National Autistic Society (The)

Blackdown House

Inspection report

Somerset Court
Harp Road, Brent Knoll
Highbridge
Somerset
TA9 4HQ

Tel: 01278761905
Website: www.nas.org.uk

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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

We undertook an unannounced inspection of Blackdown House on 31 July 2018.

When the service was last inspected in June 2017, two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. These related to the agreed conditions of one person's Deprivation of Liberty Safeguards authorisation was not being fully met and the provider's quality assurance systems were not always effective in ensuring that all areas for improvement were identified or that improvements were made.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions, Effective and Well led to at least good.

The provider wrote to us in August 2017 and told us how they would achieve compliance with the regulations. During this inspection we found the identified improvements had been made.

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

Blackdown House is a large detached bungalow situated in the extensive grounds of Somerset Court, along with five of the providers other homes. Somerset Court is described as a 'campus' setting. Campuses are a group homes clustered together on the same site and usually sharing staff and some facilities. Staff are available 24 hours a day. The campus model does not meet the underlying principles of the Registering the Right Support guidance. This model of care would be reviewed and scrutinised in line with the principles of Registering the Right Support guidance by CQC, if an application were to be received at this moment in time. Although Blackdown House was situated in a campus setting, we found the service was working in line with the values that underpin the Registering the Right Support guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

The home accommodates up to 12 people who have autism and complex support needs.

The home comprises of the main building and two self-contained flats attached to the home. During our inspection there were five people living in the main part of the home and one person living in each of the flats.

There was a registered manager in post. 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. The registered manager was not available on

the day of the inspection, the deputy manager, a covering manager from one of the provider's other homes and senior managers were present for the inspection.

Relatives told us they thought their family members were safe living at Blackdown. People were protected from abuse because staff understood the correct procedure to follow if they had any concerns. Staff informed us they were confident concerns would be followed up if they were raised. People appeared happy in the company of the staff.

Risks to people were assessed and managed. People received effective support from staff to help them manage at times when they became anxious. Staff understood their responsibilities to raise concerns and report incidents and accidents.

Medicines were stored and administered safely, where there had been medicines errors in the past, learning from this had been implemented.

Although we received some mixed feedback from relatives relating to the staffing of the home, we found there were suitable staff available.

Staff were recruited safely and received on-going training and support to ensure they had the skills and knowledge required to effectively support people. Staff were aware of the measures in place to reduce the risk of the spread of infection.

Consent to care and treatment was sought in line with legislation and guidance. Where restrictive practices had been identified, such as medicines being locked away, these were reviewed to ensure they were the least restrictive option.

People were involved in planning their menus and supported to be involved in preparing their meals.

Staff monitored people's health and well-being and made sure they had access to other healthcare professionals according to their individual needs.

People's diverse needs were supported; staff described how they supported people with their cultural needs.

Staff had built trusting relationships with people. Staff interactions with people were positive and caring.

Staff knew people and understood their care and support needs. People were supported by staff to plan and achieve their goals. Relatives were involved in reviewing their family members care and support.

There was a management structure in the home, which provided clear lines of responsibility and accountability.

The provider had notified the Care Quality Commission (CQC) of significant events in line with current legislation. This meant external agencies were able to monitor the care and safety of people using the service.

The provider had systems in place that were effective in identifying shortfalls in the service and developing action plans to address these.

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 sufficient staff available to meet people's assessed care and support needs.

People's medicines were managed safely, where there had been errors in the administration of people's medicines there were plans in place to address this.

People were protected by the prevention and management of infection control.

Lessons were learnt and improvements made when things went wrong.

People were supported by staff who had completed safeguarding adults training and were able to tell us how they would recognise and report abuse.

People were protected from harm because risk assessments and emergency plans were in place and up to date.

Is the service effective?

Good

The service was effective.

People's legal rights in relation to decision making and restrictions were upheld.

People were well supported by health and social care professionals. This made sure they received appropriate care.

Staff had a good knowledge of people and how to meet their needs. They received training to make sure they had the skills and knowledge to provide effective care to people.

Is the service caring?

Good

The service was caring.

Staff described how they treated people with dignity and respect.

Staff interactions with people were positive.

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People made decisions about their day to day lives.

Is the service responsive?

Good

The service was responsive.

People had detailed care plans that described their needs.

People had access to a range of activities to meet their preferences and needs.

