National Autistic Society (The)

# Overcliffe House

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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

This inspection was carried out on 17 November 2017 and was unannounced.

The home provides care and support for up to twelve people with learning disabilities and/or autism. People who used the home had moderate to low care needs, with some now needing consideration as elderly people having lived at the home for over thirty years. At the time of our inspection there were twelve people living at the home. The home consisted of two houses next door to each other with accommodation split over two floors. There was one bedroom on the ground along with communal living space and the rest of the bedrooms were on the first floor.

A registered manager was employed at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

At the previous inspection on 30 September 2016, we made one recommendation concerning finances and found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, we found people were at risk of scalding as the water temperature had been too hot. Records showed that the temperature had been taken regularly, however when they had gone above what is considered safe for people who are vulnerable, no action had been taken to protect people.

At this inspection, we found the registered manager had robust audits of water temperatures around the home and immediate action had been taken when necessary to keep people safe.

At the last inspection we found that there were not robust quality control measures in place. The manager had not reviewed audits being undertaken by staff and therefore opportunities had been missed to improve the service provided to people and keep them safe.
At this inspection we saw that the manager was monitoring monthly checks being completed by staff. That the quality of records such as daily records and medication records were reviewed and action taken when appropriate.

At the last inspection, it was recommended that people's finances be audited by an external auditor, the manager confirmed this had been arranged on a yearly basis.

People were assessed as individuals so that staff understood how people's care was planned to maintain their safety, health and wellbeing. Risks were assessed within the home, both to individual people and for the wider risk from the environment. Staff understood the steps to be taken to minimise risk when they were identified.

The registered manager had plans in place for emergency evacuation should this become necessary. These were individual plans for each person and were kept in people's care files and in a grab bag should the need arise. It ensured that all staff in the home would understand how to continue people's care, should the home be evacuated in an emergency.

Incidents and accidents were recorded and checked by the registered manager to prevent these happening again.

People were kept safe by staff who understood their responsibilities to protect people living with learning disabilities and autism. Each person had a key worker who assisted them to learn about safety in and outside of the home. Staff had received training about protecting people from abuse. The staff and management team had access to and understood the safeguarding policies of the local authority and followed the safeguarding processes.

There were policies and procedures in place for the safe administration of medicines. Staff followed these policies and had been trained to administer medicines safely.

People had access to GPs and their health and wellbeing was supported by prompt referrals and access to medical care if they became unwell. Records were kept to assist people to monitor and maintain their health. Staff had been trained to assist people to manage daily health challenges they faced from conditions such as epilepsy. Staff were also mindful of those people who were now aging and the conditions they may now face.

The home was welcoming and friendly, with some people coming forward to find out who was at the door and introduced themselves. Staff provided friendly compassionate care and support. People were encouraged to get involved in how their care was planned and delivered. Staff were deployed to enable people to participate in community life, both within the home and in the wider community.

Staff upheld people's right to choose who was involved in their care and people's right to do things for themselves was respected. People were consulted about their care and staff were flexible to requests made by people to change routines and activities.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. Restrictions imposed on people were only considered after their ability to make individual decisions had been assessed as required under the Mental Capacity Act (2005) Code of Practice. The registered manager understood when an application should be made.

Many people had been at the home over thirty years, others having lived in other homes within the organisation before coming here. Staff knew people extremely well and people were very involved in their own routine and activities.

Recruitment was robust. The registered manager recruited staff with relevant experience and the right attitude to work well with people who had learning disabilities and autism. New staff were given extensive induction and on-going training which included information specific to learning disability and autism services.

Staff received supervisions and training to assist them to deliver a good quality service and to further develop their skills.

Staff understood the challenges people faced and supported people to maintain their health by ensuring people had enough to eat and drink and had access to health care professionals when required.

The registered manager produced information about how to complain in formats to help those with poor sight or communication skills to understand how to complain. This included people being asked frequently if they were unhappy about anything in the home.

## 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 was robust auditing of possible risks within the environment keeping people safe.

People's finances are appropriately audited.

People's risks assessments were relevant to their individual needs, and included risks involved with emergency evacuation of the home.

Safeguarding concerns and incidents were reported appropriately.

With the registered manager and staff were committed to preventing abuse.

Medicines were administered by competent staff.

Recruitment processes for new staff were robust.

