Prospect NSS Limited

Prospect Neuro

Inspection report

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Ratings

Overall rating for this service	Good ●

Is the service safe?	**Good** ●
Is the service effective?	**Good** ●
Is the service caring?	**Good** ●
Is the service responsive?	**Good** ●
Is the service well-led?	**Requires Improvement** ●

Summary of findings

Overall summary

The inspection took place on the 22 and 23 March 2018 and was announced. It was the first inspection since the service was registered with us on 16 December 2016. The provider was given 48 hours' notice because the location provides a domiciliary care service. We wanted to be sure that someone would be in to speak with us.

Prospect Neuro is a domiciliary care agency registered to provide personal care to adults with physical disabilities, sensory needs, learning disabilities and those living with mental health conditions. It provides a care to people living with an acquired brain injury who live in their own houses and flats.

The service also provides an outreach service and became registered when it started to provide personal care. At the time of our inspection one person was receiving a personal care service, and a further eleven people were supported by the outreach service. Not everyone using Prospect Neuro receives a regulated activity; CQC only inspects the service being received by people provided with personal care; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

The service had a registered manager. 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.

A person and their relative told us they felt safe and that the care was good. The relative told us, "I can trust the staff 100% with my relative's safety".

Quality assurance and governance systems were not fully developed. The provider did not have up to date policies and procedures in place to ensure staff had all the information and guidance they needed, For example, the equalities policy was not inclusive of promoting people's equalities characteristics and there was no comprehensive system of monitoring trends and themes in relation to potential complaints, safeguarding's or health and safety incidents. The impact of this was reduced due to the size of the service. However as the service had plans to expand we have made a recommendation that provider sources reputable guidance on developing their overarching governance of quality and improvement.

The person's communication needs were anticipated and met and staff and the provider had an understanding of the Accessible Information Standard (AIS). This is the standard that since August 2016 had required services to promote people's information and communication needs. We made a recommendation that the provider sources further information about the AIS.

There were good systems and processes in place to keep people safe. Risks and accidents were assessed and staff received guidance on what actions to take to mitigate risk and ensure people and staff's wellbeing at the service site and in the community. Staff knew how to recognise the potential signs of abuse and what action to take to keep people safe.

The registered manager ensured that when new staff were employed, safe recruitment practices were followed. They also ensured there were sufficient suitably skilled staff available to meet people's needs. Staff received an induction and training to ensure they had up to date guidance on how to carry out their roles and responsibilities. Staff told us they felt well supported through supervision, appraisal and regular contact with each other.

People were supported to maintain good health and had assistance to access health care services when they needed to. Where needed, people were supported to receive their medicines safely, by staff that were trained and competent in administering medicines. Staff had a good understanding of the needs of people with an acquired brain injury.

The service and staff considered people's capacity and worked in line with the Mental Capacity Act (MCA) 2005. People's capacity to make decisions was assessed and staff recognised the importance of choice respecting people's choice and self-determination. People's right to privacy, to be different and to be treated with dignity was respected. One staff told us, "I accept and treat people as I would want to be treated myself".

A person, relative and social care professional told us the service was caring and kind. The person showed us the pictures of people they cared for that staff supported them to have contact with. They used gestures and facial expressions to tell us what was important to them and how staff cared for them. For example, they had really wanted a particular DVD and staff had helped them find it. Staff understood the person's life history, emotional and health needs and this was also reflected in the care planning. A relative and social care professional spoke highly of how staff listened to the person to fully understand their goals, needs and choices. The service supported the person to access food and drink of their choice and adaptations to ensure they could live as independently as possible in their home.

There were clear management lines of responsibility and accountability. The service had an established leadership and the values discussed and demonstrated by the registered manager and operations manager were reflected in their staff teams actions and motivations. One staff member told us, "We aim to give people a sense of achievement, build their self-esteem, set goals, and maintain their health and relationships". The provider was committed to supporting people with an acquired brain injury to gain as much independence as they could achieve. The service had an open transparent culture, where complaints and surveys were encouraged and acted on.

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

People were supported by staff that were trained and understood their responsibilities in relation to protecting people from harm and abuse

People were supported to access medicines safely. Staff were trained and assessed as competent to administer medicines.

There were a sufficient number of staff to meet the needs of people. Staff were recruited safely.

Is the service effective?

Good ●

The service was effective

People were supported by staff that were knowledgeable and had suitable training and support.

