Community Homes of Intensive Care and Education Limited

Ballards Ash

Inspection report

Brinkworth Road
Wotton Bassett
Wiltshire
SN4 8DS

Tel: 01793840807
Website: www.choicecaregroup.com

Date of inspection visit:
11 February 2021

Date of publication:
01 April 2021

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Ballards Ash is a residential care home which is registered to provide a service for up to 10 people. People living at Ballards Ash had diagnosed needs including a learning disability, mental health disorders and some people were on the autistic spectrum. At the time of our inspection seven people were living in the home and one person was in hospital.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This was a focused inspection and did not cover all areas of the Right support, right care, right culture during this inspection. People had limited access to external activities and reduced social contact due to the current government guidelines around the pandemic.

Improvements had been made in documenting and reviewing incidents within the service. Care plans had detailed information around identified risks. Medicines were being managed safely and staff had received appropriate training. Improvements had been made to infection control measures to ensure the service followed safe practices.

Staff feedback was mixed around the support they received and how the management team dealt with raised concerns. Staff felt the morale continued to need work and that some documentation was more of a tick box exercise than an actual review of practice. During this inspection we received two whistle-blowing concerns which have been safeguarded and raised with the management to investigate.

Quality systems were in place and actions set where improvements were identified. Additional management support was in place to oversee and drive improvements. Staff felt mixed on changes within the service, some felt good improvements had been made and others felt that the high staff turnover impacted negatively on the skill mix in the service and wasn't being considered by the management team.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The last rating for this service was Requires Improvement (published 8 July 2020).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations. We have made one recommendation for the provider around reviewing the

management of raised concerns.
The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
This was a planned inspection based on the previous rating.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service is Requires Improvement. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ballards Ash on our website at www.cqc.org.uk.

Follow up
We will continue to engage with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Ballards Ash

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
One inspector attended the service visit.
Two inspectors made phone calls to seek feedback from staff and health and social care professionals following this site visit.

Service and service type
Ballards Ash is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave a short period of notice to the provider of this inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to

send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spent time observing people in their home environment as some people had limited speech or communicated through signing, expressions or tone. We spoke with 11 members of staff and three members of the management team, which included the registered manager, assistant regional director and member of the in-house behaviour team. We reviewed a range of records. This included three people's care records and medication records. A variety of records relating to the management of the service were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with six professionals who regularly visit or have regular contact with the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has now improved to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our last inspection on 8 July 2020, the provider had failed to ensure staff were supported to safely manage and meet people's needs. Incidents and accidents had not been used as an opportunity to change and review practice to keep people safe. This was a breach of Regulation 12 (safe care and treatment). At this inspection the provider had made improvements and were no longer in breach of Regulation 12. However, further improvements are needed to ensure processes are used effectively after all incidents.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Staff understood their safeguarding responsibilities and how to keep people safe. Work had been completed to improve staff safeguarding knowledge through discussions in supervisions and working through examples in staff meetings. All staff had completed safeguarding training. The safeguarding policy had been reviewed and revised in November 2020.
- Staff spoke confidently about the actions they would take in reporting a concern, however not all staff felt their concerns would be listened to or managed in a timely way. Comments included, "Would have no problem in raising anything to the registered manager or the assistant regional director. People here don't have a voice and I will say it for them", "Would be confident to raise concerns, but not totally confident things would get addressed. No urgency which is a worry" and "I would raise any concerns and have done in the past. Nothing ever changes. I am not confident things would be addressed unless really serious."
- During this inspection we received two whistle-blowing concerns. The concerns included the care and management of one person's needs by Ballards staff and external professionals and the failure to ensure a risk assessment for staff was implemented appropriately. We have made one safeguarding referral and raised these concerns with the provider who are actively investigating the concerns.
- Appropriate action had been taken when incidents and accidents had occurred. There were clear improvements in the information recorded and the detail around actions taken.
- Most incidents were used as learning opportunities for staff and discussed further in supervisions and staff meetings. However, some staff felt this needed to be done more effectively, especially for less serious concerns. One staff told us, us "Would like incidents to be discussed, to look at why and how to minimise it happening again." We raised this concern with the provider who told us this would be reviewed immediately and addressed.

