Home from Home Care Limited

The Reeds

Inspection report

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Ratings

Overall rating for this service	Outstanding ☆

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

Summary of findings

Overall summary

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

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

There was a registered manager for the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This was the first inspection since the service was registered.

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

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

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

People's medicines were available to them when needed and stored safely. People were able to make choices about their food and their diet was individualised to meet their needs. Appropriate advice was taken to ensure that people could eat and drink safely.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

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

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

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

Medicines were safely managed.

Is the service effective?

Good

The service was effective.

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

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

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

Staff supported people to access healthcare when needed.

Is the service caring?

Good

The service was caring.

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

People's privacy and dignity were respected.

People were able to make choices about their everyday lives.

Is the service responsive?

Outstanding

The service was responsive.

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

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

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

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

Is the service well-led?

Outstanding ☆

The service was well led.

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

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

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

The Reeds

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

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

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

During the inspection of the office we spoke with three members of the executive team, the nominated individual, the senior locality manager and the locality manager. We also spoke with the learning and development team, the positive behavioural support manager and the management support manager. At the home we spoke with the registered manager, assistant manager, the positive behaviour support staff and two members of care staff. We also spoke by telephone to the families of two people who lived at The Reeds.

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

Good

Is the service safe?

Our findings

People received safe care at The Reeds. One person's relative said, "Oh yes I think [name] is safe, and I have no concerns at all about [name]." Staff had received training in how to keep people safe from abuse. They were able to recognise the signs of abuse and raise concerns both within the provider's organisation and externally.

Some people displayed behaviour that could have caused harm to themselves and others. Staff knew how to offer safe support should this occur. We saw that risk assessments and support plans were in place to support people to manage their anxieties. Staff could describe the strategies that they used. The support strategies were based on a positive behaviour support model. Positive behaviour support aims to enhance the life of people who can show challenges and looks at ways of focusing on the good things that people achieve. Staff had received positive behaviour support training. In these ways staff understood and knew how to respond to people's behaviours.

The provider had a team of six positive behavioural support (PBS) staff. These were staff who had expertise in supporting people's distressed reactions and who worked with staff to minimise the restrictions placed on people. They were able to monitor incidents in real time in each of the provider's homes and provide proactive support to the staff in the home about how to support people's behaviours to improve. They were able to spend time supporting people as part of their care team to observe the person's behaviour and the care provided by staff. This enabled them to provide ongoing training and support to staff on how people's care could be delivered to encouraged them to self-manage their behaviours and reduce the need for restraint. We saw that they had removed the restrictions placed on two people in the home who no longer needed to be restrained when sitting in a chair.

Risk assessments had been completed on areas such as accessing community facilities, nutrition and epilepsy. Completion of these assessments enabled risks to be identified and guidance for staff to be put in place to minimise the impact of these risks. For example, soft furniture had been put in place in one room as the person was at risk of walking into furniture. In another room curtains had been designed with Velcro to come apart if the person tried to pull them down.

Additionally if people were not at a stage in their lives where they mixed happily with others their door into the central area could be shut and their lounge/bedroom/bathroom could become an independent unit accessed from outside. We saw that for two people this option had been taken. In addition as there was a risk of them being unable to keep themselves safe when out in the community and as they were able to climb over normal fencing security fencing had been put in place around their private gardens. People's outside space had also been risk assessed and personalised to people's individual needs. For example, one person had their outside space covered in a protective rubber material. This was because they liked to drop to their knees, The rubber was bouncy and ensured that they did not hurt themselves.

Specialist equipment was used and measures had been in place to prevent harm. For example, some people had sensors on their bed to alert staff if they had an epileptic seizure. People's ability to interact with others

had also been considered and where people were currently a risk to others they were living in separate areas with no unsupervised access to communal spaces. In addition risks related to people's behaviours had been identified and plans put in place to keep them safe. For example, after each deep clean using cleaning solutions one person's living quarters were washed down with clean water as the person was known to lick the walls. In between deep cleans non-toxic products such as lemon juice were used to wipe down spillages.

