Hollybank Trust

The Beeches

Inspection report

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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 19 September 2016 and was unannounced. At our last inspection of the service on 1 July 2014 the registered provider was compliant with all the regulations in force at that time.

The Beeches is a care home for young adults with profound complex needs. It is part of the Hollybank Trust which is an organisation specialising in providing education, care and support for young people and adults with profound complex needs. The service is registered to offer up to 13 people with accommodation and care (which does not include nursing care).

The registered provider is required to have a registered manager in post, but the last manager was deregistered in February 2016. At the time of our inspection there was an acting manager in place, but they were not in the service during our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 told us that they felt confident about their safety. We found that the care staff had a good knowledge of how to keep people safe from harm and the staff had been employed following robust recruitment and selection processes. We found that the management of medication was safely carried out.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people. The plans of care were individualised to include preferences, likes and dislikes. People who used the service received additional care and treatment from health professionals based in the community. People had risk assessments in their care files to help minimise risks whilst still supporting people to make choices and decisions.

People that used the service were cared for and supported by qualified and competent staff that were regularly supervised and received appraisal regarding their performance at work. Communication was effective, people's mental capacity was appropriately assessed and their rights were protected.

People received adequate nutrition and hydration to maintain their levels of health and wellbeing. They told us they were satisfied with the meals provided by the service. People had been included in planning menus and their feedback about the meals in the service had been listened to and acted on.

People were able to see their friends and families as they wanted. There were no restrictions on when people could visit the service. People spoken with said staff were caring and they were happy with the care they received. They had access to community facilities and most participated in the activities provided in the service.

We observed good interactions between people who lived in the service and staff on the day of the inspection. We found that people received compassionate care from staff who were keen and who knew about people's needs and preferences. People were supplied with the information they needed at the right time, were involved in all aspects of their care and were always asked for their consent before staff undertook support tasks.

People's comments and complaints were responded to appropriately and there were systems in place to seek feedback from people and their relatives about the service provided. We saw that the manager met with people on a regular basis to discuss their care and any concerns they might have. This meant people were consulted about their care and treatment and were able to make their own choices and decisions.

People's wellbeing, privacy, dignity and independence were monitored and respected and staff worked to maintain these wherever possible. This ensured people felt satisfied and were enabled to take control of their lives.

The people who used the service and the staff told us that the service was well managed. The manager monitored the quality of the service, supported the members of staff and ensured that there were effective communication and response systems in place for people who used the service.

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.

There were processes in place to help make sure people were protected from the risk of abuse and staff were aware of safeguarding vulnerable adults procedures.

Assessments were undertaken of risks to people who used the service and staff. Written plans were in place to manage these risks. There were processes for recording accidents and incidents. We saw that appropriate action was taken in response to incidents to maintain the safety of people who used the service.

There were sufficient numbers of staff on duty to meet people's needs and medicines were managed safely so that people received them as prescribed.

Is the service effective?

Good

The service was effective.

Staff received relevant training, supervision and appraisal to enable them to feel confident in providing effective care for people. They were aware of the requirements of the Mental Capacity Act 2005.

People reported the food was good and that they had a choice of quality food. We saw people were provided with appropriate assistance and support and staff understood people's nutritional needs. People told us that they received appropriate healthcare support.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

The people who used the service had a good relationship with the staff, who showed patience and gave encouragement when supporting individuals with their daily routines.

We saw that people's privacy and dignity was respected by the staff and this was confirmed by the people who we spoke with.

The people who used the service were included in making decisions about their care whenever this was possible and we saw that they were consulted about their day to day needs.

Is the service responsive?

Good

The service was responsive.

Care plans were in place outlining people's care and support needs. The staff were knowledgeable about each person's support needs, their interests and preferences in order to provide a personalised service.

The people who used the service were able to make choices and decisions about their lives. This helped them to be in control and to be as independent as possible.

The people who used the service were able to make suggestions and raise concerns or complaints about the service they received. These were listened to and action was taken to address them.

Is the service well-led?

Good

Some aspects of the service were not well-led.

The service was without a registered manager. This is a requirement of their registration and will be followed up by CQC with the registered provider.

People were at the heart of the service and staff continually strived to improve. Staff were supported by the manager. There was open communication within the staff team and staff felt comfortable discussing any concerns with the manager.

The manager and registered provider carried out a variety of quality audits to monitor that the systems in place at the home were being followed by staff to ensure the safety and well-being of people who lived and worked there.