People were supported by staff that understood their emotional, health and physical needs and supported them to access adaptations to support them to live as independently as they could.

Staff had a good understanding of the Mental Capacity Act 2005 and worked in line with tits principles

People were supported to eat and drink sufficiently and their health needs were monitored, reviewed and planned for by staff who communicated well with health professionals.

Is the service caring?

Good ●

The service was caring

People were supported by staff that knew them well and understood what was important to them.

Staff adapted their communication style to meet the needs of the people they supported and encouraged people to be independent

Peoples' dignity, diversity and privacy was respected and their independence promoted.

Is the service responsive?

Good ●

The service was responsive

The service provided information in an accessible format to meet the needs of the person.

Care plans and risk assessments provided guidance on how people needs were to be met

People and their families were encouraged and supported to raise and issues or concerns they had with the service.

Staff were knowledgeable and responsive to people's emotional and health needs and promoted their independence.

Is the service well-led?

Requires Improvement ●

The service was not always well led

Quality assurance systems did not monitor themes and trends and some policies were not consistently reviewed and updated.

The service had effective communication with social care and health practitioners.

The service had a clear value base that promoted people's independence and there were clear lines of responsibility and accountability

Prospect Neuro

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.

We gave the service 48 hours' notice of the inspection visit because we needed to be sure the manager, staff and people we needed to speak to were available.

The inspection took place on the 22 and 23 March 2018, and was the first inspection at the service. It included visiting the site office, visiting one person with communication difficulties in their home with staff present and speaking to one relative by telephone so that we could further understand their experiences. The inspection team consisted of one inspector.

Prior to the inspection, we gathered and reviewed information we held about the service. This included notifications from the service and information shared with us by the commissioning local authority and health professionals. We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with two people using the outreach service, one relative, a social worker, three staff, the registered manager and the operations manager. We visited one person at home, with their agreement and made observations of staff interactions with them. We looked at one person's care plan, four staff files, staff training records, policies and procedures, quality assurance documentation and information and policies in relation to people's medicines. We contacted one relative, one commissioner and local authority contract teams during the inspection process. We have included their feedback in the main body of the report.

Good

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Our findings

The person and the relative we spoke with told us they felt the service was safe and they were well cared for. The person told us that they trusted the staff that visited and that they helped them when they had problems and showed us their bathroom where they had recently had problems with the plumbing. The relative told us, "I can trust the staff 100% with my relative's safety. They will provide additional support when they need it."

We looked at the management of medicines. Policies and procedures had been drawn up by the provider to ensure medicines were managed and administered safely and they also referred to the local authority's medicines policy. Staff had received medicines training and competency checks were completed by the registered manager. Staff were able to describe how they completed safe medicines practice including the use of the Medication Administration Records (MAR) and the process they would undertake. People, who were currently using the service, self-administered their medicines and the policy recognised people's right to do so and that consent should always be obtained when medicines were being administered. Staff were able to describe the importance of gaining consent and the importance of people being supported to self-administer medicines even if they could only manage some of their medicines. Staff told us the person received their medicine safely as they were very aware of when and how to take their medicines. For example, they had identified that the brand of medicines used had recently changed and shared this information with staff.

People were protected from the potential risk of abuse because staff understood and had good access to current policies, safeguarding training and understood how to identify and report safeguarding concerns. They had a good understanding of the needs of people living in the community with acquired brain injury and were able to define types of abuse that they may experience such as financial and self-neglect. Staff and a relative told us they would be confident in raising concerns about risks to people or poor practice with managers and that this would be taken seriously and acted on by managers. One staff member said "I wouldn't hesitate to whistle blow if I saw anything untoward". Information on how to report abuse including the local authority contact details were available in the staff handbook and office. Although the service had not identified any safeguarding incidents at the time of the inspection, the registered manager and staff described the steps of how they would be reported to the local authority and the Care Quality Commission when required.

Risk assessments included community and site based risk and identified hazards and how to reduce or eliminate the risk to people and staff. The registered manager and operations manager carried out risk

assessments when the service began, covering areas such as supporting people with community activities, manual handling, infection control, communication and their health and wellbeing including what to do it they were unexpectedly not present for a visit. For example, lone working risk assessment and guidance included on call details, analysis of what staff should do when travelling or when unknown visitors were present during a visit. Staff were provided with a portable circuit breaker and guidance on potential hazards and responses while in the person's home. People were encouraged to take part in regular meetings with the registered manager and records showed the assessments were reviewed annually or when there were any changes.
This meant that risks to individuals were identified and well managed so staff could provide care in a safe environment.