Actions to keep people safe in an emergency had been identified along with the risks for people. For example, one person's evacuation plan indicated that they would go into their minibus. This was because it was a safe space for them which they were familiar with. In addition they would be able to be removed from the area if they became distressed.

There were enough staff to meet people's needs. A relative said, "There is always enough staff and [name] can do their own thing with support." Staff told us that there were enough staff available to support people. There was a core number of staff offering support to people but support hours could be flexible to ensure that people received the support they required at the times that they wanted to. If additional support was required this could be quickly sourced from other homes in the vicinity. This meant that people received support from staff who were familiar with their needs and able to respond to keep them safe.

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

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

Relatives told us that medicines were administered safely and were available for people when needed. One relative said, "Medication is given on time. There was an issue with medication at the start. The GP had written up the wrong script. This was sorted and resolved." They added, "Staff will prepare medication for us to take out with us. We have to sign the medication in and out."

Staff were trained to administer medicines safely and they were observed administering medicines on six separate occasions to check that they followed the correct processes and administered the medicines safely. There were systems in place to ensure that medicines were safely managed. Checks ensured that medicines were securely stored at appropriate temperatures.

People's medicine administration records had been accurately completed. Information in the Medicines Administration Record (MAR) chart included how people liked to take their medicine. Some people did not have the mental capacity to make an informed choice about refusing to take their medicines. These people had their medicines hidden in their food and drink and at times the medicine was crushed. Where this

happened the staff had taken advice from the prescriber and a pharmacist to ensure that this was an appropriate way to administer medicine.

Where people had medicines prescribed to be taken as required there was information available to staff about when this medicine should be offered, however, more information was needed to support staff to offer this medicine consistently. For example, we saw that one person was prescribed a laxative. There was no recording in their protocol to tell staff when this should be administered. We discussed this with a member of staff who administered medicines and they were able to tell us what signs that they would look for to indicate the medicine was needed. We raised this lack of detail with the registered manager who told us that they would ensure that protocols were reviewed to include all the information needed.

The provider had signed up to an initiative called Stop Over Medicating People (SOMP). This is an NHS England national project to reduce the use of psychotropic medicines in people with learning disabilities. This is important as reducing the use of these medicines may improve people's quality of life.

Good

Is the service effective?

Our findings

People were supported by staff who had received training and support to meet their needs. There was a four week induction program for new staff to complete. This was a mixture of in house training at the provider's head office and shadowing experienced staff at the home. New staff were assigned a mentor on their first day working in the home and were required to complete a reflective diary after each shadow shift. The training mentor, training manager and the registered manager reviewed the diary to see if more support was needed in certain areas.

One member of staff said about their induction, "It was really good training and included people at all levels in the organisation and with different experiences. We all completed the same learning." They added, "I completed a shadow shift and saw an (epileptic) seizure. All the staff who dealt with it were really good and I hoped I could be as good as them when trained." They told us that they had completed the reflective diary and had been honest about their thoughts and that they had discussed any concerns with the training manager.

New staff were supported to complete the care certificate. This is a national set of standards which supports care staff to provide safe care. The training manager told us how the feedback from new staff was important as they had just completed training and were a fresh pair of eyes in the service and so could identify workforce issues within the home.

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

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

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Records showed where people were unable to choose to live at the home appropriate applications for DoLS had been submitted. If people were suspected to not have the capacity to make decisions with regard to their care needs an assessment had been completed. The relevant people had been consulted and best interest decisions had been made on behalf of people in line with the requirements of the MCA. An example of this was where people had their medicines administered in a covert way, for example, hidden in food and drink. There was a mental capacity assessment to show that they did not understand the impact of not taking their medicines and a best interest decisions made including family and appropriate health care professionals about if the medicines could be stopped, changed or administered covertly.

People's decisions were respected. For example, one person was choosing not to spend time with their family when they visited. The family had requested for the person to be restrained in a chair so that they could spend time with them. However, staff had recognised that this impacted on the person's right to make this decision and supported them to be able to leave the family gathering if they chose to.