The Beeches

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 registered 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 19 September 2016 and was unannounced. The inspection team consisted of one adult social care inspector.

We looked at information we held about the service, which included notifications sent to us since the last inspection. Notifications are when registered providers send us information about certain changes, events or incidents that occur within the service. We also contacted Kirklees local authority safeguarding and commissioning teams who told us they had no concerns about the service. We asked the registered provider to submit a provider information return (PIR) and this was returned within the agreed timescale. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

At this inspection we spoke with the head of residential care and the head of risk and compliance. We also spoke with three care staff and three people using the service. We observed the interaction between people and staff in the communal areas and during mealtimes.

We spent time in the office looking at records, which included the care records for two people who used the service, the recruitment, induction, training and supervision records for three members of staff and other records relating to the management of the service.

Good

Is the service safe?

Our findings

People who used the service said they felt safe and that they could discuss any worries or concerns they may have with the manager or the staff. One person told us, "It is lovely here, the staff are great and we all get along really well." Two people who used the service had completed safeguarding training as part of their own personal development and were able to talk to us about how they kept themselves safe.

Discussion with the staff revealed there were people living at the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010: age, disability, gender, marital status, race, religion and sexual orientation. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

The registered provider had policies and procedures in place to guide staff in safeguarding adults. The manager had completed safeguarding training and checks of three staff files indicated that the staff had completed safeguarding training during their induction and again as refresher training. The members of staff on duty were able to clearly describe how they would escalate concerns, both internally through their organisation or externally should they identify possible abuse. Discussion with the local council's safeguarding and commissioning teams prior to our inspection indicated they had no concerns about the service.

We had been notified of one safeguarding incident in the last 12 months. This had been reported to the local council's safeguarding team and was around the distressed behaviour of one person using the service towards others in the service. The manager had asked for input from relevant health care professionals and they had amended risk assessments and care plans to ensure people remained safe and well. This demonstrated to us that the service took safeguarding incidents seriously and ensured they would be fully acted upon to keep people safe.

Care files had risk assessments in place that recorded how identified risks should be managed by staff. These included falls, fragile skin, moving and handling and nutrition; the risk assessments had been updated on a regular basis to ensure that the information available to staff was correct. The risk assessments guided staff in how to respond and minimise the risks. This helped to keep people safe but also ensured they were able to make choices about aspects of their lives.

We saw that staff worked well with individuals using the service and were able to effectively manage the agitated and distressed behaviours of some individuals. We saw there were behaviour management plans and risk assessments in some of the care files we looked at. These detailed the types of behaviour exhibited by individuals and what impact this had on them and others around them. Staff had identified trigger points and patterns of behaviours and the care plans gave staff clear instruction on how to diffuse situations and keep people safe from harm.

The manager monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and actioned as needed. They recorded any accident on the day it

occurred and each month completed an analysis of these to identify any trends or problems within the service. The quality assurance report for August 2016 showed there had been no accidents within the service and our records showed that in the last year there had been no serious injuries or safety incidents reported to the Care Quality Commission. This indicated that the safety measures within the service were effective.

We looked at documents relating to the servicing of equipment used in the home. These records showed us that service contract agreements were in place which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required. The equipment included alarm systems for fire safety, portable electrical items, hoists and slings, electrical wiring and the gas system. We saw that there was a monthly check in place for Legionella, which is a water borne virus and this had last been completed in August 2016. Clear records were maintained of daily, weekly, monthly and annual health and safety checks carried out by the senior care staff and nominated contractors. These environmental checks helped to ensure the safety of people who used the service.

We saw that the fire risk assessment for the service was up to date and reviewed yearly. Personal emergency evacuation plans (PEEP's) were in place for people who would require assistance leaving the premises in the event of an emergency. Each individual sheet included the person's mobility assessment and photographic identification. Fire drills were part of the service's emergency plans, although we saw that the last recorded drill took place in August 2015. The records indicated that staff had responded appropriately during the drill. The head of residential care said that they would organise a fire drill as soon as possible and ensure that these were carried out regularly in future.

We looked at the registered provider's policies and procedures and found that they had a business continuity plan in place for emergency situations and major incidents such as flooding, fire or outbreak of an infectious disease. The plan identified the arrangements made to access other health or social care services or support in a time of crisis, which would ensure people were kept safe, warm and have their care, treatment and support needs met. It had been reviewed in the last year.

