National Autistic Society (The)

# NAS Community Services (Lancashire)

## Inspection report

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30 November 2017

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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

This inspection was carried out on 29 and 30 November 2017.

NAS Community Services (Lancashire) is registered to provide personal care and support to people on the autistic spectrum who are living in their own homes. This included people living in shared housing as part of a supported living arrangement. People's care and housing are provided under separate contractual agreements. The Care Quality Commission does not regulate premises used for supported living; this inspection looked at people's personal care and support. At the time of our visit 21 people used the service.

The service was managed by 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.

At our last inspection on 14 and 17 October 2017 the overall rating of the service was 'Requires Improvement'. There was a breach of regulations relating to staff training and development. We asked the provider to make improvements on these matters. We received an action plan from the provider indicating how and when they would meet the relevant legal requirements. We also made a recommendation on improving quality monitoring systems. At this inspection we found sufficient improvements had been made.

We found there were management and leadership arrangements in place to support the effective day to day running of the service.

Recruitment practices made sure appropriate checks were carried out before staff started working at the service. Systems were in place to ensure staff received ongoing training/learning and supervision.

There were sufficient numbers of staff at the service. Support was provided in response to people's agreed plan of care. The use of agency staff was being monitored and kept under review.

Risks to people's well-being were being assessed and managed. Systems were in place to support people in maintaining a safe and clean home environment.

Processes were in place to support people with their medicines. We found some matters needed improvement; however these were put right during the inspection. Checks were carried out to identify medicine errors and make improvements.

Staff were aware of the signs and indicators of abuse and they knew what to do if they had any concerns. Staff said they had received training on safeguarding and protection matters. They had also received training on positively responding to people's behaviours.

We observed positive and respectful interactions between people using the service and staff. People made positive comments about the staff team.
Arrangements were in place to gather information on people's backgrounds, their needs, abilities, preferences and routines before they used the service.

Each person had detailed care records, describing their individual needs, preferences and routines. This provided clear guidance for staff on how to provide support. People's needs and choices were kept under review and changes were responded to.

Staff expressed a practical awareness of promoting people's dignity, rights and choices. People were supported to engage in meaningful activities at their homes and in the community. Beneficial relationships with relatives and other people were supported.

Processes were in place to support people with any concerns or complaints. There was an 'easy read' complaints procedure for people, which provided guidance on making a complaint.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. Policies and processes at the service supported this practice.

People were encouraged to lead healthy lifestyles. They were supported with their healthcare needs and medical appointments. Changes in people's health and well-being were monitored and responded to.

People's individual dietary needs, likes and dislikes were known and catered for. Arrangements were in place to help make sure people were offered a balanced diet and healthy eating was encouraged.

There were systems in place to consult with people who used the service, relatives and staff, to assess and monitor the quality of their experiences and make improvements.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

Staff recruitment processes included relevant character checks. Staffing arrangements were sufficient in providing people with safe care and support. Staff were trained to recognise any abuse and they knew how to report any concerns.

We found there were satisfactory processes in place to support people with their medicines. Checks were carried out to identify errors and make improvements.

Processes were in place to support people in maintaining a safe, clean environment. Risks to people's individual wellbeing and safety had been assessed and managed.

### Is the service effective?

Good

The service was effective.

Processes were in place to find out about people's individual needs, abilities and preferences. People's health and wellbeing was monitored and they were supported to access healthcare services when necessary. They were supported to eat healthily; their preferred meal choices were known and catered for.

People were encouraged and supported to make their own choices and decisions. The service was meeting the requirements of the Mental Capacity Act 2005.

Arrangements were in place to develop and support staff in carrying out their roles and responsibilities.

### Is the service caring?

Good

The service was caring.

People made positive comments about the supportive and caring attitude of staff. We observed positive and respectful interactions between people using the service and staff.

Staff were aware of people's individual needs, characteristics,

backgrounds and personalities, which helped them provide personalised support.