### Is the service effective?

Good

The service was effective and remained good.

### Is the service caring?

Good

The service was caring and remained good

### Is the service responsive?

Good

The service was responsive and remained good .

### Is the service well-led?

Good

The service was well led.

There were robust audits monitoring risks within the building, with immediate action to minimise any risks identified.

There were systems to measure the quality of the service being

provided and how that has impacted on peoples' lives.

The home had benefited from consistent and stable care and management staff bringing continuity to the care and support provided.

# Overcliffe 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 17 November 2017 and was unannounced. The inspection was carried out by one inspector.

Before the inspection, we looked at notifications about important events that had taken place at the home, which the provider is required to tell us by law.

We spoke with four people about their experience of the home. We spoke with five staff including the registered manager, team leader and three care staff. We observed the care and support provided.

We asked the local authority contracts and other health professionals involved in people's care for their views about the home.

We spent time looking at general records, policies and procedures, complaint and incident and accident monitoring systems. We looked at three people's care files, three staff record files, the staff training matrix, the staff rota and medicine records.

Good

# Is the service safe?

## Our findings

At the last inspection we found that records showed hot water temperatures in the home would at times reach above the recommended safe water temperature. Water temperatures should not be above 44°c as this places people at risk of scalding. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that hot water temperatures in peoples' rooms and bathrooms had been recorded regularly and were with in normal parameters with the exception of one. The registered manager and staff had learned from the previous issue so when the temperature was over 44°c this had been reported immediately. The staff made sure that people understood that this tap should not be used and put up a sign that indicated it was out of order. This was removed and people were informed once value was replaced, the next day.

At the last inspection we made a recommendation about how people's finances were monitored. At this inspection we found people who needed assistance to manage their finances are supported by staff. All transactions are fully documented and checked by two staff. The records are checked by the registered manager monthly and once a year they are being independently audited.

Some people were able to speak to us other people were less able or had less confidence to express their views directly to us. We listened when people spoke to us about their experiences and observed how other people responded to staff when care and support was delivered. People told us they felt safe. One person said 'I have lived here a long time, I feel safe and really like being here, I know the staff and the staff know me'. People went to staff who listened to them when they were concerned or they just wanted to share news about something they experienced that day.

We asked a relative whether they were confident that the staff kept their family member safe, they said, "I am certain they keep my daughter safe, staff know her well, they take time to explain things to her, she couldn't be in a better place".

Staff were aware of the identified risks for each person and how these should be managed. These included looking at people's risk assessments, their daily records and by talking about people's experiences, moods and behaviours at shift handovers. Records detailed the information shared between staff about risks within the service.

Behavioural support care plans detailed early interventions based on people's individual needs. This enabled staff to intervene early if they saw people becoming upset or agitated. Staff understood the recorded behavioural triggers for each person. If people's needs could no longer be met at the service, the registered manager worked with the local care management team to enable people to move to more appropriate services. This was only considered when people's behaviours had become distressing to others living in the home.

Although there were very few incidents and accidents occurring they were recorded and checked by the registered manager for any learning. The registered manager told us these are closely monitored and steps would be taken to reduce incidents and accidents from happening again. The registered manager was clear about reporting incidents that affected the health, safety and welfare of people being notified to regulatory bodies such as The Care Quality Commission and the local authority safeguarding team.

There were personalised risk assessments and behaviour intervention plans if appropriate for each individual living at the home. The actions that staff should take to reduce the risk of harm to people were included in the detailed care plans. The behaviour care plans were in place for people and used to identify triggers for behaviours that had a negative impact on themselves or others or put others at risk. The steps and early interventions staff should take to defuse these situations and keep people safe was fully recorded. Staff understood their roles in assisting people to understand and manage their behaviours. Risk assessments were reviewed regularly to ensure that the level of risk to people was still appropriate for them.

People were protected from the risk of receiving care from unsuitable staff. Staff had been through an interview and selection process. The registered manager followed a policy, which addressed all of the things they needed to consider when recruiting a new employee. Applicants for jobs had completed applications and been interviewed for roles within the service. New staff could not be offered positions unless they had proof of identity, written references, and confirmation of previous training and qualifications if relevant. All new staff had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with people who needed safeguarding. A new member of staff we spoke with confirmed they had been through a vigorous application and selection process. Which included being asked to explain gaps in their employment during the interview process.