Accident and incident records demonstrated that staff and the registered manager took appropriate actions following incidents. Where the incident involved actions of people, these were investigated and recorded in more detail. This was done by looking at what happened prior to the incident, during and after, so that risk assessments could be developed, lessons could be learned and care plans adjusted to reduce the likelihood of reoccurrence.

People were protected by the prevention and control of infection where possible. Staff received infection control and food hygiene training. Staff were aware of the importance of using personal protective equipment (PPE) to avoid cross contamination when supporting people, and the service provided staff with gloves and aprons to be used when needed.

There were a sufficient number of staff on duty to meet the needs of the people using the service. Staffing levels were planned around the needs of people and rotas showed these were consistent. People their relatives and staff confirmed this. The operations manager told us that they did not provide short visits as their ethos was to provide people with acquired brain injury the time they needed so they were not rushed when being supported. The rotas showed there was travel time between the care calls to allow staff to get to people at the right time. Staff absence, such as annual leave or sickness, was covered by regular staff or the registered manager. The registered manager and staff confirmed they would always advise people if there were any changes or if they were running late. The person, their relative and social care professional told us they were supported by staff that they knew well and we observed staff interact with the person in a confident and informed manner.

Staff recruitment processes were followed to ensure that staff were safe to work with people. Staff files included previous work history from the employer's previous company arrangements. Records showed staff had completed an application form and interview and the provider had obtained written references from previous employers to assure themselves that staff were suitable to employ. The provider was not able to provide copies of the evidence they had seen on recruitment of people to ensure that people's identity and eligibility to work in this country. However, they ensured and confirmed this was in place by the second day of the inspection. Checks had been made with the Disclosure and Barring Service (DBS) before employing any new member of staff. The DBS is a national agency that keeps records of criminal convictions.

Good

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Our findings

The person, relative and social care professional told us their needs were met and they were confident in the skills of the staff. The person told and showed us how staff supported and met their needs by gesturing and picking up objects of references including; the telephone, letters and pictures of relatives. The relative told us, "They are skilled; they speak up for my relative when they need help with letters and can manage their needs when my relative has good or bad days".

A social care professional told us, "Staff are conscious of working in the moment with the person, which is important when supporting people with an acquired brain injury". They told us, "I respect the registered manager, they respond quickly and are competent in discussing difficult issues with the person". For example, when the wanted to immediately return home after a stay in hospital, the registered manager took time to explain that the assessments and equipment required to ensure they were safe to return home would take time.

Staff told us that they felt well supported and that regular supervisions and annual appraisals took place. Staff undertook a variety of mandatory training which equipped them with the skills and knowledge to provide safe effective care. One staff member told us, "I am able to dovetail my work with training", for example, "I find challenging behaviour less stressful now, as training has helped me understand the behaviour is not meant personally, but is part of the impact of the brain injury". Staff told us they received thorough inductions which included shadowing experienced staff that were able to demonstrate how to work with the complexity of need. Training was specific to the needs of the people using the service and included acquired brain injury awareness, MCA, medicines, moving and handling, epilepsy and positive behavioural support and training. Staff supported people in wider services and had a thorough understanding of acquired brain injury and how to support people to improve their memory and develop skills to live in the community. The provider recognised the importance of best practice and continual professional development. To inform best practice they ensured that established staff had relevant qualifications and that new staff would have access to the Skills for Care certificate. The Skills for Care certificate is a set of standards for health and social care professionals that ensures that workers have the safe introductory skills, knowledge and behaviours to provide safe care.

Staff told us that the team worked well together and had good communication systems in place to ensure information about the person's care needs and wellbeing was current and shared between the office and staff working in the community. We observed evidence of this in the person's care plan, individual daily visit records and staff communication records. Records demonstrated that the person was regularly offered appointments with health professionals including occupational therapist, physiotherapist and their GP. The person was supported by professionals and staff to access adaptations to their home including; grab rails, level access shower to ensure they could live as independently as possible in the community. Staff also encouraged them to use a portable telecare alarm so they had someone to contact in an emergency, which further ensured independence.

Staff demonstrated a good understanding of the person's emotional and health needs and could describe how they ensured they maintained a healthy weight and had access to food and nutrition. Health needs were reviewed and planned for with the support of the person's GP. For example, staff would promote information on increasing exercise and reducing the use of cigarettes and alcohol.