At our last inspection on 8 July 2020, the provider had failed to take appropriate measures to mitigate risks and ensure people received safe care. At this inspection the provider had made improvements and were no longer in breach of this part of Regulation 12 (safe care and treatment).

Assessing risk, safety monitoring and management

● Risk management information was available within the appropriate section of people's care plans. We saw good detail recorded around risks including epilepsy, positive behaviour management and choking risks. Staff we spoke with felt they now had more time to be able to read the care plans when they began employment and since any updates. One staff said, "I think we have come a long way with the care plans. I check parts and will ask for more information on behaviour monitoring plans where needed."
● One staff told us they had been put at risk due to not being given all the information about one person they were supporting and the wrong action caused the person to react in a distressed way which could have been avoided. The staff told us there had not been any support given from this incident.
● Improvements had been made in the recording and review of people's behavioural incidents. Most staff had received some further external workshop training around behaviour management.□Changes had also been made to the documentation to encourage staff to reflect on any incidents and give the opportunity for further support where required. The management team told us that staff support had been a focus area for the service and improvements made.
● We observed the lunchtime period in the service. This had previously been a heightened time for some people in the home and had not always been managed effectively or safely. At this inspection we saw staff worked in co-ordinated ways to ensure people were engaged in a calm and supportive manner.
● Support was offered to people in line with their care plans. For example, one person liked to have their pudding served at the same time as their main meal. We observed that this happened. Staff sat with people during lunch if they needed additional support and gave encouragement and clear directions where required.
● We received some mixed feedback from health and social health care professionals around how staff had been observed to manage behavioural related incidents. Most felt staff responded well to people's behaviours with one professional commenting, "One person has very complex needs. Staff went beyond their means, above and beyond, and did all they could to support them well. They followed the care plan and any instructions given. Staff work in a person-centred way and know the person well." Another health and social care professional however felt at times staff actions heightened behaviours in some people and could cause a negative impact.
● There was mixed feedback from staff we spoke with about the support given to manage difficult situations. Some staff said they were confident and felt the training and insight they had received was effective commenting, "I feel confident and have learnt to use techniques and it's not nerve wracking, there is a lot of teaching in place" and "Right in the beginning I was terrified and didn't know what to expect. Now, I am much more confident and had training and support."However, others felt training didn't cover all aspects of managing challenging behaviour and mangers had failed to act on this feedback. Support for staff after incidents was available and could be requested after all incidents. However, this was not always taken up by staff. Some staff agreed they did not always use this opportunity as they felt it wasn't undertaken well. We fed this back to the management team to further review.

Staffing and recruitment
● During our inspection visit we observed safe levels of staffing to support people when they required. Staff were visible around the service and people were engaged in activities with staff support.
● Staff feedback continued to voice concerns; however, this was more about the high staff turnover within the service and the skill mix deployed on shifts than staffing levels. Staff told us, "Little consideration is given to the skill mix of staff", "I think we have enough staff, but we don't always have the reliable staff" and "It's getting worse as there are so many new staff that are not up to speed. It's not their fault. Expectations on them are too great." Another staff commented, "I'm not sure it's about staffing numbers. It's lack of experienced staff as so many staff have and are leaving. There is a high number of new staff, who are inexperienced. The pressure is really on established staff, and there aren't many left." The provider explained there had been an increase in staff recruitment due to some people being assessed as needing