There was enough skilled and experienced staff to meet people's needs. The registered manager had ensured that the staff both permanent and their own bank staff had the correct skills, training and experience. We looked at the rotas and saw that staff were deployed in line with people's choices around activities and in extra one to one time some people had for assessing the community in the evening. Staffing levels were increased when people needed additional staff assistance for example one person is receiving end of life care and they have a member of staff available to meet their needs at all times.

People had practiced evacuating the service, for example when the fire alarm sounded. Emergency drills and tests were recorded. People had personal emergency evacuation plan (PEEP) written to meet their needs. Staff and people living in the home received training in how to respond to emergencies. The registered manager was part of an out of hours on call system, which enabled serious incidents affecting peoples' safety or care to be dealt with at any time. Staff understood people's individual communication styles, like body language or behavioural changes which may indicate people were unhappy or distressed.

There was a current safeguarding policy and the up to date safeguarding protocol issued by the local authority. Staff told us that they had received training on safeguarding procedures and were able to explain these to us. Staff described the types of concerns they would report as safeguarding and understood what whistle blowing was. Staff were aware of reporting to social services safeguarding teams if they believed their concerns were not taken seriously.

There were safe processes in place for the management and administration of people's medicines. We

observed medicines being given and the staff administered the medicines appropriately. Once they were confident that the person had taken the medicines they signed that it had been administered. During our observation one person was asked by staff asked the person if they had pain and at what level it was at. Staff did this to see if paracetamol would be enough or whether they needed a stronger PRN medicine The current medicines policy was available for staff to refer to should the need arise.

Access to medicines was restricted to those staff that had completed training and were competent. People had been given information about what medicines were for and when they should be taken. People had been assessed individually about their abilities to understand information about medicines. We reviewed the records relating to how people's medicines were managed and they had been completed properly. Medicines were stored securely and audits were in place to ensure medicines were in date and stored according to the manufacturers guidelines. The registered manager ensured that regular audits of medicines happened and that all medicines were accounted for daily. These processes helped to ensure that medicine errors were minimised, and that people received their medicines safely as prescribed and at the right time.

The registered manager explained that they do not own the building people live in and therefore some of the maintenance is not their responsibility. They work closely together to ensure that the building is fully maintained to keep people safe. For example there were copies of the required gas and electric safety certificates, the water had been checked for legionella and small electrical appliances had been checked yearly. The outcome of this was that maintenance repairs were carried out quickly and safely and these were signed off as soon as they were completed. People were also protected from environmental risks and faulty equipment.

The building was kept clean and there were no unpleasant odours. The people living in the home were responsible for cleaning their bedrooms and some communal areas such as the kitchen with staff support. There was a member of staff who was responsible for cleaning both houses on a daily basis. They cleaned for example bathrooms, toilets and emptied bins. They completed a cleaning schedule, showing what areas they had completed each day. There was a COSSH file which contained a safety sheet for all the cleaning products used with in the home. This gave the staff emergency information on what to do if for example the cleaning liquid or powder got into people's eyes or it was swallowed. All staff spoken with knew where this file was located and how to use it.

There were policies and procedures available for staff to refer to if they were unclear what they should do in different circumstances. These included topics such as if a person went missing, an unexpected death and reporting accidents and incidents.

Good

# Is the service effective?

## Our findings

Staff had the skills required to care and support the people who lived in the home. Staff learning was provided in a number of ways, including by e-learning, distance learning courses and face to face training and this was supported by records we checked. Additional training was provided in relation to person centred care planning and its delivery for people with autism and epilepsy.

Staff also told us that they received supervision and felt supported in their roles. As soon as new staff started working at the home they began training and induction. Supervision meetings with staff were held with senior members of staff and took place about four times per year more often if it was felt necessary. Supervision and appraisal assisted staff to maintain, improve and develop their work practice and skills to benefit people in the home. A newer member of staff said, "I have done my induction and the training I needed to help me to become a good carer. I have done the basic training and I know I have more to do. I have found the whole staff team very supportive". This meant that staff were supported to enable them to provide care and support to a good standard.