Relatives told us that their family member received appropriate support around their nutrition. One relative said, "Yes the diet seems good, have to watch [name's] weight a little." Another relative told us, "[Name] will not eat fresh fruit, [name] always drinks Pepsi, and the staff have started using bottles so that small amounts can be poured."

Staff described how they were concerned about one person who had a limited diet and how they were supporting them to try different foods to increase their health and well-being. For example, they had tried the person with different meats as the person was lacking in protein in their diet and they had found that the person enjoyed sausages. Where people were able to be involved they had a weekly meeting regarding the menu and were able to discuss what they wanted to eat each week.

People were supported to maintain good health and had access to healthcare services. Records showed that people had access to a variety of health care professionals for routine check-ups as well as emergency appointments. For example, the registered manager and staff took action when they identified concerns about people's health. They had arranged an appointment with a neurologist to review a person's medicines as the number of epileptic seizures they were having was impacting on their quality of life and their ability to take part in activities. Records also showed that where one family had raised concerns about the management of their relative's epilepsy the staff had worked with an NHS epilepsy specialist nurse to review their medicines and when and how they should be given. One relative told us that they were happy with the healthcare provided. They said, "The staff arrange for the GP to attend the home. There was an issue with the medication but they met the GP and things were resolved."

Good

Is the service caring?

Our findings

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

One relative raised concerns about the continuity of care due to a perceived high turnover of staff. They told us, "It is an excellent service but we feel continuity of care is needed to build up a trusting relationship between [name] and staff and staff and family. We have found that the turnover of staff is very high and this brings its own problems for us and for [name]. Understanding [name] and their behaviour patterns needs to be learnt by staff. However, [name] is very happy and settled at the home." An assistant manager we spoke with confirmed that there had been a lot of changes in staffing but felt that this had been because the home was new. They told us that the changes the provider had made to develop core teams for individuals had improved the continuity and support provided.

People were supported by staff who were kind and caring and understood their needs and what was important to them. For example, we saw that one person was sitting having their hair stroked by a member of staff. We could see that they were really enjoying the attention and that it calmed them down and helped them to relax.

People were treated with dignity and respect. We observed staff knocking on doors and asking permission before entering people's rooms. Throughout our visit we saw staff interacting with people. It was clear that they were familiar with each other and that people were comfortable in staff's presence. Staff demonstrated a caring nature and a passion for providing good quality care.

People were given the opportunity to be alone in their bedrooms when they wanted some personal time. At present no one living at the home was in a relationship, however, staff told us that they would be happy to support relationships. Care plans recorded how care should be tailored to support people's religious beliefs. For example, we saw one person's care plans recorded that the person should only be supported by a member of staff who was the same sex as they were. In addition the restrictions their religion places on their diet was recorded and staff were aware of this.

We saw that the provider and staff made every effort to maximise people's ability to communicate their thoughts and choices. Each person's core team look at effective communication and this was well documented in the communication care plans. Where people had limited vocal communication they were supported to express their needs or to be involved in their care with the used of communication aids. For example, one person had a communication board and another person had reference objects. We saw that one person had developed their own words and these were recorded on a board in their lounge area. This

supported staff to understand what the person was asking for. Another example was a person who was not able to verbalise to communicate. The provider had purchased a tablet computer and used this as a communication tool for the person. Relatives confirmed that staff use communication aids and sign language to communicate with people. One person's relative said, "The staff are trained in Makaton and use it with [name] that is non-verbal. Another person's relative told us, "[Name] is encouraged to make decisions using the PECS system."

Staff understood people's rights to have their privacy and dignity respected. For example, a member of staff told us how one person often chose to remove their clothing. They told us that it was the person's choice if they wanted to put their clothes on but that it was staff's responsibility to support them to keep trying to wear clothes. In addition, they told us they had requested a review meeting not be held in the person's rooms as they were not dressed. Staff told us how they also respected a person's rights not to have certain objects in their room. When the person identified an object they did not like they had a post box they could put it in to get rid of the object. Staff ensured that they only emptied the post box when the person was in bed as this distressed them. In addition the person had decided that they did not like the television remote and so the provider had purchased small remotes that could go on the staff's keychain to support the person's needs.