People were supported in a way which promoted their dignity, privacy and independence.

## Is the service responsive?

Good

The service was responsive.

People received personalised care and support. Processes were in place to monitor, review and respond to people's changing needs and preferences.

People had opportunity to maintain and develop their skills. They had access to community resources, to pursue their chosen interests and lifestyle choices.

There were processes in place to manage and respond to complaints, concerns and any general dissatisfaction with the service.

## Is the service well-led?

Good

The service was well-led.

There was a management team, providing leadership and direction who were committed to the ongoing development of the service.

Staff were knowledgeable and positive about their work. They indicated the managers were supportive and approachable.

There were processes in place to monitor and check the quality of people's experience of the service.

# NAS Community Services (Lancashire)

**Detailed findings**

## Background to this inspection

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

This inspection took place on 29 and 30 November 2017. We contacted the service two days before the visit to let them know we were inspecting. We did this because they provide a supported living service and we needed to be sure that someone would be available for the inspection. The inspection was carried out by one adult social care inspector.

Before the inspection, we reviewed the information we held about the service, including notifications and previous inspection reports. A notification is information about important events which the service is required to send us by law. We contacted the local authority contract monitoring team and had discussions with the local authority safeguarding team. We used information the provider sent us in the Provider Information Return. 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 also sent questionnaires to staff and community professionals. We received five completed questionnaires from staff and two from community professionals. We used all this information to decide which areas to focus on during the inspection.

We used a number of different methods to help us understand the experiences of people who used the service. During the inspection we visited people in their own homes. We spent time with people and observed how they were supported. We spoke with three people who used the service. We also talked with three support workers, two deputy managers and the registered manager. We looked at a sample of records, including three care plans and other related documentation, three staff recruitment records, staff training records, records of complaints, policies and procedures and quality assurance records. Following the visit

we had contact with the service's area manager.

Good

# Is the service safe?

## Our findings

We reviewed how the service protected people from abuse, neglect and discrimination. The people we spoke with indicated they felt safe with the support they received. One person explained, "Yes I feel safe, because I have other people around me." Each person had a 'keeping me safe' assessment and a 'positive behaviour' support plan in response to their needs and vulnerability.

Prior to the inspection, we reviewed the information we held about the service relating to safeguarding incidents and allegations of abuse. We discussed and reviewed some of the previous safeguarding concerns with the registered manager. Records showed how safeguarding and protection matters were reported, managed and the action taken to reduce the risks of re-occurrence.

We discussed the safeguarding procedures with staff. They expressed a good understanding of safeguarding and protection matters. They were aware of the various signs and indicators of abuse. They were clear about what action they would take if they witnessed or suspected any abusive practice. Staff said they had received training and guidance on safeguarding and protecting adults. They had also received training on low arousal techniques and proactively responding to behaviours of concern. This meant they could respond to people by focusing upon defusing tension and using the least restrictive approaches. The service had policies and procedures to support an appropriate approach to safeguarding and protecting people. We noted safeguarding information produced by the local authority was available in the properties we visited.

All the staff completing surveys indicated people using the service were free from abuse and harm. They were aware of the reporting procedures and most felt protected by the service's lone worker policies. There was also a whistleblowing (reporting poor practice) policy in place which encouraged staff to raise any concerns. Staff spoken with and all those completing surveys, were aware of the policy and expressed confidence in reporting any poor practice to the managers.

We reviewed how people were protected by the prevention and control of infection. People spoken with described their involvement with keeping their homes clean. At our last inspection we found people were not always adequately supported to maintain a clean and hygienic environment. At this inspection we noted improvements had been made. The properties we visited were clean in the areas we viewed. Cleaning schedules and records had been introduced. These provided guidance for people and staff on keeping their environment clean. Records showed when areas had been cleaned, this meant they were monitored and checked to maintain satisfactory standards. Records and discussion indicated staff had completed training on infection control and basic food hygiene.