The head of residential care showed us a dependency tool which was completed monthly and linked people's dependency levels to the number of staff required each day. It also took into account any one-to-one care needed by people who lived at the home. We saw rotas that indicated which staff were on duty and in what capacity and checks during the inspection confirmed these were correct. The rotas showed us there were adequate staff on duty to support people safely and enable them to take part in activities. We observed that the service was busy, but organised. Staff worked in and around the communal areas throughout the day and we found that requests for assistance were quickly answered. We saw people going out to activities and appointments supported by staff and there still remained sufficient staff in-house to meet people's needs.

Staff told us, "The levels of staff are good. We have enough on duty to enable us to offer people the support they need and carry out day to day tasks in the home." We found that there were 12 people in residence and there were usually between eight and ten care staff on duty from 7am to 10pm. Two staff then came on duty and both were awake throughout the night. The head of residential care told us that staffing in the service was flexible to accommodate health appointments and social activities. The manager was usually on duty from 9am to 5pm Monday to Friday within the service and offered additional support as needed.

We looked at the recruitment files of three members of staff. Application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client

groups. Interviews were carried out and staff were provided with job descriptions and terms and conditions. This ensured they were aware of what was expected of them.

We looked at how medicines were managed within the service and checked a selection of medication administration records (MARs). We saw that medicines were stored safely, obtained in a timely way so that people did not run out of them, administered on time, recorded correctly and disposed of appropriately. The care staff informed us that they had received training on the handling of medicines. This was confirmed by our checks of the staff training plan and staff training files.

There were a couple of minor medication issues that were of low risk to people using the service and of low impact on their safety. We noted that the temperature of the medicine fridge was not consistently being recorded on a daily basis and the temperature of the medicine room needed to be checked and recorded daily. These checks made sure medicines were stored within the correct range of temperatures to ensure they remained fit for use and effective. Staff were not using the topical medicine charts to record the application of external creams and lotions, instead they were recording on the MAR charts. The head of residential care said they would speak with the care staff and ensure these points were acted on immediately and we observed this in practice. This assured us that medicine management was safe.

The provider information return form indicated that there had been 26 medicine errors made in the last year. When we checked this during the inspection we found that these related to the medicine audits carried out each month and each time a member of staff had forgotten to sign the MAR chart for a medicine administered this had been counted as one incident. This demonstrated that the registered provider viewed all errors as potentially serious and we noted the manager had taken action to speak with staff through meetings and supervisions to ensure practice was improved.

Good

Is the service effective?

Our findings

People told us they got on well with the staff and were able to talk about their care and support whenever they needed to. One person said, "The staff go with me to the Doctor's and the hospital. I can do a lot of things myself, but they are around if I need any help."

We looked at induction and training records for three members of staff to check whether they had undertaken training on topics that would give them the knowledge and skills they needed to care for people who used the service. The head of residential care showed us the induction paperwork completed for staff in their first three months of employment. We found that the registered provider used the 'Care Certificate' induction that was introduced by Skills for Care in April 2015. Skills for Care is a nationally recognised training resource.

We saw documentation that indicated new staff completed a four day induction where they covered essential training such as safeguarding adults, health and safety, fire safety, complaint handling, Mental Capacity Act 2005 (MCA) and deprivation of liberty safeguards (DoLS), equality and diversity, record keeping, moving and handling, incident management, communication, eating and drinking, and infection prevention and control. Following the four day induction the new staff were assigned a mentor and they shadowed the more senior staff for the first few weeks of employment. As they gained new skills or were deemed competent in certain aspects of care, these were signed off on their induction paperwork.

All new staff were introduced to the people who used the service at the time of their job interview and during their induction, so there was already a degree of knowledge before new staff worked as part of the staff team. We were shown the power point presentation given by two of the people who used the service during new staff's inductions. This gave the new staff guidance about the people's view of their care and how they wished to be treated.

We saw that the staff team had access to a range of training deemed by the registered provider as both essential and service specific. The staff training plans showed that they were up to date with their refresher courses and had access to courses on gastrostomy care, administration of buccal midazolam, disability awareness and end of life care.

Checks of the care staff files showed that they received regular supervision from the senior care staff and had a yearly appraisal of their work performance with the manager. Records seen indicated that supervision meetings were held every two to three months. Staff told us that they found the supervision sessions beneficial as they could talk about their concerns and were given feedback on their working practice. However, we found that the supervision sessions were not always well recorded as they lacked detail of what had been discussed or decided and some had no dates or signatures of the supervisor or supervisee. The head of residential care was aware of the poor recording and said that this was being addressed through a further training programme with the senior care staff called 'leaders of the future'. We were given details about the training and staff development.

