This included primary, secondary and reactive interventions and crisis management techniques. Staff had access to specialist resources within the service to support them in reviewing and managing people's behaviour. This included both the development manager, who was instrumental in supporting staff in developing behaviour support plans, and the intensive interaction team, a multi-professional group, who provided advice to staff in how to appropriately support people with behaviours which could have a negative impact on them or others. Staff spoke to us about people's behaviours. They explained that some people were able to recognise when they were becoming distressed and could take themselves out of the situation to calm them-selves down. They also explained the use of de-escalation technique to support people in managing their behaviour when they became anxious or distressed. People's care plans contained clear information for staff about how to support people and manage behavioural changes if they were to become upset or anxious, and we saw staff putting this guidance into practice during the inspection.

People communicated with staff in a variety of ways. We saw staff supporting some people to communicate using a communication board. The board pictorially showed the sequence of events and activities planned for the day and the staff who were on duty. Other people used Makaton sign language and we saw that

information was available to help staff understand the signs people used.

Activities took place which reflected people's individual needs and wishes. On the day of our inspection we observed people coming and going all day with varying levels of staff support. Everyone we met required the support of at least one member of staff to access the community in order to ensure their own and other people's safety. The service had its own transport, which some people used, whilst others walked the short distance into town. One of the houses was staffed to enable one to one support for a person and there was also a designated activities person whose hours had recently changed to enable them to support evening activity. People attended different appointments, went out for lunch, shopping, swimming and a number of people went to college to play football, pottery and dance. One person had been horse-riding and clearly communicated how much they loved it and how they were improving as their confidence grew. Each person had an activity folder which showed what they had been doing and what plans there were for the future.

The service worked closely with family members and had established effective working relationships with other agencies. Staff took into account people's wishes and aspirations and tried to support people, when appropriate, to progress on from the service. At the time of the inspection there were vacancies at the service because some people who had previously been living at the service had expressed the desire to move on to more independent living and the service had worked in conjunction with outside social care agencies to support them to be able to do this. One staff member said, "We are enabling people to live fulfilling lives and moving people on." They went on to tell us about another person who they were supporting to move on and how they had been involved in a detailed transitional plan over several months to try and help ensure that the move was successful.

The service had a procedure in place for handling and responding to complaints. We looked at the complaints file and saw that any complaints that had been made had been responded to by the manager and, where appropriate, any issues raised had been addressed with the staff and action had been taken to resolve the problem. For example, the service had received a complaint that their recycling bags were visible and unsightly, the service had built an area to store the bags so that they were no longer visible from the roadside.

Is the service well-led?

Our findings

Staff were positive about the management team and described them as "accessible" and "responsive". One staff member told us, "They promote family values, it's a really grass roots organisation." Another said, "I have learnt a lot from them, they make me think and reflect on what I am doing and the reasons for doing it." Another told us, "I feel supported and we have autonomy, the manager makes you think, they don't hand it to you on a plate."

Staff told us that the registered manager was visible throughout the service; this meant that they knew the people living in the service and were able to respond to any concerns raised by staff. Everyone that we spoke with felt that the registered manager listened to them and that both the managers and team leaders were responsive and responded promptly to actions where required.

The service ran an on-call rota to ensure that staff were supported by senior members of staff overnight and at the weekend. The manager told us that they used to have a system whereby one team leader was rostered on to cover the whole service. However, this had resulted in them receiving enquiries for people who did not live in the units where they worked and whose needs they were not familiar with. Therefore, the service had changed the system so that team leaders were rostered on for the unit in which they worked. The manager told us and records confirmed that this had reduced the number of calls received by the staff member on call and had created a safer and more effective service for both staff and people living in the service.

In one house staff were trialling a new rota system that required staff to work twelve hour shifts. This was felt to give greater continuity for people and enable staff to support people with their day activities without having to get back due to the end of their shift. Changes to the shift pattern had been introduced after consultation and were being reviewed to ensure the changes were beneficial to the people being supported. One staff member told us, "Longer shifts mean we are no longer governed by inflexible shift patterns." However, some staff felt changes were potentially divisive in terms of creating two teams and establishing divisions between them. This was fed-back to the manager who told us they would rotate staff and teams to ensure cohesive working.

Staff told us that working at the service could be mentally challenging and in the past fluctuating staffing levels had affected the stability of the service. Some staff felt the reason staff left was because of how challenging the work could be and that whilst the service had introduced incentives for new staff to join the organisation there were insufficient incentives to reward long standing, committed staff. The manager explained that they tried to develop and progress their staff by providing them with opportunities for promotion and management opportunities within the service.

The manager and the director of operations demonstrated a commitment to resolving on-going challenges over recruitment. Changes had included enhancing training opportunities, improving the support available for new employees and the introduction of incentives for new starters. We discussed with the management team the need to ensure that the same consideration was also given to retaining existing staff.

The manager worked closely with the local authority to develop and improve the service. They explained that they were involved in, STOMP, in a national health and social care project, aimed at reducing the use of psychotropic medication and increasing the use of intensive support, psychology and specialist nursing support to manage behaviours. The manager went on to explain that they were advocates of using non-pharmacological techniques to manage behaviours and how this was promoted throughout the service and reflected in the training opportunities for staff which included positive behavioural training and sensory training.

The registered manager told us that although each unit had its own staffing allocation, they supported each other in regard to covering sick leave and crisis interventions. The manager of each house collected their own statistical data on incidents, falls and accidents but this information was not collated centrally. The registered manager knew the details of the information held for each unit and had oversight of the service as a whole, which enabled them to monitor and manage the service. However, because this information was not formally recorded there was no formal process in place to monitor the quality assurance of the service as a whole. Therefore, it was not possible at a glance to see the figures for the service and if the manager was not present it was less clear to see how the service was run cohesively as one registered service and not as separate units. This on going measurement and monitoring was discussed with the manager and the director of operations during the inspection.

Organisational management meetings were held every six weeks. These were attended by the director of operations, the development manager and training manager and the registered managers of each service within the wider provider organisation. We looked at minutes recorded from these meetings and saw that they were used as a forum for discussing lessons learnt from safeguarding's across the organisation, the management and outcome of complaints and to develop and progress the service. This showed that systems in place was driving improvements within the organisation.

In addition to this the registered manager met with the unit managers once a month to discuss any concerns and to monitor and manage the service as a whole. Monthly staff meetings were also held on each unit. We reviewed the staff meeting minutes and saw examples of how information had been cascaded down to staff through these meetings. The unit staff meetings were also used as an opportunity for staff to share information and discuss any concerns that they had about people they were caring for. This showed us that the service used reflective practice to learn and develop.

Resident and relative meetings were organised within some but not all of the units.

The service conducted annual resident and relative surveys. We looked at the records for the last survey conducted in October 2015 and saw that on the whole the responses were largely favourable and that where issues had been identified measures had been taken to address the situation. This showed that the service measured and reviewed the quality of care.