We looked at how risks to people's individual safety and well-being were assessed and managed. We found risks to individuals had been assessed and recorded in people's care records. There was information defining the risks and the action to be taken to minimise risks for people's wellbeing and safety. The risk assessments were written in a person centred way and covered aspects of support and care including as appropriate: behaviours, accessing the community, managing finances, travelling, relationships, individual

routines and support with personal care. We noted the risks assessments were dated and kept under review. Staff spoken with had access to, and were aware of people's individual risk assessments.

We looked at the way people were supported with the proper and safe use of medicines. One person said, "Staff look after my medicines they give them to me on time." Each person had a 'medicine profile' which made reference to the prescribed items, the dosage, amount, any side effects and details of the support to be provided. This information was presented in a way to make it more accessible to the person. People had been routinely risk assessed to check their ability and preferences to manage their own medicines. There were individual plans in place to direct staff on providing support. The service encouraged people to use a MDS (monitored dosage system) for medicines. This is a storage device designed to simplify the administration of medicines by placing tablets in separate compartments according to the time of day.

There were specific protocols for 'when required' and 'variable dose' medicines. We noted one recently obtained 'over the counter remedy' did not have a protocol in place however the staff member took action to rectify this matter during the inspection. There were 'body map' diagrams available to provide clear direction on the application of topical creams and lotions. This meant staff were instructed on offering/providing medicines in response to a person's needs and well-being.

We noted some low risk and good practice matters were in need of development. However we discussed these with staff and the registered manager, who took action to make improvements during the inspection. The registered manager also agreed to ensure the regular medicine checks were updated to reflect and address these matters and make any improvements.

Records and discussion showed staff providing support with medicines had completed training. There were processes in place to assess, monitor and review staff competence in providing safe effective support with medicines. We noted some staff had not had their competency re-assessed for more than 12 months. However the registered manager had identified this shortfall and plans were in place to ensure all staff were re-assessed annually. The service had medicine management policies and procedures which were accessible to staff.

We looked at the processes in place to maintain a safe environment for people who used the service, visitors and staff. Health and safety screening checks had been completed on environmental matters in people's homes. We noted people who used the service were involved where possible with the safety checks. One person told us, "I do the fire alarm checks every week."

Each person had a personal emergency evacuation plan. Records were kept of any accidents and incidents that had taken place. Processes were in place to monitor any accidents and incidents so the information could be analysed for any patterns or trends. There were policies and procedures providing instructions for staff on responding to accidents, emergencies and untoward events. Records and discussion indicated staff had received training on health and safety matters.

We checked if the staff recruitment procedures protected people who used the service. One staff member we spoke with confirmed appropriate recruitment processes had been followed. We reviewed the recruitment records of three members of staff. The recruitment process included candidates completing a written application form and attending a face to face interview. The required character checks had been completed before staff worked at the service and these were recorded. The checks included an identification check, obtaining written references and clarification about any gaps in employment. A health screening assessment was also completed. Records showed an appropriate DBS (Disclosure and Barring Service) check had been completed. The DBS carry out a criminal record and barring check on individuals

who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. Arrangements were in place for new employees to undergo a probationary period to monitor their conduct and competence.

We reviewed how the service managed staffing levels and the deployment of staff to support people to stay safe and meet their needs. We found there were enough staff deployed at the service to provide care and support and keep people safe. All the staff completing surveys indicated there were enough staff and they had sufficient time to provide safe support and care. People we spoke with indicated staff were always available to provide their contracted care and support. Referrals were made to the local authority commissioning team if people's needs changed and the provision of staff support needed to be reviewed. The staff rota planning system involved small teams of staff working at designated properties. There was an on-call system in place which meant a member of the management team could always be contacted for support and advice. The registered manager explained that the service was using agency staff to achieve safe support levels. However, the same agency staff members had been enlisted to help promote continuity of support for people who used the service. At the time of our inspection the recruitment of additional staff was ongoing.