People who we spoke with told us that staff only carried out tasks or provided assistance with personal care when they had obtained consent or 'implied' consent, and that they were encouraged by staff to make decisions about their care. We saw that the care plans were signed by people wherever possible to indicate these had been discussed and agreed with them. One person told us, "The staff are great and they are here to help us. I like going out with them and you can do what you want to do, within reason. They talk to me about things that are bothering me and we sort everything out."

Information in the care files indicated people received input from health care professionals such as their GP, physiotherapists, dentist, optician and chiropodist. One person had a health action plan in their care file, which had been put together by their GP. This document was written using a clear print format and pictorial information, which people found easier to understand. The GP allotted people an hour time slot when they went for an appointment. That gave the GP time to talk with people and allowed people to take the time to listen and ask questions. We saw that people had their medicines reviewed regularly and blood tests were carried out where necessary.

Each person had a health 'passport', which was taken with them to hospital or medical appointments; they gave clear information to other health care professionals about the abilities and needs of the person, where the person had difficulty communicating with others. One person whose care file we looked at had a communication passport to make sure their wishes and choices were heard, as they used Makaton and adapted sign language/gestures. We observed them communicating effectively with the staff throughout our inspection. The staff were able to tell us how the use of facial expressions, body language, laughs/smiles and even shouting out was each person's way of communicating. We observed staff to be kind, patient and intuitive with people who could not directly say what they wanted or needed.

People were weighed on a regular basis according to their needs; this usually meant a weekly or monthly check by the staff which was then recorded in their care file. The care staff monitored their weight gain or losses and liaised with the GP, dietician and the Speech and Language Therapist (SALT) as needed. All visits and outcomes were recorded in the care files. We saw that input from these specialists was used to develop the person's care plans and any changes to care were updated immediately. This meant people's health and wellbeing was monitored so they remained well and received appropriate care and support.

Observation of the midday meal showed that people were having a selection of sandwiches and yoghurts. Where people required a specific diet such as food cut into small pieces or finely chopped, they had an appropriate meal prepared for them. The meal time was organised and people were quickly provided with a drink and their choice of food. We saw that the meal time experience offered people a social and stimulating activity that promoted their independence. People who spoke with us said they really liked the food on offer and that if they did not like something then there was always a choice available.

We saw that staff were completing fluid intake charts for some people using the service. However, the recording of this information could improve. We noted that in the two care files we looked at care plans for nutrition and hydration did not describe how much fluid the person should be consuming each day, the daily charts were not added up to see how much fluid the person had drunk and there was no written information to indicate what action the staff should take when the fluid level intake dropped. Both people looked well and hydrated indicating this was more a recording issue than a lack of care. We discussed our concerns with the head of residential care who said they would review the care plans and charts immediately with the senior staff to ensure accurate records were kept.

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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Documentation had been completed appropriately by the manager and we saw that five DoLS applications had been submitted to the authorising body and one DoLS had been approved. Staff told us they had received training on MCA, DoLS and equality and diversity which had given them more confidence in the way they approached people who used the service. This was evidenced in their training files. They were able to tell us about how they used this knowledge in their daily practice. We saw in care records that staff had taken appropriate steps to ensure people's capacity was assessed to record their ability to make complex decisions.

People told us there were few if any restrictions on their day to day life. One person told us, "We can go out with family or with the staff depending on what we want to do." We saw that where people had wheelchair straps or belts in place when they used this equipment, there was a corresponding risk assessment and care plan for the restraint in their care files. Staff told us they did not use physical restraint with anyone using the service and this was confirmed by the people who spoke with us.

Good

Is the service caring?

Our findings

People were supported in everyday activities of daily living. We saw staff offer gentle physical and verbal prompts to assist people to eat and drink well. We also observed people going out to the on-site facilities including the hydrotherapy pool and to the 'enterprise shop' supported by staff. Individuals told us, "I like going to the pool" and "I enjoy working in the shop and going out meeting my friends." Staff told us, "We try to encourage people to be as independent as possible. People enjoy baking, doing household tasks and going shopping for personal items as it helps them gain important life skills."

Discussion with people, members of staff and the head of residential care indicated that the care being provided was person centred and focused on providing each person with practical support and motivational prompts to help them maintain their independence. We were told that regular discussions about care and support were held with people who used the service. People had a key worker and they wrote notes in the care files to show where people had been, activities they had attended and what issues had been discussed.