People's needs had been fully assessed and care plans had been developed on an individual basis. The plan detailed the professional people who they had access to if the need they needed that specialist support. This meant people and staff could access this professional support, review and care planning advice easily and quickly. Assessments were completed and reviewed with people, their care manager from the learning disability team or their relatives whenever possible. Before people moved into the service an assessment of their needs had been completed to confirm that the service was suited to the person's needs. After people moved into the service they, their families where appropriate and keyworker, were involved in discussing and planning the care and support they received. A review of the plan was undertaken monthly by the keyworker with the person to keep it current and document any changes.

Assessments and care plans viewed reflected people's needs and were well written. People's plans had some good examples of personalised care planning. With people's involvement in their care planning being recorded. The registered manager of the home continued to monitor the personalisation of care plans, however this meant these plans had become very long and it was not always easy to find specific information quickly. The registered manager had recognised this and was putting together a mini plan for each person that recorded the main agreements to care and support. This meant new and bank staff could access the information they needed straight away.

People were supported with their agreed and recorded daily routines by staff if that's what they wanted to do that day. Staff were conscious that the older people living at the home may not always want to go out every day to do activities, and staff respected their choices. People's health needs were monitored by staff and comprehensive information was provided about people's conditions. For example, a person who was receiving end of life care had treatment guidelines in place which were detailed and staff knew how to follow.

People were assisted to access other healthcare services to maintain their health and well-being, if needed.

The registered manager and staff had been reassured by the support they were receiving from other health professionals in the care of a person near the end of their life. Staff told us about the support they give to people to go and see their GP or getting help from other health and social care professionals like the Eleanor Nurses. Records confirmed that people had been seen by a variety of health professionals, including a GP, nurse and dentist. Referrals had also been made to other healthcare professionals, such as psychiatrists.

There was lots of flexibility for people around eating, drinking and meals. People had access to their kitchen and could make drinks and chosen meals and snacks independently or with support. This helped people maintain their independence and created a person centred culture around meals. People's likes and dislikes in respect of food and drink was seen in the care plan file. Staff supported people to eat healthily but it was their choice and staff respected that. Food preparation areas were well presented and clean. They were accessible to people at any time. There was plenty of food available for people to choose from. 'Use by dates' were checked and people helped formulate the menu and do the shopping.

People we spoke to about the food were happy with the choices they got. People said, "I like most meals and I get involved in cooking." And, "I get support from staff to cook and make my own meals." People had choices about the menus and could change their minds about what they ate and drank. The way eating and drinking was managed enabled independence and worked well for people.

People were encouraged not only to make day to day choices about things like meals and activities they were encouraged to be part of the decisions made about their home. People were encouraged and enabled to personalise their bedrooms and also chose paint colours for other parts if the home. Staff supported people to choose, for example one person had their bedroom decorated recently and staff supported them to go out to buy new curtains. The person enjoyed showing off their room to staff.

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.

There was good communication between staff and people living at the home, staff were friendly and caring. Best interest meetings about important decisions were recorded. All people were encouraged and enabled to make day-to-day decisions about their care and were offered choices. They were provided with information if necessary to help them decide what they wanted to do.

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

The registered manager understood when an application should be made and how to submit them. Care plan records demonstrated DoLS applications had been made to the local authority supervisory body in line with agreed processes. This is to ensure that people were not unlawfully restricted, however there was a back log of applications being confirmed and therefore staff were mindful not to restrict peoples liberty and offered choices whenever possible.

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. Care plans for people who lacked capacity, showed that decisions had been made in their best interests. For example, some people may need

to be supported in making best interest decisions about DoLS by an independent mental capacity advocate (IMCA). IMCA's are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. These decisions could include the use of physical interventions, and show how other relevant people, such as GP's, Community Mental Health Nurses and people's relatives had been involved.

Good

# Is the service caring?

## Our findings

During the inspection visit we saw people interacting well with staff. The staff took time to listen to people and responded in a friendly and patient way. People knew all the staff names and called out to them to check out things like 'how long is it before we go', 'will I need a coat today' and 'are you coming with us today'. The staff were polite, and there was still good natured banter between people and the staff and with each other. This showed that people were at ease with each other and the staff.

People were positive about staff and living at Overcliffe House. Four people spoke to us about their experiences living in the home. They talked about the relationships they had with staff and one person described their keyworker as being a kind person, they said,' [name keyworker] takes me out, up the town if that's what I want to do. They make me laugh, they are my friend, and they know what I like'. Another person said 'The staff look after me, I can ask them anything, they don't mind, they always listen and they are nice and kind'.