increased support but, that consideration was paid to ensure each shift had a mix of a senior, and staff who were male and female to meet people's preferences.
● One health and social care professional told us, "One staff with a person was new and did not know them well, the staff was very passive , it appeared their role was to sit next to the person and watch TV rather than engage them in some other more meaningful activity." We raised this feedback with the management team to consider and review.
● The management team were open about the fact there were new starters within the service and that it took time to build up skills of knowing people well. One person was currently in hospital and two experienced staff members had to be present at hospital supporting this person of this duration which impacted on the skill mix at times within the service. This situation would shortly be coming to an end and those staff would then be back full time in the service.
● Safe recruitment procedures ensured people were supported by staff with the appropriate experience and character. We saw two people's identification documents had not been signed and dated at the time they were reviewed. The registered manager said that this had been an omission on their part, but they had seen the original documents. We saw that other staff had this in place.

Preventing and controlling infection
● At our last inspection in July 2020, infection prevention control had not been well managed. At this inspection there had been significant improvements.
● All staff were wearing the correct levels of personal protective equipment (PPE). There were appropriately positioned stations for staff to safely put on and take off their PPE. Staff told us they had always had good access to PPE and felt the systems in place kept them and the people they supported safe commenting, "I have felt very safe here, they provided the right stuff for me."
● All areas of the home were clean, and records demonstrated the additional cleaning had been completed. We also observed this being undertaken during our visit.
● COVID-19 testing was being carried out for staff and for people in the service who were accepting of this, in line with the latest guidance. People and staff who had accepted, had been supported to receive the COVID-19 vaccine.
● At times when it was safe to do so, the provider had a system in place to allow safe visits to take place with people's relatives.
● We saw one bin in a staff toilet that did not have a lid on it, but discarded PPE had been put in this bin. We raised this with the management who said they would take the necessary action.

Using medicines safely
● People were supported to take the medicines they had been prescribed. Safe administration practice was observed, and two staff undertook this to minimise the risk of error.
● Medicines were securely stored. The maximum and minimum refrigerator temperatures were recorded to ensure medicines required to be kept this way were at the optimum temperature for safe use.
● Medicines administration records had been fully completed. These gave details of the medicines people had been supported to take.
● Each person had a medicines care plan in place. This included information on the person's understanding of taking their prescribed medicines and how staff could support them with this.
● Staff had received training in safe administration of medicines. Their practice had been assessed to ensure they were following the correct procedures.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection on 8 July 2020, the provider had failed to effectively evaluate and improve the quality of their practice for people and staff. There was a lack of good governance and oversight within this service. At this inspection although further improvements are needed to address staff morale enough improvements had been made and the provider is no longer in breach of Regulation 17 (good governance).

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- During our inspection the atmosphere in the service did appear calmer and more organised. Staff engaged with people easily and we observed people's decisions and choices being asked and respected. One health and social care professional told us, "I have always been impressed by the dedication and knowledge of the management and staff of the home, and their willingness to undertake further training to support those under their care. The staff team is particularly well led, the manager, being very knowledgeable about all aspects of caring for those with learning disabilities."
- However, there was mixed feedback from staff regarding the culture, with some feeling it was now more positive but others who felt the culture needed further improvement. Some staff told us, "We have come a long way in the last few months. There are massive improvements in the staff team, and we've worked hard at this. There was some negative staff. The culture is much better and friendlier, staff get on better and support each other better", "I have never felt that I can't speak to the manager. There are some good leaders in the service" and "[assistant regional director] has been a really good support, he's lovely. I wouldn't have any problems going to registered manager or assistant regional director, they are fantastic."
- Other staff did not feel that improvements had been made in the support they received or the morale in the service. Staff told us this was why many staff had left and others were currently considering taking the same action. Staff commented, "It's a very stressful atmosphere. Something is not right but I can't be specific. Manager doesn't value staff", "The manager isn't approachable and spends most of their time in the office with the door shut. Feels they have their favourites and if you're not one of those, it's difficult", "Management are always in the office, don't see them on the floor. Would like better management, better leadership, things explained better, better training. We are losing good staff because of this" and "Management not approachable at all. We have supervision so it looks good on paper, but nothing happens. I don't feel comfortable with them. They talk about you to other staff."
- Although there is clearly a divide in the feelings and level of support experienced within the staff team, we did not find evidence of this negatively impacting on people living in the service at this inspection. We have

raised this with the management team to consider how they will address this going forward to improve the staff culture further.