People's relatives knew how to raise concerns.

Is the service well-led?

Good

The service was well led.

People were supported by staff who were positive about their job and felt supported by their managers.

The quality assurance systems were effective in ensuring that any areas for improvement were identified and addressed.

People were supported by staff who had clear lines of accountability and responsibility within the team.

Blackdown House

Detailed findings

Background to this inspection

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

This inspection took place on 31 July 2018 and was unannounced. It was carried out by two adult social care inspectors.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed notifications sent in by the service. A notification is information about important events, which the service is required to tell us about by law.

People were unable to tell us about their views on the quality of the care and support being provided; we therefore undertook observations of their interaction with staff. We also received feedback from three relatives involved in people's care.

During the inspection we spoke with five members of care staff, the covering manager, the deputy manager, the area manager, the quality assurance manager, the provider's behavioural specialist and the provider's Speech and Language Therapist. We received feedback from one visiting professional and the local authority commissioning team who had been working with the service.

We also looked at records relevant to the running of the service. This included three care and support plans, four staff recruitment files, staff training records, medication records, and quality monitoring records.

Good

Is the service safe?

Our findings

People were not able to tell us if they felt safe with the staff supporting them, however we observed they looked happy and relaxed in the presence of the staff.

Relatives told us they thought their family members were safe in the service and with the staff supporting them. One relative told us, "I am quite happy that [name of person] is safe." Other comments included; "I do think that [name of person] is safe, I've not had any concerns" and "Yes they are safe, no concerns there."

Risks of abuse to people were minimised because staff received training in how to recognise and report abuse. Staff we spoke with had a good understanding of abuse and all said they would report anything they were concerned about. All were confident that action would be taken to make sure people were safe. One staff member said, "I would contact the manager or speak to safeguarding, I would whistle blow if I needed to and have done in the past although not whilst working here." Other comments included, "I have never had to report any concerns but I would not hesitate to report anything if I had to", "There is a great deal of emphasis on safeguarding. It's heartening to see the changes in people due to team endeavour" and "I would know who to contact if I ever saw anything that concerned me. I have not seen anything here."

People had complex needs and sometimes could be involved in incidents where they became anxious towards others. Staff told us they learnt from incidents when they occurred. One staff member told us, "Something may go wrong and we analyse what we could do differently and update the care plans."

When incidents occurred these were recorded and where required analysed by the provider's behavioural specialist, if there was unexpected increase in incidents for example. The behavioural specialist had been involved with one person where incidents had recently increased. Their analysis in conjunction with feedback from staff had identified the root cause of the anxiety, and plans were in place to address this. Staff spoke with good understanding of why the person was anxious and they described their approach to the person at these times as being supportive and reassuring.

People had detailed care plans in place which identified what made them anxious, the signs that they were becoming anxious and how staff should respond. Staff were aware of the plans and what could make people anxious and felt confident in managing incidents. One staff member told us, "I feel confident to manage incidents, and I think we manage them well. We stop them from escalating by giving the residents the attention they need." Another commented, "Some incidents can be difficult, but we have the right skills and training to manage them, the team works together and we know what makes them anxious."

Effective plans were in place to minimise risks and protect people from harm. For example, people had risk assessments in place in relation to accessing the community, travelling in vehicles, specific activities and health conditions. Risk assessments had management plans in place to reduce the risk and the staff we spoke with were aware of the identified risks. The risk assessments we reviewed were reviewed and updated regularly.

There were arrangements in place to keep people safe in an emergency. People had their own plans if they needed to be evacuated in the event of a fire or if they needed a hospital admission.

There were enough staff available to maintain people's safety and to meet their needs. Relatives gave mixed feedback in relation to the staffing in the home. One relative told us, "As far as I can gather there are enough staff, I'm happy with the staffing levels." Other comments included, "There have been changes in staff, although there are still some long standing staff there" and "There have been times recently where they have admittedly been short staffed."

Staff commented at times they were short staffed for example when staff phoned in sick. They said however that every effort was made to cover these shifts with regular agency staff. One staff member commented, "It's not too difficult for the guys, they may be agency but they are like part of our team." Another commented, "Sometimes I am asked to cover extra when there is sickness, shifts are generally covered and we use agency staff if needed."