The Mental Capacity Act 2005 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 capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA) 2005.

The person's rights had been protected because staff were knowledgeable and had an understanding of the Mental Capacity Act 2005. There were policies in place and staff told us they had completed training, and had access to guidance within people's assessments and care plans about people's level of capacity. Staff encouraged choices and recognised that the needs and capacity of people with an acquired brain injury may change. A social care professional told us that they had worked with the registered manager when carrying out capacity and best interest assessments in relation to a person's care and accommodation needs. They told us that the registered manager demonstrated a thorough understanding of the principles of the Act and how to support people when they are making specific decisions, including moving home.

To ensure people could be offered choice in an accessible and meaningful way staff used a range of communication methods. Staff listened, observed gestures and acknowledged what the person said by repeating their words and checking they had understood them. For example, when the person was requesting a trip to a local town they showed staff a way to describe where they wanted to travel to and the staff member sought confirmation on the town to be visited. The person also used their computer to plan the route of their community activity with staff by using a website that provided local maps.

Good

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Our findings

The person, their relative and a social care professional told us that staff were caring and kind. The relative told us, "My relative is cared for, they even visit them when they are in hospital, and when they need additional support they provide it". A social care professional told us, "Staff interact with the person in an empathetic way; they are caring and understand the nature of the loss the person has experienced through their acquired brain injury".

The person received consistent care from staff that knew them well. Rotas were organised so that the support was provided from a small number of staff. Staff were able to describe the person's, likes, dislikes, background and routines. One staff member told us, "They love rock and roll and shopping, collecting music". During the inspection we visited the person's home and observed how the person and staff interacted with each other. Throughout the visit the person used both speech, gestures and objects of reference for example, pictures of family members to make their needs and choices known. Staff adapted their tone and always gave the person time to confirm that they had understood what the person had said and wanted. The person and staff initiated and received good eye contact and appeared relaxed and comfortable in each other's company, frequently using humour. The person was also comfortable sharing their concerns and frustrations they experienced in their day to day life with the staff. In response the staff were consistently reassuring and reminded the person of their achievements. For example, living independently with the support of adaptations, had reduced the level and frequency of support they required with personal care.

The person was supported to have contact with the people who were important to them including their children. Staff supported them to write, make phone calls and arranged visits with loved ones. During the inspection the person contacted their relative and asked staff to share information with them about recent financial changes. The relative and staff told us that with the person's consent the relative was regularly informed and updated about changes in activities, health appointments or any incidents involving their wellbeing. The relative was complimentary about the ongoing care and support of their relatives needs and told us, "They support him to understand changes, which is important as he doesn't always get on with people". The relative told us they were not involved in reviews of their loved ones care needs as they lived far away and their relative was very independently minded. This was recorded in the care plan.

Staff supported people to express their views and be actively involved in making decisions about their care and treatment. Staff and records confirmed that the care plan reflected the care given, and that the person was very clear they did or didn't want to do something. For example, the care plan detailed that staff should knock on the window on arrival rather than ringing the bell, as this was preferred by the person. One staff member told us, "They are very strong willed and able to challenge anything they don't want to happen". The visit observed evidenced that the person was supported to make decisions and plan for future visits, for example a trip to Worthing. The person told us that they wanted more visits during the week and that they had a preference for staff members that they would like to support them. The registered manager was made aware of these requests and had discussed them with the person. The registered manager advised the person that they could not increase the days of the service without the funder's agreement. However, they were looking at reviewing the staff as requested.

The person's independence was encouraged and promoted. The person found it difficult to give examples of how staff helped them to be independent and told us that they were frustrated that they had lost the life and independence they had before they acquired their brain injury. Staff and social care professionals told us that the person was supported to be as independent as possible, with their daily routines. For example, self-administering medicines, mobilising independently indoors, using a walking aid rather than a wheelchair for travelling shorter distances in the community and planning the routes they would take with staff when going shopping.

People's diversity was respected and promoted within their day to day experiences and care planning. Religious and cultural beliefs and activities were promoted and staff were aware when important events were happening and made a point of asking how the events had gone. For example, the person we visited told us that they had enjoyed St Patricks Day celebrations with a family member. The registered manager also gave an example of how they had improved communication with one person whose first language was not English by using a phone application that could translate sentences into their first language to aid understanding.