Good

# Is the service effective?

## Our findings

We looked at how the service made sure that staff had the skills, knowledge and experience to deliver effective care and support. At our last inspection we found the provider had failed to ensure all staff had received appropriate training. This was due to a lack of refresher training for established staff, which meant they had not adequately updated their knowledge and skills.

At this inspection we found improvements had been made. Staff spoken with during the inspection with told us of the training they had received. One commented, "I am up to date with all the training. It's been really good." The majority of staff completing surveys also indicated they got the training needed to enable them to meet people's needs, choices and preferences. We spoke with the training coordinator and reviewed records of the training completed; ongoing and arranged. We noted examples of certificates confirming the training in staff files. The provider's mandatory training programme included: Basic health and safety, basic first aid, safeguarding adults and children, food safety, data protection and equality and diversity. Additional training was also available in response to people's specific needs, for example epilepsy awareness and moving and handling. Team leader training had also been arranged for senior staff.

Arrangements were in place for new staff to complete an initial 'classroom based' induction training programme. We spoke with one staff member who confirmed they had completed the induction training. They explained, this had included a person who used the service describing how autism had affected their journey in life. The induction training incorporated the Care Certificate training modules. The Care Certificate is a nationally recognised set of standards that health and social care workers adhere to in their daily working life. All staff had completed, or were working towards achieving the Care Certificate.

The induction also incorporated an introduction to the framework known as SPELL, which had been developed by the National Autistic Society (NAS) to understand and respond to the needs of people on the autistic spectrum. SPELL stands for Structure; Positive (approaches and expectations); Empathy, Low Arousal and Links (links with other health and social care agencies and families).

The service supported staff as appropriate, to attain recognised qualifications in health and social care. Twenty five staff had a National Vocational Qualification (NVQ ) level 3 or equivalent, in health and social care. Arrangements were being made for staff new to care to complete the Quality and Credit Framework QCF diploma in health and social care. It was also mandatory for all new employees to enrol in the NAS Academy, as part of their induction and ongoing development. The Academy provided a value based staff development framework underpinned by SPELL and ongoing reflective practice. The Academy's aim was to develop, embed and maintain excellent autism practice organisation wide. At the time of the inspection the NAS academy was in the process of achieving recognised accreditation status.

Staff spoken with indicated they had received one to one supervisions with a member of the management team. We saw records confirming individual and group supervision meetings had been held. The meetings had provided the opportunity for staff to reflect upon their experiences and discuss their role and responsibilities. Processes were in place for staff to receive an annual appraisal of their work performance;

this included a training needs analysis of their ongoing learning and development.

We reviewed how people's needs and choices were assessed and their care and support delivered to achieve effective outcomes. The people we spoke with indicated they were satisfied with the care and support they experienced. Their comments included, "Its fine," "I'm okay with my support" and "It's sort of alright."

The registered manager described the process of assessing people's needs and abilities before they used the service. This involved the completion of a comprehensive 'support design plan' assessment tool. The assessment involved gathering information from the person and other sources, such as families, social workers and health care professionals. The assessment took into consideration people's compatibly with others if the accommodation was shared. The preferred characteristics of staff to provide support also formed part of the process. Transitional arrangements for the provision of support were tailored in response to the person's needs. The care records we reviewed included people's initial assessment, this confirmed their needs and preferences had been fully considered and planned for.

We looked at how consent to care and treatment was sought in line with legislation and guidance. People spoken with indicated they were involved in matters affecting them. During the inspection, we observed examples where staff consulted with people on their individual needs and preferences and involved them in everyday decisions. Staff spoken explained how they routinely consulted with people about their support and their lifestyle choices. We noted in care files, there were signed records of people consenting to their care and support. There were individual service agreements provided by the local authority, which outlined the basic terms and conditions of people's support package.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA and whether any conditions or authorisations to deprive a person of their liberty were being met. There were individual mental capacity screening assessments and a decision making assessments within the care planning process. There was supporting information to provide clear guidance for staff on least restrictive practice in order to protect people's rights and maintain their choices. The registered manager confirmed that action had been taken to liaise with the local authority in relation to Court of Protection referrals. This process had recently progressed as part of an ongoing 'pilot scheme' in consultation with them. There was information to show the progress of pending referrals which was being monitored. Staff spoken with indicated an awareness of the MCA and the Court of protection, including their role to uphold people's rights and monitor their capacity to make their own decisions. Records and discussion showed that staff had received training on this topic. The service had policies and procedures which aimed to underpin an appropriate response to the MCA 2005.