The service used some agency staff to cover their vacant shifts, and they used the same staff members to ensure consistency. One of the agency staff we spoke with confirmed they had worked at the home for two years and they received some of the provider's training sessions. They told us they read all of the care plans and guidelines and worked at the same levels as permanent staff.

Staffing levels were based on people's individual hours and rotas were designed to enable staff to support people when they required staffing for specific activities. We looked at the staffing rota and noted staffing levels varied, depending on people's plans for the day. During the inspection we saw staff responded to people promptly and had time to socialise with people.

There were medicine administration systems in place to ensure people received their medicines when required. Prior to our inspection we noted there had been six medicines errors within six months. One person had a complex pain relief medicines regime and we were told this had resulted in some staff not administering the appropriate medicines at the right times. Following the medicines errors investigations had been carried out and measures implemented to prevent the likelihood of another error occurring. The learning from the incidents was shared with the team. Medicines audits had also been carried out and an action plan had been implemented to drive improvements. We saw the action points were in the process of being completed.

People's medicines were supplied by a pharmacy on a monthly basis; a record was kept of all medicines received at the home. All medicines were stored securely and in line with the manufacturer's guidelines to ensure they remained safe and effective.

Staff administered medicines to people; no one self-medicated. Each person had a detailed care plan which described the medicines they took, what they were for and how they preferred to take them. People received their medicines from staff who had received training and had their competency assessed to make sure their practice was safe. Medicine administration records were accurate and up to date.

Systems were in place to protect people from the risk associated with hot water and legionella bacteria in the water system. Legionella bacteria can cause serious lung infections. Regular water temperature checks were carried out by staff and the maintenance team also carried out a range of checks on the water system. The provider also arranged various checks on the environment to ensure it remained safe. These included checks on the fire system, gas, electrical installation, fire equipment and electrical appliances.

There were measures in place to reduce the likelihood of the spread of infection. All areas of the home were kept clean and fresh. Staff had allocated cleaning tasks to complete each shift and people were encouraged to help out with some of the tasks. A visiting health professional told us, "The home is always clean, and smells clean." Staff had access to personal protective equipment such as gloves and aprons.

The provider had systems and policies which made sure people were cared for by suitable staff. The service had safe recruitment processes. Pre-employment checks were obtained prior to staff commencing employment. These included references, and a satisfactory Disclosure and Barring Service (DBS) check. The DBS checks people's criminal record history and their suitability to work with vulnerable people. We looked at four staff's personnel files and found the recruitment process was followed. Staff confirmed these checks were in place before they started working for the service.

Good

Is the service effective?

Our findings

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 Mental Capacity Act (2005) (MCA). The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At our last inspection in June 2017 we found where people had DoLS authorisations in place, not all of the conditions in one person's DoLS were being met. This meant their legal rights were not fully protected. During this inspection we found the required improvements had been made.

Four people had existing DoLS authorisations in place, where one person had specific conditions on their DoLS the deputy manager demonstrated how those were being met. DoLS applications for the other three people in the home had expired. The deputy manager told us they had applied to local authority for these to be authorised and they were waiting for the outcome of the assessment.

People were able to make most of their own day to day decisions as long as they were given the right information, in the right way and time to decide. However, there were some decisions people were not able to make for themselves and we therefore looked at how the MCA was being applied.

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

Records showed where people lacked the capacity to make specific decisions, their capacity was assessed and best interest decisions were made with relevant others, such as family members. Areas covered included, managing finances, staff administering and storing medicines and having a positive behaviour support plan in place. Where people had restrictions placed on them, for safety reasons for example, the service had reviewed the reasons for these being in place. They had also reviewed when the restrictions had been put in place, and strategies that had been tried to reduce the restriction, and if these were successful. There were plans in place to reduce and remove restrictions, where possible to make sure care was provided in the least restrictive way.

People were supported by staff who had the right skills and training to carry out their role. Staff received an induction when they started working for the service and they commented very positively about the training and support they received during this period. One staff member told us, "My induction was brilliant, it took two weeks and you could ask the trainer anything. They even made health and safety exciting." Other comments included, "The induction was very good, we immediately had two weeks of training which I found very good and useful. I shadowed seven shifts with [names of two people] and it was three months before I lone worked with [name of person]. I was gradually introduced and observed staff as well as reading care plans and protocols" and "Before I worked with the guys I read every care plan and did eight shadow shifts, I am getting to know [names of three people] and there is a slow introduction to working with other people.