● One notification had not been submitted to CQC in line with the provider's registration requirements. This had concerned unsafe practice which had the potential to put people at risk. We saw that the appropriate action had been taken internally to manage this event. The management team told us this was an unintentional oversight and would be sent without further delay.

● Quality assurance systems were in place to monitor the service that people received. There was a clear action plan with timeframes for completion and who would be overseeing which areas of improvement. There had been improvements to the overall governance systems, and this included reviewing incidents and accidents, supervisions, communication with relatives and care plans. Any actions from this were recorded and monitored for progress.

● Staff team meetings had continued monthly and minutes of these were shared. We reviewed the minutes of these meetings and saw that concerns were shared with staff and discussed. At these meetings different topics were chosen to increase staff awareness and knowledge, for example infection control and safeguarding. Meetings also included the opportunity for staff to share their strengths and concerns.

● A new suggestion box was in place at the service so staff could share ideas and areas for improvement. This could be shared anonymously if staff chose.

● The rating from the last inspection report was displayed correctly on the providers website and at the service in a visible place for people to see.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager understood their responsibilities under the duty of candour.

● We saw that the complaints procedure was displayed for people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The registered manager told us that communication had been maintained during the pandemic and they updated people's relatives on a regular basis. People had been supported to speak with their family members and see them when permitted in accordance with government guidelines. Newsletters were sent out, so relatives were kept informed of how people were spending their time.

● People, their relatives, staff and external professionals were all given the opportunity to feedback on the service. The last feedback had been completed during September and October 2020. Feedback was mostly positive from relatives and professionals. Staff had commented that further improvements were needed around communication and morale within the team. The provider was using this feedback to drive improvements in the service.

● A variety of methods were used to enable people in the service to give feedback non verbally including pictures, simple phrasing, body language, gestures, spoken/objects of reference and Makaton (Makaton uses signs and symbols to help people communicate. It is designed to support the development of spoken language).

● During the inspection the assistant regional director handed out some letters and vouchers to staff members. This was a recognition and thank you to staff that had gone above and beyond during the pandemic and the services outbreak.

Continuous learning and improving care

● Since our last inspection in July 2020, an assistant regional director had been based at the service working alongside the registered manager. The service was also supported by the provider's in-house behavioural team.

● The service had worked hard to make improvements and told us they were committed to continuing and sustaining these changes.
● Staff told us they had seen changes within the service and improvements made commenting, "There has been a drive to improve things. We work more as a team so culture is improving", "The staff are a lot more willing to talk, [registered manager] is a brilliant manager, she will listen to anyone that has something to say. We have worked hard in involving the staff in making the service better" and "Everything is a work in progress, you can never say you have reached perfection but if we can carry on moving in the direction we are going. The service users are a lot more involved now."
● Some members of staff raised more improvements needed to happen around learning about people's individual needs before supporting them directly or alone. One staff commented, "Could improve by giving staff more information about people's needs before they find out by error. It worries me a lot. A lot of responsibility is put on new staff, too quickly." We saw that staff had completed required training and an induction process upon joining the service, however we have fed these concerns back to the management team to further review and address.

Working in partnership with others
● The service worked alongside a variety of external professionals to further meet people's needs and had built some good partnership working.
● Health and social care professionals we spoke with praised the knowledge of people retained by the registered manager and staff who knew them well. Comments included, "Staff know their residents very well. They know what is the best way to approach with each resident" and "We would recommend the provider and the home, 100 percent."
● The registered manager was confident to raise questions and share information where required to effectively advocate for people living in the service.