We looked at how people were supported to live healthier lives, had access to healthcare services and received ongoing healthcare support. People spoken with told us of the activities they enjoyed which promoted a healthy lifestyle, for example: dancing, walking, horse riding and swimming.  They indicated

they received attention from healthcare professionals. They had been supported to attend routine appointments and annual healthcare checks. Their comments included, "I have a health check every 12 months," "I visit the GP as needed" and "Staff support me with appointments." We found the monitoring of people's general health and wellbeing was included within the care plan process and recording systems. People had health action plans which provided information on their past and present medical conditions. Processes were in place to record healthcare appointments, the outcomes and any actions needed. We noted the service had liaised as appropriate with a number of health care professionals, including GPs, dentists, hospitals, chiropodists' and opticians.

We checked how people were supported to eat and drink enough to maintain a balanced diet. People received differing levels of support with eating and drinking. They said, "They help me make my tea," "I enjoy my meals" and "The food we have is good." Some people were actively involved with shopping for provisions, which meant they could make choices on purchasing food and drink items. People were also supported to make their own meals. Individual dietary needs and food likes and dislikes were included in the care planning process and support plans had been devised for each person. Menus were devised and agreed to include people's known preferences, consideration had been given to healthy eating. One staff member said, "We try to be diplomatic when encouraging healthy eating. We discuss things individually with people." We found there were different ways of involving people with planning meals. People told us, "Before we go shopping we look at pictures of meals to see what we want," "I put ideas forward for the menu" and "We have a menu it's on the fridge, so we know what we are having." People's general dietary intake was monitored and their weight was checked at regular intervals as appropriate. This helped staff to help support people with their diet and food intake. GP's, speech and language therapists and dieticians were liaised with as necessary.

We reviewed how are people's individual needs were met by the adaptation, design and decoration of premises. The care planning process took into consideration each person's specific needs and preferences relating to their personal space, including their behaviours, independence and lifestyle choices. People had been also been supported to enhance their rooms in various ways, by choosing their own colour schemes, decorations, furnishings and bedding. Processes were in place to monitor the premises and people's needs for support equipment and any adaptations. We reviewed how the service used technology and equipment to enhance the delivery of effective care and support. We noted specific examples where individuals were supported to use electronic devices and internet access, to enhance communication and skill development. Staff had electronic access to the service's policies and procedures and e- leaning formed the basis of the staff training and development programme.

Good

# Is the service caring?

## Our findings

We reviewed how the service ensured that people were treated with kindness, respect and compassion and that they were given emotional support when needed. People spoken with made positive comments about the staff team and the care and support they received. They said:
"The staff here are okay," "They are always nice with me" and "The staff are good." We observed positive and meaningful interactions between people using the service and staff.

Staff showed sensitivity and tact when responding to people's needs, choices and behaviours. They were respectful and kind when supporting and encouraging people with their daily living activities and lifestyle choices. All the staff and community professionals completing surveys told us that people who used the service were always treated with respect and dignity. Staff also confirmed they were always introduced to people before working unsupervised with them. This meant people would be supported by staff they were familiar with and who knew them.