Any problems and they are very helpful. My induction was thorough, efficient and definitely enough."

The induction programme was linked to the Care Certificate. The Care Certificate standards are recognised nationally to ensure staff have the skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Staff were also positive about the on-going training they received. Comments included; "The training here is on-going, and there's enough" and "The training is brilliant, really good."

We reviewed the staff training records which demonstrated staff received training in subjects such as medicines, health and safety, equality and diversity and safeguarding. Staff had also been provided with specific training to meet people's care needs, such as administering an injection if a person had an allergic reaction and how to support people who could become upset, anxious or distressed. We noted there were a small amount of staff who required training in some subjects. The deputy manager confirmed arrangements were in place to ensure staff attend the training.

Staff told us they had supervisions (one to one meetings) with their line manager and they found these useful. One staff member told us, "I have had three supervisions since I have been here, I trust my supervisor and it has been useful." Another commented, "Supervisions are really good, you get positive feedback."

We reviewed the supervision records and noted there were some gaps in the frequency that staff were receiving supervision. We discussed this with the covering manager who demonstrated they had developed a plan to address this, and adhere to the provider's supervision policy of providing staff with supervision on a six to eight weekly basis. Staff however felt supported, one staff member told us, "We get supervision even if it's not on paper, they are very good and if you need support you can ask for a supervision."

People were not able to tell us about their thoughts about the food provided in the home. We saw there was a weekly menu displayed on a notice board in the lounge. Staff told us people had a choice about what they ate. One staff member told us, "People really choose what to eat. For example one person likes three different toppings on their toast." A relative commented they thought the meals had improved to a "Healthier regime."

People were involved in the planning of their menus. Each week people were asked to choose one of the group meals. Pictorial illustration was used as a way of identifying choices. We saw a variety of pictures of different meals. Staff supported people to be included in preparation and when possible shopping for the ingredients. People had access to food and snacks throughout the day. The kitchen area had object referencing signage such as milk, coffee and tea to help people to find specific items and therefore maintain their independence.

At the time of our inspection there had been a recent spell of very hot weather. Staff told us that they encouraged fluid intake for people living in the home by offering ice lollies, milk shakes and plenty of iced drinks.

People's health care was well supported by staff and health professionals. One relative told us, "They have regular appointments and if there are any issues they are seen by a Doctor straight away." Another commented, "They do seek medical input when things are picked up."

Records demonstrated people were supported to see their GP, dentist, optician and chiropodist. People were also supported to receive specialist support from an epilepsy nurse and psychiatrist where required.

The provider employed a Speech and Language Therapist who attended the home during our inspection to complete an assessment in relation to a person's capacity. One person has recently been identified as needing to attend a hospital for treatment, staff were regularly liaising with the person's GP, dentist and hospital learning disability liaison nurse and a treatment plan was being developed.

The environment was suitable to meet the needs of the people that lived in the home. Areas of the home had recently been decorated and people had been involved in choosing the colour scheme for these rooms. Each person had their own bedroom and their own bathroom. There was an activity room that staff told us was also used as a space to play music to support people to calm if they were becoming anxious. Staff also told us this was used as a sensory room, with use of ambient lighting.

Good

Is the service caring?

Our findings

People were unable to tell us if the staff working at Blackdown House were caring. However, we observed people looked happy and relaxed in the presence of staff. When we asked one person about the staff they told us, "Alright."

Relatives told us staff were caring. Comments included, "They are very caring and understanding", "They all do their best" and "Yes, [name of person's keyworker] has been excellent."

Relatives also told us long standing staff knew their family members well. One relative told us, "Staff know [name of person] extremely well." Other comments included, "It is difficult to get to know [name of person], the ones who have been there a long time know them well." Care plans included information relating to peoples likes, dislikes, preferences, personal history and cultural needs.

Staff talked positively about the people they supported and described how, over time, they had built trusting relationships with them. Staff recognised the importance of getting to know people well. Staff knew about people's likes and dislikes and were able to explain what was important to them such as having time to process information, family members, activities and important routines.

People used various methods to communicate their wishes and choices. These included speech, pictures, vocalisations and body language. Staff knew people well and were able to interpret non-verbal communication.