People's rooms had been personalised to reflect their personalities and their needs. The home was split into two areas and each area had a central open plan living and kitchen area. Off the central area were four doors leading to a private lounge area, bedroom and private bathroom for each person. Each bedroom had access to a private garden. People had been supported to make their individual gardens places where they liked to spend time for example, some people had garden chairs, trampolines and sandpits.

The provider had ensured that each person's private areas were decorated to match their need. For example, where people needed low stimulation rooms walls were bare and the furniture was functional and their belongings were stored out of sight. Where people may bump into furniture, padded bedframes were in place and the furniture legs were also covered to prevent painful stubbing of toes. Other bedrooms were individually decorated and supported people's need. Where suitable for people they had double beds. Where needed windows had been frosted to ensure people's privacy was maintained.

People had been supported to choose if they wanted a bath or shower in their en-suite when moving into the home. We did see that each person's bathroom had a stainless steel splash back. We had raised this as a concern when we registered the property as it gave bathrooms a very clinical feel. We discussed this with the locality manager who explained that wooden panelling became warped and unhygienic through people splashing in the bath and therefore stainless steel ensured the environment remained safe and sanitary. However, some people living at the home were able to manage their continence and this stainless steel had not been changed for something more homely.

Outstanding ☆

Is the service responsive?

Our findings

Relatives were happy with the care their family member received. One relative told us, "[Name] is very happy and settled. When [name] comes home they slot back to how they used to be. We have all just been on holiday and at the end of that time [name] did not want to go back to the home, but once they were there all was well."

The provider had a dedicated transition team to ensure that people's transition into home was planned and support put in place to help people's move be as smooth as possible. At transition people's rooms were personalised to meet their needs. People were assessed before they moved into the home and given information about how the provider could support them. One person's relative said, "I had lots of information given before [name] came to the home, it was a new home and very nice. I was asked to share information too." The level of detail in the work that the transitions team did when they undertook the assessment meant that people were more likely to have a smooth move into their new home. For example, people's communication needs were reviewed to ensure that staff could understand them.

People and their relatives were involved in planning and reviewing the care that they received. One person's relative said, "We are involved in the planning, and staff listened to a degree. We are not shy in coming forward in making comments, we are the voice of [name], staff have told us no one knows [name] better than you do. We discuss any changes and have asked for changes ourselves."

People were supported to maintain relationships with people who are important to them. People's relatives were kept informed and involved of events that occurred. One person's relative said, "I am invited to meetings and the staff will ring up and talk to me about the care." Staff supported people to meet with their relatives and take part in activities in the community together. People's relatives could visits without undue restriction. A relative told us, "We visit on a regular basis at least once a week, and we can visit any time, the care is discussed with staff on a regular basis."

People's care needs had been assessed. Care plans were in place and these guided staff to provide personalised care to people. Support was planned in partnership with people living at the home and their views were asked for regarding their needs and how they would like their care to be delivered. Care plans took into account all areas of people's lives including their mobility, nutrition, physical needs, social needs and their cultural and emotional needs. Care plans reflected people likes, dislikes and preferences. They detailed their preferred routines and things that were important to them. For example, one person had a set routine in the morning about getting up. Staff were knowledgeable about the routine and knew how to support the person when they were ready but also how to give them space as the person needed time to process what to do next.

Staff were able to tell us about people's needs and how they supported people. They reviewed the care people needed and worked out ways which supported people's needs. For example, they raised concerns about one person's oral hygiene. By introducing them to an electric toothbrush they made the experience of brushing teeth less traumatic for the person. The person was now asking to have their teeth brushed after

every shower.

The provider employed Positive Behaviour Support (PBS) staff with specialisms in supporting people with complex needs and behaviour that puts either themselves or others at risk of harm. They supported care staff in devising and implementing strategies to support people in the least restrictive way possible and enhancing people's quality of life. The positive behaviour support team met weekly to discuss any concerns that had been raised by staff or observed in people's behaviours. They reviewed the support and made recommendations for changes or additional measures to help people remain safe and manage their anxieties. This along with a consistent staff support team had meant that people were experiencing a decreased level of anxiety and risky behaviour.