The service aimed to provide people with a continuity of staff support. We found people had a small team of carers providing their support. One person explained, "I am aware of all the staff we mainly have the same ones." Staff spoken with knew people well and understood their role in providing people with person centred care and support. They were aware of people's individual needs, specific routines, backgrounds and personalities. They gave practical examples of how they supported and promoted people's individuality and specific preferences. Staff indicated they had time to listen to people and involve them with decisions. They confirmed staff rotas were devised to offer people some regular one to one support. Consideration was given to the general characteristics of staff to provide support to individuals, this aimed to sensitively match the compatibility of staff with the people supported.

We checked how the service supported people to express their views and be actively involved in making decisions about their care, support and treatment as far as possible. During the inspection we observed people were routinely supported and involved with day to day decisions. Everyone had a support plan which identified their individual needs and preferences and how they wished to be supported. This included sensory profiles and details on how their autism affected them. There were 'one page profiles' describing, matters such as, 'what's important to me,' 'what people admire about me' and 'how to provide my support.' There was information on people's background history, culture, important relationships, religion, likes, dislikes, dreams and aspirations. People spoken with were aware of their care records and indicated they had been involved with reviewing them. Records were kept to show how people had participated in the care plan process.

We reviewed how the service empowered and enabled people to be independent as possible. We asked people if the support they received promoted their independence. One person said, "I can do a lot of things, I just need a bit of help." We observed people doing things independently, making their own decisions and sharing responsibilities. This included sharing responsibility for household chores and planning activities. Promoting choice and encouraging independence was reflected in the care plan process. For example, there were individual progress plans to support people in achieving goals and developing independence skills.

One person told us, "When we go shopping for food I push the trolley." Staff spoken with explained how they encouraged independence, in response to people's individual abilities, needs and choices. This had included trying new experiences, confidence building and developing numeracy and literacy skills. People had opportunity to express their views on the service on an ongoing basis, during general discussions, care plan reviews, 'inclusion events' and satisfaction surveys.

We looked at how people's privacy was respected and promoted. People we spoke with indicated their privacy needs were upheld and that staff were respectful of their homes. Staff spoken with were aware of the importance of maintaining people's privacy and confidentiality of information. They gave examples of how they applied these principles in practice. We observed staff being respectful of people's privacy and confidentiality, by knocking on doors and being discreet when sharing information. Staff had been given guidance on appropriate record keeping and there were policies to promote confidentiality of personal information.

Good

# Is the service responsive?

## Our findings

We looked at how people received personalised care that was responsive to their needs. People said, "They try to help and encourage me," "Staff support me with the things I like to do" and "The staff know me well. We plan my activities together."

People had individual care and support plans, which had been developed in response to their needs and preferences. All the people we spoke with were aware of their care plans and we noted they were readily accessible to them. One person explained, "I have a care plan, they go through it with me." We looked at three people's care and support plans and other related records. This information identified people's needs and choices and provided guidance for staff on how to respond to them. Included were sensory and communication profiles, to highlight people's preferred methods of communication, engagement and interaction. They reflected people's preferences and included details about how they preferred their support to be delivered. The support plans were underpinned by a series of risk assessments, which aimed to proactively respond to people's rights to independence whilst keeping them safe.

Staff spoken with indicated the care plans were informative, they said they had access to them during the course of their work. They described how they delivered support in response to people's individual needs, routines and aspirations. We were given examples of the progress people had made, resulting from the service being responsive and developing ways of working with them.

Records were kept of people's daily living activities, their general well-being and the care and support provided to them. There were also additional monitoring records as appropriate, for example relating to behaviours, accidents and incidents. There were 'hand over' discussion meetings between staff to communicate and share relevant information. Two people told us they had their own diaries, these were used to record their own thoughts, feelings and experiences on a daily basis. These processes enabled staff to monitor and respond to any changes in a person's needs, expectations and well-being. There was evidence to show that the care plans were reviewed and updated with the involvement of people who used the service.

