Assessing Cultures To Ensure Capable Environments For People With Learning Disabilities – An Organisational Wide Approach

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Development of the tool: Covid-19 and the imposed restrictions highlighted some valid concerns about oversight and presence within supported living settings, at the same time CQC had released some finding and information regarding risks of closed cultures. This led to PBS4 developing Culture Checklist tool. This tool was developed using Capable Environments (McGill, 2014) and the CQC Closed Cultures work (reviewed 2022).

Tool Purpose: The culture checklist is a service evaluation that allows for key themes to be assessed within a provision; the person's quality of life, team dynamic, functional understanding of the person's needs. It uses a scoring system in line with Periodic Service review: + if outcome met and O for opportunity. Provisions were identified as requiring a culture checklist through the level of clinical input required or through internal/external concerns raised. The outcomes identified from the checklist inform an action plan to address those opportunities. This can include development of bespoke training and PSR as required.

Implementing The Tool: The checklists of multiple questions and prompts were completed by Clinical Assistants across a multiple observations and discussions. Figure 1 shows the process of a culture checklist being implemented. The aim was to complete the observations and discussions within 4 – 6 weeks. Following this, a score was produced, and a summary report was written highlighting the positives, opportunities for improvement and actions to complete.

Provisions Requiring Service Evaluation

TO

- Long-standing team that had supported him in a previous care setting and transitioned with him to PBS4
- High clinical input with no reduction over 6 months
- New permanent team were being recruited

PB

- Low clinical input over 6 months due to low incidents and therefore minimal external involvement
- Long-standing permanent team
- History of high severity incidents resulting in some risk aversion to trying new activities

SL

- Recently moved into new home
- High severity incidents
- Increased oversight from external team

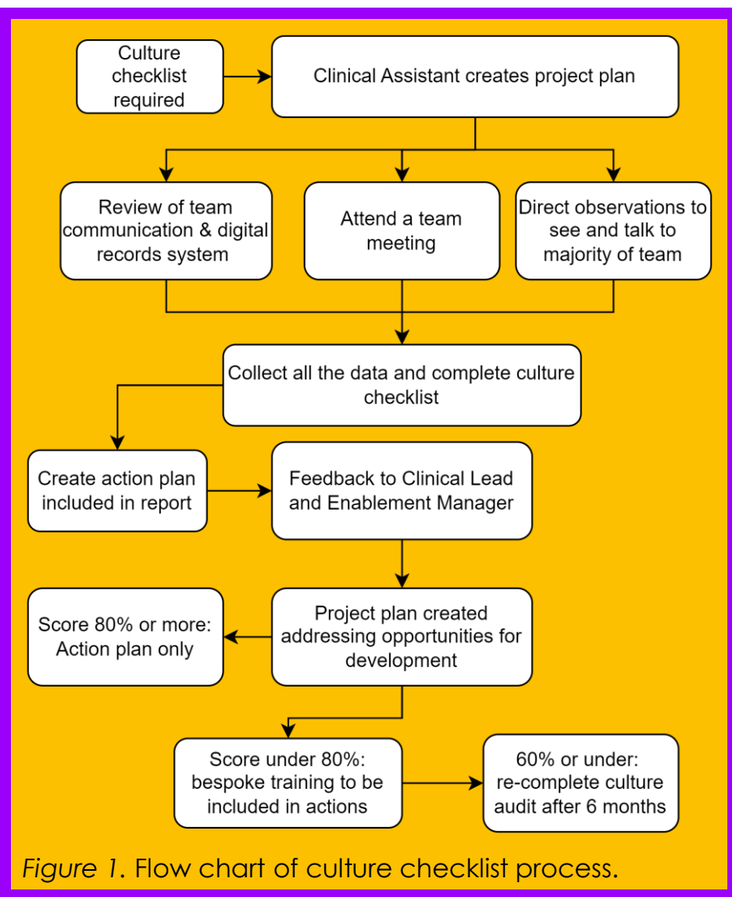

Figure 1. Flow chart of culture checklist process.

Cultures Checklist Example	
Team members say that they like the person they are supporting.	+/O
Team members can describe how they balance choice making alongside duty of care and skill development.	+/O
When observing, team members frequently interact positively with the person and in a way the person understands and can communicate.	+/O

Table 1. Examples of questions in the Cultures Checklist.

Results: Figures 1, 2 and 3 show the frequency of incidents following the cultures audit and team training (for TO and SL). The data in all three figures show variable frequencies of incidents, with both TO and PB having increasing trends prior to the culture audit. The tool itself is not designed to cause behaviour change, but there are observer reactivity as seen in TO and SL data. Furthermore, the completion of the culture audit highlighted the importance of data collection, which may also explain changes in frequency of challenging behaviour data following its implementation. PB only had the culture checklist completed, and following this there was again an increase in frequency of incidents. A team training day did not happen, but all follow up work was completed over time, which was followed by a steady decrease in frequency in incidents. For both SL and TO there is a decrease in frequency of incidents following the bespoke training day. However, SL had team PSR's developed as part of their action plan which may reflect why the decrease in frequency has remained, whereas TO data has increased.