Staff described how they supported people's cultural needs. Staff told us how they supported one person whose first language was not English. They described how they were increasing the person's exposure to their native language by learning a 'word of the week'. One staff member told us how they used the internet to search for key words relevant to where they were supporting the person. For example, they told us how they had supported the person for a walk in the woods and had learned the word for 'woods', they said the person responded positively to this. Staff also described how the person had 'vocabulary cards' and a tablet computer application which used their first language. Records demonstrated this activity was being offered to the person on a regular basis.

People were involved in day to day decisions about their support. Staff described how they used people's individual communication methods to give people choice and control over their lives. For example, during the inspection one person was due to attend an activity; staff described how they knew the person did not want to attend this because they pulled the staff member back into the home. The staff member said, "People choose what they want to do, [name of person] chose not to go out today, it's their choice. They signed they wanted to go to sleep and that's fine, it's their choice." Another staff member told us, "Our aim is for them to be leading as independent a life as possible."

People's privacy was respected and people were able to spend time alone in their rooms whenever they wanted. Staff understood the importance of people having privacy and their own personal time. We

observed staff knocking on people's doors before entering. Relatives thought staff respected their family members. One relative told us, "They are more than just staff, they treat [name of person] as an equal." Staff recognised the importance of promoting people's independence and they described how they supported people to be as independent as they could be and we observed people's independence being encouraged during the inspection.

People were supported to keep in touch with their relatives and those important to them. Staff described how they supported one person to use their computer tablet to video call their family member regularly. Relatives told us that they were able to visit their family members at any time and they were made to feel welcome. One relative said, "Staff are always polite and pleased to see me." We saw a compliment from a visiting professional commenting on how the team appeared "Happier" and "More forward thinking."

Good

Is the service responsive?

Our findings

People received personalised care and support that was responsive to their needs and wishes. Each person had a care and support plan. The care plans we read were personal to the individual and gave clear information to staff about people's needs, routines, daily living skills, health needs, communication needs, what they were able to do for themselves and the support required from staff. Staff had a good knowledge of the information in care plans and how to support people.

People's participation in the planning of their care was often limited by their communication difficulties. People's relatives however told us they were involved in the planning and reviewing of their family members care. Relatives told us they were invited to an annual review. They said they discussed their family members care plan and their thoughts about their care at the review. Comments included, "I am involved in and attend the reviews" and "We have a regular six monthly meetings, we were able to feed back and were listened to."

People had person centred plans and reviews where they were supported to identify and achieve their goals. These were created annually with the person and reviewed to monitor their progress. People's goals included, expanding meal choices, trying different foods and increasing exercise opportunities. Staff described how they encouraged people to be independent. During the inspection we observed a staff member encouraging a person to make their own breakfast and packed lunch. The staff member told us this was the first time the person had worked through the whole routine independently and how this achievement was a big step for the person. They commented, "I love seeing them [people] achieve things."

Staff recorded information about each person at the end of each shift. These records included information about the person's well-being, health and how they had spent their day. This information helped to review the effectiveness of a person's plan of care and made sure people received care which was responsive to their needs and preferences.

We saw staff used communication individuals responded to well, such as 'set phrases' and the use of objects, to help them interact with people. People's care plans contained a lot of detail about how each person communicated. For example, one person's plan explained how they would communicate they were happy or unhappy, if they were in pain or if they wished to spend time alone.

Staff described how they were supporting one person using social stories. Social stories are short descriptions of a particular situation, event or activity, which include specific information about what to expect in that situation and why. Social stories can help reassure people and help them understand what a certain situation involves. These were being used with the person to enable them to understand which rooms in the home were communal spaces, and which were private, such as other people's bedrooms.

The provider met the requirements of The Accessible Information Standard. This aims to make sure that people who have a disability or sensory loss get information that they can access and understand, and any communication support that they need. A range of communication methods were used by staff to provide

information and offer choices, such as showing objects of reference, pictures and using a communication board. The provider's Speech and Language Therapist told us they were spending time in the home reviewing current communication methods and considering if these could be further developed.

People were supported to follow their interests and take part in various activities and trips out. Records showed people went shopping, for walks, day trips, lunches out and swimming.

We saw people attended community based activities specifically designed to meet their sensory needs. People also chose to attend to some of the provider's day services on site such as art and craft, walking group and gardening. One person had their own car which staff took them out in. Other people used the home's vehicle to go out. During the inspection we observed people coming and going to various activities throughout the day.