People told us how they were supported to engage in activities within the local community and pursue their hobbies and interests. They indicated they were satisfied with the range of activities offered and supported by the service. We found positive and meaningful relationships were encouraged. People were actively supported as appropriate, to have contact their family and friends. There were individual planned schedules of proposed activities. People had been supported to attend community based resources and chosen leisure activities. These included, dance sessions, pubs, the gym, shopping, cafes, holidays, voluntary work, shows, concerts and attending social clubs. People also described some the activities they liked to do at home, including, baking, word puzzles, listening to music, computer games, gardening and crafts. Many of the activities had a defined a learning objective to focus upon the person's skill development and recognise their achievement.

We reviewed how people's concerns and complaints were listened and responded to and used to improve

the quality of care. The people we spoke with had an understanding of the service's complaints procedure and processes and their right to raise concerns. One person told us, "I would tell the staff if I was not happy they would sort it out." One person also shared their awareness and expectations of the complaints procedure with us. We discussed with the registered manager ways of using the complaints processes to proactively respond to people's expressed concern and displeasure. This would further empower people and show how any dissatisfaction was taken seriously and responded to.

The service had complaints procedures which were available to people. This information provided guidance on making a complaint and how it would be dealt with. It included the names and contact details of people who people could raise complaints with, such as the registered manager and area manager. The service had policies and procedures for dealing with any complaints or concerns. Staff spoken with expressed an understanding of their role in responding to concerns and complaints. All staff completing surveys indicated any concerns raised were dealt with effectively by managers.

There were processes in place to record, investigate and respond to complaints and concerns. We looked at records of the recent concerns raised by people who used the service. Action had been to address and respond to the concerns raised. We noted some of the complaints records, including the actions taken to investigate matters were not readily available for us to review. However the registered manager assured us this information was accessible and was currently being collated to evidence the investigation process. The registered manager described the systems in place to monitor complaints, to identify and proactively respond to any patterns and trends.

We checked if the provider was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. We looked at how the service shared information with people to support their rights and help them with decisions and choices. The complaints procedure was available in different formats, including a 'user friendly' pictorial version. We found people's support plans were sensitively written in a person centred way and included pictures and symbols to help make them more accessible to the person. 'User friendly' staff rotas were available to people who used the service. One person told us, "We have photographs of all the staff." This meant people were kept aware of who was due to provide their support.

There was a guide for people using NAS Community Services. This was available in an 'easy read' format with illustrations to help explain the contents. The guide included information about the services available and gave assurances on the standards of support people could expect to receive. There was information available on local advocacy services. Advocates are independent from the service and can provide people with support to enable them to make informed decisions. The registered manager described to us, the plans in place to introduce a custom-made 'service pack' of information for each person, to further promote their rights to information. We noted the service's CQC rating was on display at the service's office base and this was uploaded to the provider's internet website. This was to inform people of the outcome of the last inspection.

We evaluated how people were supported at the end of their life. The service did not usually provide end of life care. However we discussed with the registered manager ways the service had sensitively planned for people's needs and preferences in consultation with other agencies. And the processes in place to support people who may experience bereavement.

Good

# Is the service well-led?

## Our findings

We reviewed the service's management and leadership arrangements. The people we talked with did not express any concerns about the general management or organisation of the service. One person commented, "I think everything is running fine."

Since our last inspection there had been some changes in the management team. This had included a new registered manager and a change in the senior/area management arrangements. The management team in place included the registered manager and two deputy managers. Members of the management team were available between 9:00 and 17:00 each day during the week. There was a 24 hour on-call system for management support when staff were on duty. There were also 12 team leaders, providing ongoing support and direction in people's homes. Staff spoken with made positive comments about the managers, describing them as "Approachable" and "Supportive."

Throughout the inspection, the registered manager expressed commitment to the ongoing developments at the service and demonstrated a proactive response to the inspection processes. The registered manager had attained recognised qualifications in health and social care. She had updated her skills and knowledge by completing the provider's mandatory training programme and through attending relevant training courses and seminars. The registered manager was supported and monitored by an area manager and had access to resources and support within the organisation. There were also regular meetings with managers from other National Autistic Society (NAS) services.