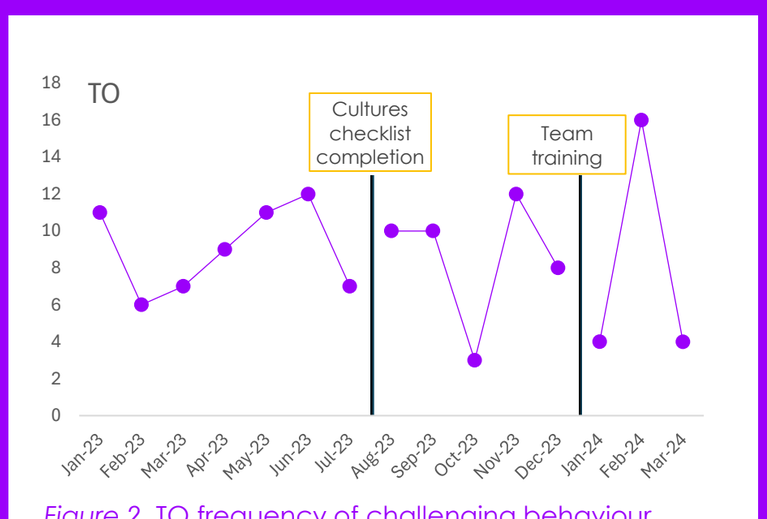

Figure 2. TO frequency of challenging behaviour.

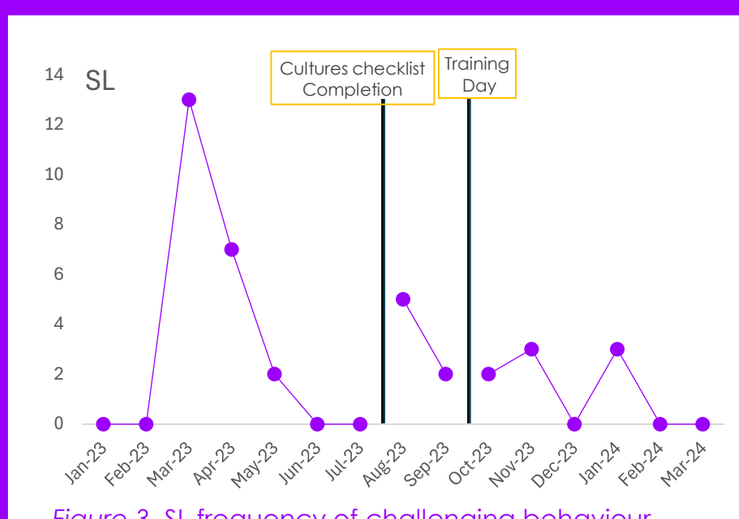

Figure 3. SL frequency of challenging behaviour.

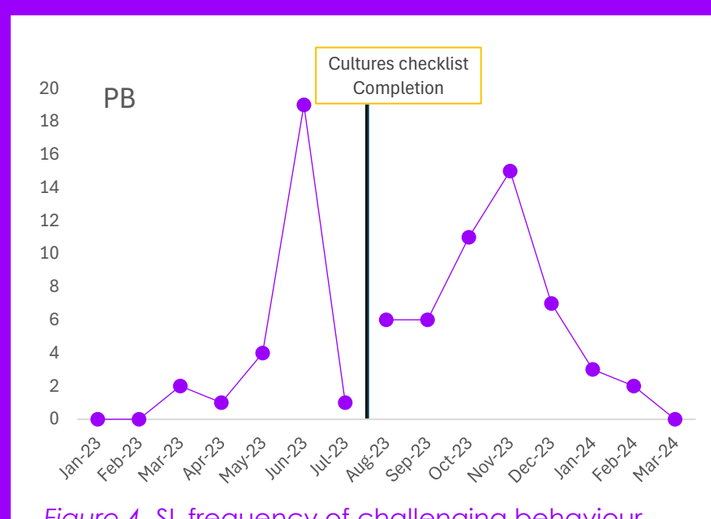

Figure 4. SL frequency of challenging behaviour.

Findings: Overall, the culture checklist tool has been a great tool for assessing team cultures. It has been a pathway to identifying areas of support needed for teams, with those opportunities being transformed into specific, measurable, achievable, relevant and time bound goals. For example, TO had increased clinical and managerial support to ensure consistent support across the team, and for PB there was a review around their health needs and protocols. This provided evidence to inform bespoke training and team PSRs, addressing areas of need directly. The goal of the culture checklist is not to change behaviour but provide assessment and data to inform person centred interventions of support. The bespoke training led to a reduction in frequency of challenging behaviour in the short term for SL and TO. However, team PSRs are necessary for ongoing improvement, as observed in SL data compared to TO data. PB's actions were completed over time, as a specific training day was not required. Having a Clinical Assistant complete the checklist was beneficial as they were impartial to the team and could spend long periods of time in the setting, ensuring that team members felt relaxed and could be honest in their discussions and more natural in their work.

Limitations: This work has been completed within real life situations, therefore there are extraneous variables that have impacted the outcomes, such as team changes throughout the process. Direct pre-and post-comparison of before versus after the culture checklist and actions following is limited. Another limitation is that the culture checklist and training days were not completed when incidents were of increasing/high frequency to fully assess their impact.

Future Plans: Overall aim of this work is to build a 3-tiered service evaluation model with the culture checklist being the first level, bespoke training being tier 2 and team PSRs being tier 3. This would support development of a clear process flow following scores of the checklist. The Aberrant Behaviour Checklist may also provide a clear pre and post measure of the impact of the culture checklist and actions following. For the culture checklist, PBS4 will continue to use this tool to develop 4 key themes of where opportunities of development highlight, as our current findings highlight teams typically have key areas where opportunities for development are. PBS4 would also like to trial this service evaluation within other settings, such as within a school.

McGill, P., Bradshaw, J., Smyth, G., Hurman, M., & Roy, A. (2020). Capable environments. *Tizard Learning Disability Review*, *25*(3), 109-116.
Closed Cultures, Care Quality Commission (2020). https://www.cqc.org.uk/sites/default/files/20191104_closedcultures_supportinginformation_full.pdf