People were not able to verbally raise concerns or complaints and needed to rely on staff or their family members to raise these on their behalf. Relatives told us if they had any concerns they would speak with staff or the manager or deputy manager. One relative told us, "I can't think of a time when I've made a complaint but I'm happy I would get a response straight away if I did." Another told us, "I would speak to [name of deputy manager] and they would definitely take action." There were pictorial complaints procedures displayed within the home stating who people should talk to if they had a concern. There had been no complaints raised since our last inspection.

Relatives told us communication with the home was good and they were contacted if there were any changes to their family member's needs. One relative commented, "We are kept up to date on the phone quite regularly." Staff supported people to write newsletters to their relatives updating them on their wellbeing, activities and any achievements. One person's relative however told us they had not received a newsletter for a while and how they missed receiving them because they found these helpful. We discussed this with the deputy manager who reassured us these would be reinstated. Staff told us how they translated one person's newsletter into the person's first language and sent this to their relatives.

The quality assurance manager told us if people had bereavement plans in place and if people became terminally ill or reached old age, end of life care plans would be created in order to address people's end of life wishes. There were no end of life care plans and no one was receiving end of life care at the time of our inspection.

Good

Is the service well-led?

Our findings

At our last inspection in June 2017 we found the quality assurance systems were not always effective in ensuring that all areas for improvement were identified or that improvements were made. During this inspection we found improvements had been made. For example, during this inspection where we found there were areas for improvements, such as medicines and the frequency of staff supervision, the provider's senior management team had already identified these and put actions in place to address them.

There were a range of audits and checks in place to monitor safety and quality of care. Areas covered included; medicines and care plans. The audits identified any shortfalls in the service and action plans were put in place to address these. Senior managers also conducted audits of the service called 'quality monitoring visits'. The senior managers had an action plan in place to support the registered manager and drive improvements.

There was a registered manager in post; the registered manager was not available on the day of the inspection. The provider had arranged for a manager from one of their other services to support the home in their absence. The deputy manager, area manager and Quality Assurance Manager were also available during the inspection.

Although relatives commented there had been a lot of changes in the management of Blackdown House over the past few years, they spoke positively about the management. One relative commented, "The manager and deputy manager are indeed available and approachable." Other comments included, "The [registered manager] is accessible and friendly, any grumble's we can take to the management and they listen" and "[Name of deputy manager] has been there a while and she is excellent, you can talk to them any time and they listen."

Staff also commented positively about the management of the home. One staff member told us, "The managers are always here and they are good at responding." Other comments included, "The managers are understanding, caring and helpful. I am aware of the senior managers and they are also approachable" and "The managers are accessible and supportive."

Staff meetings were held which were used to address any issues and communicate messages to staff. One staff member told us, "Team meetings are every month, I can say my piece and am confident I won't be penalised." Another commented, "I've had input into the team meetings and I feel like part of the team." Meeting minutes reviewed demonstrated subjects discussed included; any staff concerns, measures to support people in the hot weather, finances, training and updates relating to people who used the service.

Staff talked positively about the team culture, their aims and working at Blackdown House. The staff morale was good and staff were very motivated to do the best they could for the people they supported. One staff member told us, "The staff team are exceptionally good, we all work together and want the same thing." Other comments from staff included; "I love working here", "We want everyone to have a quality of life and a purpose, to fulfil their needs and treat them with respect" and "We want them to have choices and have the

same opportunities as everyone else, this is their home."

People used community facilities such as local shops, swimming pools, cafes, garden centres, national trust locations and pubs. People went out into the community with staff support during our inspection. Staff worked in partnership with a range of external health and social care professionals. People required this support due to their complex needs.

Relatives confirmed there were systems in place to give their feedback on the service. They told us they received an annual questionnaire to complete. One relative told us how they thought there was an open approach to listening to feedback and relatives views. They told us, "We have a well established relatives group at Somerset Court, and this is setting up a relatives liaison committee."

Significant incidents were recorded and where appropriate were reported to the local authority. The service had notified the Care Quality Commission of all significant incidents which have occurred in line with their legal responsibilities. We used this information to monitor the service and ensured they responded appropriately to keep people safe. Staff told us there was a culture of learning from incidents.

The manager told us about how organisational learning was shared throughout the organisation. They demonstrated how significant incidents that had occurred in the providers other homes, these had been discussed with the staff team to identify learning and how to prevent similar incidents.