The staff we spoke with had a good understanding of what was important to people and were knowledgeable about their medical histories, their preferences, hobbies and interests. This information we saw in the 'Person centred care plans', which had been developed through time with peoples' agreement. This information enabled staff to provide care and support in a way that was appropriate and met peoples wishes and preferences.

A relative told us, "She is well cared for here, she is asked what she wants all the time', and, 'all the staff are smashing, she is comfortable here with the staff that understand her.". "Her communication is not easy to understand but they have learnt to communicate with her. Her body language lets them know if she is not happy".
One person at the home did not have family or friends available to offer impartial advice and support. An advocate was arranged for this person and they were currently seeing them once a month. The advocate was able to liaise with the staff on the person's behalf if that is what they wanted them to do.
Staff were able to describe ways in which people's dignity and privacy was preserved, such as making sure staff knocked on people's doors and waited until people were happy for them to come in. Staff made sure doors were closed when they provided personal care. Staff explained that all information held about the people who lived at the service was confidential and would not be discussed to protect people's privacy. Staff were heard reassuring a person that was using the bathroom that although the door would not lock they would make sure no one would come in while they had a bath. Staff explained that all information held about the people who lived at the service was kept confidential and would not be discussed openly in the communal areas of the home to protect people's privacy.

People's rooms within the service were personalised by them and reflected their choice and taste. We heard one member of staff had been invited to see a person's room and they commented about the curtains being really nice and how they fitted well in the room.

Decisions about household routines were taken collectively by the people during house meetings or

individually with their keyworker. There were a number of information leaflets on the notice boards around the home which included information about the service, safeguarding, a complaints policy, what to do if the fire alarm goes off and activities. These had been provided in accessible formats.

Staff were aware of peoples' human rights, for example the right to be the person they wanted to be. Staff had received training in human rights and equality and diversity and understood that the people they supported for example may need to be supported to access specialist health professionals; to explore their sexuality or maintain relationships which were important to them. The registered manager said that personal relationships would be encouraged and supported. Staff spoken with understood that part of their role was to enable people to lead their lives in the way they want.

Good

# Is the service responsive?

## Our findings

The people at Overcliffe House received personalised care that was responsive to their needs. People had been encouraged to determine their own preferences and wishes regarding the support and care staff provided. When people needed assistance to communicate this, relatives were often involved in the formation of a care and support plan. Taking into account people's interests, along with the care and support the person may need.  Each person had a named key worker or they had access to an external mentor. This was a member of the staff team who worked with individual people, built up trust with the person and met with people to discuss their dreams and aspirations. We saw from care plans that when people had met and chosen activities these had been organised by their key worker and they recorded when they had taken place. Keyworkers also liaised with family and enable the person to do the things important to them.

Often we saw that continued relationships with their family member were very important to individuals. As people had got older so had their parents, consideration was now given to how the visits could be facilitated given the changes in age. Some people were still able to go home to family on a regular basis and at weekends.

We observed people getting ready to go out and participate in their chosen activities or packing a bag to visit family for the weekend.  One mum came to collect their relative and we had the opportunity to speak with them. They told us that they recognised that they were getting older and therefore they realised there would be a time when they would not be able to do this anymore. They were confident that staff at the home would make sure that contact continues even if they brought the person to them.

Activities varied day to day and some included learning, such as developing social skills and involvement in household tasks to maintain their independent living skills. People were encouraged to assist staff with cooking if they could not cook by themselves. Staff help people write a shopping list and supported people to do the shopping for the chosen meals.

Other activities were chosen to meet people know interests and to access the local community. For example one person was preparing to go clothes shopping and then have a meal out be for returning later that evening. We heard the person discussing the outing with the staff member, they also thought about how they were going to get where they were going which on this occasion was to be on the bus. Other people told how they enjoyed going to the club and meeting up with other friends they had made in other homes. We were given a long list of things they liked to do, they included horse riding, swimming, bowling, watching football and going to the pub.

We also saw that people also went on holiday normally once a year, some went with family others went we there keyworker or another member of staff if they were unable to do this.