Observations of the interactions between people and staff showed there was a good level of trust and friendship between them all. People were at ease in the service and the conversations being held between people were very much the same as you would expect within a large family. People spoke about what they were doing, what they were having for lunch and who they had seen that day. A number of people had the same friends and interests so were able to talk about familiar things and we noted that everyone was included in the conversations.

Care plans included information about a person's lifestyle, including their hobbies and interests and the people who were important to them. This showed that people and their relatives had been involved in assessments and plans of care. Some people had signed their care plans to show they agreed to the contents. Staff told us that they kept up to date with people's changing needs through handovers at the start of each shift and reading the care plans.

For people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy service was available from the manager. Discussion with people who used the service indicated that they did not use independent mental capacity advocates (IMCA) as they were either capable of speaking up for themselves or had a member of their family who acted in this capacity for them. An advocate is someone who supports a person so that their views are heard and their rights are upheld.

We observed that staff displayed kindness and empathy towards people who lived in the service. Staff spoke to people using their first names and people were not excluded from conversations. We saw that staff took time to explain what was happening to people, when they carried out tasks and daily routines within the service. The staff spoke with people in a tone and manner demonstrating kindness and respect and people responded positively towards the staff.

People who lived in the service told us that staff were friendly and they felt staff really cared about them.

One person told us, "I like living here and the staff are alright. They are kind and they listen. I can make decisions about what to wear, when to get up and when to go to bed."

We observed how staff promoted people's privacy and dignity during the day by knocking on bedroom doors prior to entering, ensuring toilet and bathroom doors were closed when in use and holding discussions with people in private when required. People who used the service told us that staff respected their wishes and would listen to them when they wanted to change things around.

Good

Is the service responsive?

Our findings

The staff were knowledgeable about the people who used the service and displayed a good understanding of their preferences and interests, as well as their health and support needs. This enabled them to provide personalised care.

A needs assessment had been carried out to identify each person's support needs, and care plans had been developed outlining how these needs were to be met. People who used the service told us there were few or no restrictions on their daily life, although risk assessments had been completed and behaviour management plans were in place to make sure people stayed safe and well. Evidence in the care files showed us that people's views were sought and listened to, and that families were also involved in reviews of people's care.

Care plans were person centred and written in a clear print and pictorial format that people could easily understand. One person's care file documented that their care plans had been developed on their behalf by their parents, the staff team and other health care professionals including their GP, Speech and Language Therapist and the physiotherapist. Their file highlighted their daily routines and evidenced where they needed support and what tasks they could do independently. Being more independent was one of their specified goals. This individual had capacity to make their own choices and decisions on daily issues about clothes, food and activities, but for more complex needs their parents assisted them with decision making.

The Beeches was one of six services on this main site for the Hollybank Trust. People were enabled to work in the on-site shop which raised funds for the different services within the complex. Two people told us they really enjoyed serving in the shop and one person was very involved in raising awareness about their fund-raising. We saw that they had emailed people in the services asking them to recycle any unwanted/unused items by donating them to the shop and we saw that people created art works in their classes and these were also sold within the enterprise shop.

The registered provider had a minibus to take people to and from their various social, educational and health related appointments in and around the community. Staff told us that they drove the minibus, as part of their duties, and they enjoyed making sure people were able to access the local shops and amenities. The service also had a lot of on-site activities as part of their enrichment programme; these included the hydrotherapy pool, IT café and Art room.

People told us about the variety of hobbies and interests that they pursued whilst living in the home. For example, one person recently came third in a local photography competition run by the Brathay Trust. They had then been invited by the Brathay Trust to take part in an exercise looking at how people with disabilities could be enabled to take part in different activities. We heard about how the service had created different photographic stands and equipment to enable this person to take photographs whilst in a wheelchair, resulting in their success in the competition that was open to the public.

Each person using the service had their own weekly activity timetable devised by the ELMs team, which

detailed the things the person liked to do. One individual went sailing, took part in carriage riding and spent time in the hydrotherapy pool. They also enjoyed doing music technology classes, craftwork and cooking. Another individual who we spoke with enjoyed gardening and shopping. The focus of the service was to enable people to be as independent as possible and to enjoy their lives. To this end the service helped people gain independent living skills through supporting them with housekeeping tasks such as bed making, room cleaning, taking laundry to the machines and cooking simple meals.

Two people whose care files we looked at had indicated they did not have particular spiritual/faith needs. However, the service had developed a quiet room for prayers in July 2016, which could be used by people of any faith or religion. Different cultures were explored and celebrated by people and the staff; for example, they held a Halal evening two weeks prior to our inspection where the manager had cooked a meal for everyone and their families.