People were supported to pursue activities that they enjoyed, where meaningful to them and promoted their wellbeing. Relatives were pleased with the level of activities offered to people. One relative told us, "[Name] goes off to the shops and the spa, likes the air museum and cinema, then there are walks. [Name] likes football, not the game, but the atmosphere and the environment, we have asked for this to happen. [Name] also likes horse riding and uses the trampoline." People were supported to access the local community at the level they could cope with and that was safe for them. For example, one person was able to access an area where they were able to run around and not hurt anyone.

The provider had split activities into different levels. Intensive, where the individual is doing something intense, like an external activity, hobby work, mirroring & other activities where direct support is needed by staff. Focused, such as accessing an activity with other individuals and the activity is used for personal development. For example, cooking, shopping and going to external clubs or the pub. Relaxing which included watching television, spending time in the garden or sensory room. Relaxing activities were included into calming strategies in people's care plans. As well as individual activities there was a day service on the same site as the home and people were able to access activities in the day service if they choose.

Staff told us that they received good support from the PBS team around suitable activities for people. For example, they had supported staff to introduce messy play, hand massage and calming music for one person. They told us how this had significantly reduced the distressed behaviours that the person presented. They told us how the PBS team review incidents and how being slightly removed from the care the PBS team noticed more trends of behaviour and supported staff to manage these. A member of the PBS team told us how they tailored activities to meet people's needs but also encouraged people to think outside the box and to take positive risks and consider activities like rock climbing.

Staff told us how one person living at the home had been very food orientated when they had first arrived at the home and would only complete activities to get a food reward at the end. They told us that they had worked with this person so that they now enjoyed the actual activity as they were less focused on food as a reward.

Relatives told us that they were happy to raise concerns and were confident that action would be taken. One relative said, "We have had concerns which we addressed with staff and they were resolved." Another relative told us, "There are no complaints but I would ring up and talk to staff if I was concerned." The provider had a complaints policy in place and we saw that they responded to complaints appropriately. Records showed that complaints were investigated and responded to appropriately. For example, we saw a neighbour had raised concerns about a person shouting a lot. We saw that the registered manager had identified that the person did this when they were happy. The provider arranged for a noise reducing fence to be put in place so that the person did not disturb other people in the area. The provider offered to contact the relatives of people living at the home on a regular basis to discuss the care their family member was

receiving and any concerns that they had. When concerns were raised appropriate action was taken.

Outstanding ☆

Is the service well-led?

Our findings

All the staff in the home were positive and passionate about the service and the people that live there. This was reflected in how well they knew people's needs and how they had supported, protected and encouraged people to live well and be the best they could be. A member of staff told us, "I love working here, everyone has got their heart in it."

The provider had restructured their workforce to introduce more stability to the home and to support person centred care. They had introduced a post below the assistant managers called Transparent Care Partners (TRACS). TRACS were there to support people's day to day needs and worked with people providing care for a large part of the week so that they understood people's needs. They were responsible for ensuring people's care plans reflected the care they needed.

Each person living at the home was allocated a core team of people who supported them. The team was led by the TRACS, but other members of the team were also given key roles in which they supported the person. For example, with activities or their general wellbeing. This gave the provider a line of accountability to follow if something was not done correctly and ensured that they could take prompt action to resolve issues. Furthermore, the TRACS were given the responsibility to take immediate action to resolve problems for the person they supported. An example of this was that they were able to arrange for a vehicle to have immediate attention when there was a problem. This was important as the vehicle was used as the part of one person's personal evacuation plan in an emergency such as a fire.

Staff felt supported. A new member of staff told us how he had found the whole staff team supportive and welcoming. They told us, "I've learnt just as much from the support workers as I have the manager. The TRACS has been really good and he will look out for me and I could ask anyone a silly question."

The provider had taken appropriate steps to ensure that staff were safe while working at the home. For example, they had identified that some people were better supported by a member of their own sex and rotas ensured that this was provided and did not put staff at risk of an assault. In addition there were safe spaces for them to access if people became distressed and tried to hurt staff. In addition some of the people living at the home tried to interact with staff by biting them or spitting at them. We saw that staff had protective equipment in the form of jackets and gloves made out of a metallic fabric which kept them safe. The fabric looked like normal material and so preserved the dignity of the people living at the home.