People could change their minds and told us they did not have to do their chosen activity for any particular day. Most went to the day centre run by the provider for the four similar care homes in that area. They provided all sorts of activities to match people's interests and advancing years. Other people had one to one staff support in the community. This included participating in leisure activities, going to the pub for lunch and personal shopping. Staff had been allocated to people's activities based on their skills and experience.

The registered manager had sought advice from health and social care professionals when people's needs changed. With people getting older they now needed to explore end of life care. We saw that staff had been receiving training in how to care for people with life limiting illnesses. The staff were also being supported emotionally to ensure they were confident in providing end of life care for a person they have known for many years. Records of multi-disciplinary team input had been documented in care plans. For example Eleanor Nurses had given guidance on making sure people experience a pain free death. Health professionals gave guidance to staff in response to changes in people's health or treatment plans. This meant that there was continuity in the way people's health and wellbeing were managed.

The registered manager and staff responded quickly to maintain people's health and wellbeing. Staff had arranged appointment's with GP's or other specialised practitioners when people were unwell. People had a patient passport which holds information about the person and their needs when going to hospital. The information had been down loaded on a USB fob that goes with them if they go into hospital, so hospital staff have immediate access to important information about that individual.

Where people were going to have treatment in hospital the staff endeavoured to take people to the place where the procedure would take place and give them time to ask questions and understand what would be happening. By familiarising the person it was hoped it would be less stressful for them and they would have a good outcome.

There was a policy and procedure about dealing with complaints that the staff and manager followed. The complaints procedure was displayed within the home in a way that met people communication needs. Staff explained that if someone wished to make a complaint that their keyworker would support them in doing this. Staff understood that people with learning disabilities, autism may not always be able to verbally complain. Staff compensated for this by being aware of any changes in people's mood, routines, behaviours or health. Staff told us that all complaints are taken seriously; the registered manager explained that they saw complaints as a way of improving the service for not only the individual but also as learning tool for staff.

Good

# Is the service well-led?

## Our findings

At the last inspection we found that systems in place were not robust enough to assess, monitor and improve the quality and safety of the services being provided to people. This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection the registered manager recorded the quality monitoring she undertakes monthly and this sent to senior managers at head office. The registered manager also keeps them informed of issues that related to people's health and welfare and they in turn would make sure that these issues were being addressed. There were systems in place to escalate serious complaints or incidents to the highest levels with the organisation so that they were dealt with to people's satisfaction.

Over time there had been continuous improvement in the quality of the service which included the development of person centred care plans. These developments supported people to make individualised life choices and participate in the life of their community. People and their relatives had been asked about their views and experiences of using the home. We found that the registered manager used a range of methods to collect feedback from people. There were regular individual or group meetings for people were they are encouraged to contribute. Where communication was a barrier the keyworker would put their views forward.

The registered manager had experience of working in different positions in services for people living with learning disabilities and autism. The registered manager had carried out quality audits of the service on a monthly basis. Audits enabled them to identify areas of the service that needed improvement, and the action which needed to be taken and when to keep people safe.

Although the staff were not familiar with the providers actual vision and values as documented they did describe the similar good outcomes for the people living in the home that they strived for. For example, to provide the best individualised support for people. So people enjoyed their lives, enabled them to continue their interests. Staff received training and development to enable this to be achieved. The registered manager had a clear understanding of what the service could provide to people in the way of care as they become elderly. This was an important consideration and demonstrated the people were respected by the registered manager and staff.

Staff told us they enjoyed their jobs. The provider asked staff their views about the service. Staff felt they were listened to as part of a team, they were positive about the management team in the service. Staff spoke about the importance of the support they got from the registered manager and team leader, especially when they needed to respond to incidents in the service. They told us that the manager was approachable. One member of staff said, 'I have been supported to develop with in my role. I have further training to develop my management skills and I am being mentored by the manager.' "Another member of staff said, "We have regular supervision and training is arranged so our knowledge and understanding is up to date. We work together as a team and we support each other, but we put the people first and remember this is their home".

There were a range of policies and procedures governing how the service needed to be run. They were kept up to date and reviewed at least yearly. Staff told us that they were able to view these when they needed to.

The registered manager reviewed the quality of the records staff had completed. They checked that risk assessments, care plans and other systems in the service were up to date. All of the areas of risk in the service were covered; staff told us they practiced evacuations and these were recorded.