We checked if the monitoring systems ensured that responsibilities were clear and that quality performance, risks and regulatory requirements were understood and managed. At our last inspection we found quality monitoring was not always sufficient. However at this inspection we found there were improved systems in place to monitor the quality of the service.

The NAS had devised and introduced a new quality monitoring audit tool kit in January 2017. The audit tool was designed to monitor and achieve adherence to the regulations and was carried out by senior managers. The findings of the audit process were appropriately shared with the registered manager and any plans for action were identified and agreed in a set time-frame. Progress in achieving improvements was then monitored during subsequent visits. There were quality monitoring visits carried out at the service, by other managers within the NAS organisation every six months. Reports following visits included any recommendations and resulted in an action plan to achieve progress.

The NAS Community Services management team also carried out regular checks to monitor the quality of the service. Arrangements were in place for ongoing audits and spot checks on routine processes and systems including: medicines management, service user finances, health and safety, accidents and incidents, complaints, staff training and support plans/reviews. Systems were in place to identify and respond to any shortfalls. Furthermore information included within the PIR showed us the registered manager had identified some matters for development within the next 12 months.

We reviewed how the service continuously learned, improved and developed. We found there were service development plans available to provide direction and oversite of the service and the wider organisation. We noted the plans used the framework of safe, effective caring, responsive and well-led. Included was the aim to reduce the use of agency staff and the number of staff vacancies across services in the north region. The NAS had also focused on staff retention. Therefore staff recognition schemes had been introduced and further scope for staff consultation, training and development. The service, along with the other NAS services in the region had achieved Autism Accreditation status in February 2017. Autism Accreditation is an internationally-recognised process of support and development for services providing support to people with autism.

We reviewed how the service promoted a clear vison and approach, to deliver high-quality care and support which achieved positive outcomes for people. The service's vision and philosophy of care was reflected within the written material including, the statement of purpose, job descriptions and policies and procedures. There were care quality and value statements on display in the office base, these had been shared with staff across the service. Staff expressed a good working knowledge of their role and responsibilities. They were aware of the management structure and lines of accountability at the service. Staff had been provided with job descriptions, contracts of employment and codes of conduct, which outlined their roles, responsibilities and duty of care. They had access to the service's policies, procedures and any updates. Various staff meetings were held on a regular basis. We looked at the records of the most recent staff meetings and noted various work practice topics had been raised and discussed. Staff spoken with told us the meetings were useful in sharing relevant information and that they were encouraged to make suggestions and voice their opinions. The meetings resulted in an action plan to provide a framework for implementing and monitoring ongoing developments. The registered manager had recently introduced a service 'Newsletter' to share relevant information with people who used the service, relatives and staff.

We looked at how people who used the service, staff and others were consulted on their experiences and shaping future improvements. There were processes to consult with people on their experience of the service. This included gaining feedback from people who used the service, relatives and staff. People who used the service were enabled to express their views and opinions, within their support reviews. Consultation 'inclusion events' had also been held. These were informal gatherings in various settings, which were structured to enable people to share their experiences of the service and make suggestions for improvements. A survey with families had also been carried out. The registered manager showed us the outcomes of the consultation processes. The information had been collated and there were action plans in response to the findings. The results of the surveys and the actions taken were due to be shared across the service.

Staff had opportunity to share their views annually via a national computer based staff survey within the NAS organisation. All staff completing our surveys indicated that managers asked what they thought about the service and took their views into account. We had sight of the results of the last staff survey for the north services carried out in September 2017. There were management strategies and action plans which aimed to make progress and respond to the issues staff had raised.

We evaluated how the service worked in partnership with other agencies. We found arrangements were in place to liaise with other stakeholders including: local authorities, health authorities, housing associations, landlords and commissioners of service. There were procedures in place for reporting any adverse events to the CQC and other organisations, such as the local authority safeguarding and deprivation of liberty teams. Our records showed that the managers had appropriately submitted notifications to CQC.