We saw that there was a complaints policy and procedure in place for the service and this had been reviewed in the last year. The policy was available in different formats including Makaton to help people understand how to make their voice heard. Picture cards were used to help people express their opinions of the service and detailed records were kept of the six complaints received in the last year. These were available for us to look at on the computer and included the responses from the manager to each issue that was raised. The service provider monitored and reviewed any complaints received through their quality assurance visits and produced a report of each visit with outcomes and actions as needed. The August 2016 quality assurance report showed there had been no complaints made in the last month.

People told us they knew how to make a complaint saying, "I would talk with [Name of staff] if I had any concerns" and "You can always talk with the staff or the manager about any problems. They sort them out for you."

Good

Is the service well-led?

Our findings

The registered provider was required to have a registered manager in post for this service. The last registered manager left 203 days before the date of our inspection. There was a manager in post who was not present on the day of this inspection. The head of residential care said the manager was in the process of applying to register with CQC and we received an application in October 2016 which is currently being processed.

The provider information return (PIR) contained information that indicated the registered provider monitored and reviewed the quality of care and support provided within the service on a regular basis.

We were informed through the PIR that the Hollybank Trust held a series of meetings at senior management and residential manager levels. These included full trustee meetings, trustee sub-committee meetings, executive board meetings, residential advisory group meetings where service user families were involved, medication meetings, residential manager meetings and admissions panel meetings. Issues such as home vacancies, staffing levels and medication issues were discussed. Quality assurance, compliance and staffing managers were involved and feedback was passed to the Trust board meetings. Issues such as staff training and service user involvement were discussed, and policies and procedures were updated and ratified. Senior staff recruitment was appraised, company structures were agreed, and income and expenditure was discussed and agreed. Training programmes and learning, improvements to training and key performance indicators were also discussed and budgets were looked at and set.

We were given a copy of the latest quality assurance report completed by the registered provider following their visit to The Beeches. The report covered all aspects of the Health and Social Care Regulations 2008 (Regulated Activities) Regulations 2014, looking at different parts of the service including record keeping, staff practice, care and support, the environment, health and safety and people's privacy and dignity. Where issues were noted then an action plan was produced setting out what could be done to improve practice. These actions were then reviewed at the next visit.

In March 2016 the registered provider was accredited with the quality assurance award Investors in People. This indicated that there were robust monitoring and assessment procedures in place. Our observation of the service was that people were treated with respect and in a professional manner. We asked the staff on duty about the culture of the service and they told us, "It focuses on person centred care and is based on people being treated as individuals. We work towards improving the quality of their lives." We were given information about the registered provider's aims and values, which included safety, fulfilment, independence, choice, privacy and dignity, equality and rights. From our observations of the service we found that staff worked to these values within their everyday practice and people experienced appropriate, safe care that maximised their potential for leading independent and fulfilled lives.

Staff said that they felt well supported and were not asked to do tasks they were not confident about completing. The staff training plan showed that all care staff completed essential training and then went on to undertake vocational training courses such as diplomas in health and social care to further develop their knowledge. This demonstrated that people were looked after by well trained and knowledgeable staff, who

were confident and capable of meeting their needs.

Feedback from the people who used the service and the staff team was obtained through the use of satisfaction questionnaires, meetings and staff supervision sessions. This information was usually analysed by the registered provider and where necessary action was taken to make changes or improvements to the service. We were able to look at a selection of documents that confirmed this took place. A meeting was last held with the senior staff team in June 2016 where they spoke about completing supervisions, continuity of care and completion of audits amongst other issues. This demonstrated that staff were able to talk about practices within the service and looked at where these could improve so making the service more effective and safe for the people living there.

We were shown minutes of the meetings for people using the service, which were produced in a large clear print and pictorial format so everyone could read and understand them. We saw that people were kept abreast of changes in the service including staffing. People were able to talk about their news such as new family members and siblings getting married and organise activities that they wished to attend. In June 2016 one person had asked if they could chair the next meeting and this was agreed; in the following meeting we saw that this took place. This showed that people's views and opinions were listened to and influenced what took place in The Beeches.

We saw that accidents, falls, incidents and safeguarding concerns were recorded and analysed monthly by the manager and registered provider, and again annually. We also saw that internal audits on infection control, medicines and care plans were completed. This was so any patterns or areas requiring improvement could be identified. □

We asked for a variety of records and documents during our inspection. We found these were well kept, easily accessible and stored securely. Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The manager of the service had informed CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.