Staff surveys had been completed and the results analysed. The changes made from the staff survey had been fed back to staff in a newsletter. This showed that the provider had reviewed the induction process for people and developed a framework to ensure all staff were able to access coaching and mentoring to help with career progression as part of the actions from last year's survey.

Staff told us that they had two staff meetings each month. One was a general meeting to update them on any changes within the home. The second meeting was for the core team of staff who supported a person to discuss if they felt the care was meeting the person's needs or if any changes were needed.

Staff spoke positively about working for the provider and how they were supported to develop their career. One member of staff told us, "The company has shown a lot of faith in me." They told us how the company recognised talent in their staff and developed staff into management roles. The assistant manager told us that when they had first become an assistant manager they had received positive support from the organisation to help them make the transition from care worker to manager. For example, they told us how they were supported with experienced staff sitting in when they completed supervisions. The provider had put in place supervision meetings for key members of staff with external experts including clinical consultants to ensure that staff stayed up to date with changes in best practice.

The provider was working to develop a no blame culture which supported staff to identify issues with the systems and raise concerns in a non confrontational way. They used data collated on the computer system to show why they were concerned. This removed the subjective element of the challenge and allowed staff to focus on what needed to change as opposed to the personalities raising concerns. This resulted in a framework of continuous improvement. One member of staff told us, "There are lots of points where we can assess if we are winning and as we want the home to be a success we are open to that and if something is not working then we will change it."

Where people were able they were encouraged to engage with the running of the home. The Positive Behavioural Support (PBS) team had developed training and processes for some people who lived at the provider's homes to become recruitment partners. This had included working with the people to identify what they wanted from staff and mock interviews to help people understand if they wanted to be part of the interview process. At the end of the six week program people had been provided with awards to show that they had completed the training and were offered the opportunity to sit in on interviews when recruiting staff. They had developed 10 qualities that they wanted to see in staff employed to support them. These included someone who makes me feel safe, someone who talks to me and listens and someone who doesn't sit on their bum. In addition these outcomes had been developed onto easy read questions so that people who chose to take part in the interviews had their own questions and were able to record their thoughts.

People were also supported to input into the development of the service through residents' meetings called our voice. These were held at provider and home level. During these meetings people were able to offer suggestions and comment on aspects of the service.

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

People living at the home had a survey to complete. The provider had produced this in a format which was accessible to them. In addition families were also contacted to gather their views about the care provided. All the information was analysed and used to drive improvements in the quality of care provided. One relative told us, "I am phoned once a week by the care worker to talk about the care of [name]."

The registered manager told us how they only worked two days a week in the office and then worked supporting people the other three days. They explained how this supported them to know all the people in the home and their care needs. This was possible due to the way the provider had structured their staff

teams to support the registered manager and remove tasks such as the completion of the rota to head office staff. For example, the registered manager had a dedicated contact in the human resources department. They supported the registered manager with fact finding for incidents and performance monitoring of staff. In addition the registered manager told us that they were supported by the quality and compliance director to monitor the quality of care provided. They said, "It's good as we have access to everyone and get advice."

The registered manager completed a weekly walk around the home to monitor the quality of the environment and identify any areas where action was needed. In addition there was a weekly medicines audit and a compliance audit completed. The company had designed and invested heavily into computer systems and programmes. This enabled them to really understand how the service runs and what it needs to run. It offered up to the minute information on incidents, staffing issues, care plans, rota systems and every other function of the day to day running of a care home. The registered manager was able to access all the information needed to monitor the quality of care and staffing in their home on the provider's computer system. For example, the registered manager was able to see how many staff had received supervisions in line with the provider's policy.

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

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

There was also two incident monitoring group meetings a month. They discussed the incidents reported and any trends within or between homes. They identified where the PBS team needed to provide support and any other actions needed at home or provider level to improve the quality of support people received.

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