People's privacy and dignity was respected. Staff were aware of the need to preserve people's dignity when providing care to them in their own home. Staff spoke respectfully and without judgement about and to the people they supported. Staff were able to describe how they would approach personal care, and confirmed that it would only be provided at times that the person felt they were not able to complete it themselves, for example if they were unwell. People's right to privacy was ensured as personal information was stored securely in a locked room, and the provider had gained written consent for the person as to what third parties they could share their information with, for example GPs and hospitals.

Where people did not have relatives involved. The registered manager and staff told us that people had the right to have an advocate involved and knew of local advocacy providers. An advocate is a person who is able to speak on a person's behalf, when they may not be able to do so for themselves.

Good

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Our findings

The person, their relative and social care professionals told us they received care that responded to their needs. Staff listened to the person and were knowledgeable about their life history and personal goals. The person, their relative and social care professionals told us they were listened to and involved in making decisions about their care and support needs. Staff told us that they understood people's needs and had positive relationships with them and their relatives. One staff told us, "It's all about the person making decisions; they are the leader of the band".

The person's communication needs were anticipated and met as staff were given guidance and had a good understanding of the person's language, gestures and facial expressions. For example, the gestures they made if they were unhappy. The person's care plan included information on communication needs relating to their emotional needs and communication.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify record, flag, share and meet peoples' information and communication needs. The registered manager and operations manager had an awareness of the principles of AIS and acknowledged people would need to have full information about the service made available in a format appropriate to their communication needs as the service expands.

We recommend that the provider obtains information, sources training and implements policies and procedures in relation to compliance with AIS.

Care plans and risk assessments provided guidance on how people needs were to be met and risks mitigated; including physical, emotional and communication needs. For example, personal care information detailed where staff should place towels and the gestures the person would use when they needed support, or if they did not require support with personal care. As needs changed the care plans were reviewed and updated. For example, initially the person required support with their medicines and had access to regular food deliveries. As their mobility and skills improved they were able to access their food choices through shopping with minimal support and began to self-administer their medicines.

The person's needs were assessed before the service commenced, so that the provider could ensure they were able to meet the person's needs. Care plans were personalised and detailed their life experiences, interests, preferences and what was important to them. The person's communication needs were clearly described and guidance given on plan was personalised and detailed the person's goals. For example, the person had access to the local community and was encouraged to develop positive relationships with local shopkeepers and neighbours to improve their skills and emotional wellbeing. The registered manager and staff were aware of the importance of people remaining as independent as possible. One staff member told us, "Independence builds self-esteem, which is important for people's wellbeing".

Staff we spoke with found the care plans to be detailed and informative. The provider told us that the service was in the process of assessing the needs of a new person, and that the person's family were very involved in the development of the care plan and were keen to be involved in the recruitment of the staff to ensure that their relative's preferences for locally based staff could be achieved.

Staff were knowledgeable about the emotional and health care needs of the people they supported. Staff were able to describe how they supported the person to maintain their self-esteem and build rapport with new people. Records and staff demonstrated that staff were confident on how to respond to a medical emergency, for example when the person had fallen and required support from the ambulance service. Staff were also confident and knew how to obtain support and advice from their managers through an on call system.

People using the service had a written complaints leaflet that explained what they needed to do if they were unhappy with the service. There was a complaints policy in place and although no formal complaints had been recorded the registered manager made regular records of contacts and told us that low level complaints were being resolved and recorded within these records. The person receiving a service told us that they would tell staff or contact the manager at the office if they were unhappy with the service. During the visit the person stated that they wanted one of their visit days to be supported by a different staff member. They were comfortable discussing this with a staff member and the registered manager was made aware of the request for a change. The registered manager has since met with the person and agreed a timescale of when they can be supported with another worker. This demonstrates that people can make comments and complaints about the service, and that they will be acted on in an open and timely manner.

Although the operations manager confirmed that the service was unlikely to provide end of life care, as it had a focus on rehabilitation based support. The operations manager was confident that people's individual wishes in relation to advance care planning would be known and planned for through the initial assessment process being thorough. Staff were able to describe how they would support people to have a comfortable and dignified death.

Requires Improvement

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Our findings

A relative, social care professional and staff told us the service was well managed. The person receiving the service had established a good relationship with the registered manager and told us they trusted them and felt well supported by them in the past.

The office was based within a busy day activities service. Throughout the day of the site visit the atmosphere was friendly and professional. We observed the registered manager and operations manager speaking with staff about the person in receipt of the regulated activity, asking how they were and providing advice and support. Staff spoke positively about the management of the service and how they were supported within their roles. One staff member told us, "This is one of the best services I have worked for as they put people first", another told us, "I feel 100% supported, I have a good rapport with the managers built on mutual trust". Despite this positive feedback some areas of practice needed to improve.

Quality assurance systems were in place to monitor the running and overall quality of the service. However, the provider was unable to fully demonstrate their governance approach to maintain standards and to continually improve the quality of care as the service developed.

The registered manager and operations manager stated they were committed to improving the service. However, they were not fully informed of the revised Key Lines of Enquiries that were introduced from the 1st November 2017 and were not able to demonstrate that the service had developed their promotion of equalities, diversity and human rights processes when people were making care and support decisions. This was demonstrated by a lack of clear guidance for staff within policies and inconsistences in their documentation. For example, the medicines policy made reference to people's equalities characteristics needing to be respected and staff were able to give examples of good practice. However, the provider's Equal Opportunities policy document focussed on the protection of staff rights within employment processes and did not give staff current guidance on how to protect people from the equalities characteristics from discrimination. This is an area that needs to improve.

The Provider Information Return (PIR) noted they had introduced more regular registered manager visits to people's homes, and the more timely return of records to promote feedback about the service and monitor the quality of records to ensure a good level of care was maintained. The service carried out audits of medicines records, health and safety and care plans using a combination of reminders including a calendar and spreadsheet to remind the registered manager to complete them. However, the registered manager was unable to provide a full schedule of quality assurance processes, audits and actions in relation to areas such as policy documents, safeguarding, complaints, risk assessments and health and safety incidents to demonstrate that the service analysed trends and themes and designed action plans to embed and improve quality within the service. This is an area that needs to improve.

We recommend that the provider obtains further reputable information and guidance on developing quality assurance and governance systems.

The registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). The registered manager understood that they were required to submit notifications to us, in a timely way. So that we could confirm that appropriate action had been taken. There was a policy in place in relation to the Duty of Candour and the manager was aware of their responsibilities under the Duty of Candour. This is where a registered person must act in an open and transparent way in relation to the care and treatment of people.

A social care professional told us "The registered manager responds to things in a timely fashion, he is interested in getting things done efficiently, sees the bigger picture but does not rush things". They told us the registered manager and staff communicated well with the local authority, sharing ideas, updating the assessors of changes and raising any concerns about risks to people. The social care professional had also observed the registered manager conduct potentially difficult conversations with a person using the service. They confirmed that they struck the correct balance of providing the person with time to express themselves while being clear about the information that they had to deliver that the person may find difficult to hear. They told us, "The registered manager always has good values, has a holistic approach and always comes across as giving people the time of day".

The service had a registered manager who was supported by an operations manager and ten support staff. A team of three support staff provided support to the person receiving the regulated service. The registered manager and operations manager were very present at the service. Staff told us there were clear lines of accountability and responsibility through their roles and the embedded management structures. This was demonstrated on the day of the inspection through observations of staff interactions with the management team. Daily plans and management schedules underpinned the day to day service delivery tasks ensuring that staff were supported and individual one to one support needs were met. The operations manager and registered manager were committed to providing a range of services for people with acquired brain injuries, and the service value base was known and demonstrated by staff throughout the day. One staff member told us, "We aim to give people a sense of achievement, build their self-esteem, set goals, and maintain their health and relationships". Another told us they aimed to support people to be as independent as possible.

The provider encouraged open and transparent culture and was aware of how isolated lone workers could be and looking at improving the culture of the service for example, the registered manager had requested daily notes to be presented at the service sooner to improve communication. They also were looking to visit each person at least once every three months to provide more feedback opportunities. The person and their relative told us that they would discuss any concerns they had with managers and were confident they would be heard.

Satisfaction surveys were completed, which provided people and their relatives with an opportunity to feedback about the quality of the service provided. The areas discussed in the survey included, access to regular workers, privacy, confidentiality, choice, punctuality, safety and wellbeing. The survey outcomes were consistently positive and where people gave feedback that required a change the registered manager took action. For example, one person had shared that their visit was too early as they preferred to sleep longer, and their visit was adjusted to a later time. One person using the wider outreach service that told us, "The visits feel like meeting a friend, someone that you get on with and can help make changes happen". They told us that they were able to relax with staff and not feel judged or assessed.