Aspens Charities

Wentworth Close

Inspection report

17 Wentworth Close
Bexhill On Sea
East Sussex
TN40 2PQ

Website: www.autismsussex.org.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

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

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism who used the service can live as ordinary a life as any citizen.

Wentworth Close provides accommodation and personal care for up to four people who have learning disabilities and some associated physical and/or sensory disabilities. There were four people using the service at the time of inspection. The building was a purpose built bungalow situated in Bexhill-On-Sea, close to local shops and public transport links. People had their own bathrooms attached to their bedrooms. There was a kitchen, lounge and dining-room for people to relax in. There was also a large garden, with seating areas and raised flower beds for growing vegetables.

This is the service's first inspection. They were previously registered under a different provider; however, the same people were living at the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. During this inspection, the registered manager was on long term leave. Therefore, the service was being managed by an interim manager and interim deputy manager. They had been in post for one month prior to the inspection.

We were told during inspection that the service had been through a difficult period of losing staff. As a result, some areas, such as activities, staff support and meetings had lapsed. The new interim management team had identified a lot of areas for improvement. Some had already been addressed, whilst others, such as activities and communication tools for people, required more time to be implemented and imbedded into everyday practice. Mental capacity documentation did not reflect the views of the person or how the decision was made that they lacked capacity. Some people could not make decisions related to restrictive practices, such as locks on the main doors. They did not have mental capacity assessments specific to these. However, people were not distressed by these restrictive practices and therefore we considered the impact on them to be low.

Staff understood people and risks to their wellbeing. There were robust risk assessments for people and the environment, which informed ways to keep people as safe as possible. People received their medicines from staff who had appropriate training and their competency regularly assessed. Staff were recruited safely and

had a good understanding of safeguarding processes. Although some concerns had been raised by relatives about recent staffing issues, we found there were suitable numbers of staff to meet people's needs.

Staff had the skills and knowledge to meet people's needs effectively. They told us that the interim management team had improved the frequency of supervisions and team meetings, which they found helpful in discussing concerns. Staff felt the new induction process allowed them enough time to get to know people, their preferences and routines. Although we identified areas for improvement with documentation, people were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. People's nutritional needs were consistently met and they were supported to access health and social care professionals to improve their wellbeing.

We observed that people had built good relationships with staff that they were happy to be with and trusted. Relatives felt that staff were kind and caring. People's independence, privacy and dignity was promoted at all times. Staff also had a good understanding of confidentiality and how to keep people's information private.

Staff knew people's communication needs well. Although no official complaints had been received, people and relatives were reminded regularly of the process to follow if they were unhappy with any element of care provided. Staff were responsive to people, their preferences and what made them anxious.

Staff and professionals spoke highly of the new interim management team and felt they had made a lot of positive changes in the short time they had managed the service. The interim management team were aware of improvements needed and had worked hard to address these. They were passionate about improving the lives of people and encouraged team work in managing concerns and generating ideas for the future of the service.

Further information is in the detailed findings below.

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 were recruited safely and there were suitable numbers to meet people's needs.

People received their medicines safely by trained and competent staff.

There were detailed assessments of risk for people and the environment.

Staff had a good understanding of infection control and how to reduce the spread of infection.

Is the service effective?

Good

The service was effective.

Staff had a good understanding of choice and supported people to make decisions about their care.

Staff received induction, training and supervision to give them the skills and knowledge required in their role.

People's nutritional needs were met.

People had involvement from health and social care professionals when it was needed.

Is the service caring?

Good

The service was caring.

Staff had built good relationships with people and genuinely cared for their wellbeing.

People's privacy, dignity and independence was respected and promoted.

People's personal information was kept confidential and shared on a need to know basis.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Although it had been identified that activities were not as varied as they had been, more time was needed to implement and imbed improvements.

Staff knew people's communication needs well, however some opportunities for using communication tools to promote this, had been missed.

No one was receiving end of life care at the time of inspection, however the interim management team had ideas to improve people's knowledge and understanding of death and bereavement.

People and relatives were aware of who they could speak to if they had any concerns or worries.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Documentation regarding mental capacity did not reflect the views of people, nor how a decision regarding capacity was reached.

Areas identified for improvement required more time to implement and imbed into everyday practice.

Staff, relatives and professionals were positive about the interim management team. They told us they were supportive and passionate about improving the service.

Wentworth Close

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.

The inspection took place on the 29 November 2018 and was undertaken by one inspector. This visit was announced. We gave the service 24 hours' notice of the inspection visit because it is a small service. This was because we needed to be sure that our visit would not disrupt the lives of people more than necessary.

Before the inspection, we checked the information we held about the service and provider. This included previous inspection reports and any statutory notifications sent to us by the registered manager. A notification is information about important events which the service is required to send to us by law. We reviewed the Provider Information Report (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make.

People were not always able to tell us about their views and experiences living at Wentworth Close. Therefore, we observed the care received to help us understand the experience of people who could not talk with us. We spoke with the interim manager, interim deputy manager and three care staff. We reviewed records, which included four care plans, three staff files, medication administration records, staff rotas and training records. Other documentation that related to the management of the service such as policies and procedures, complaints, compliments, accidents and incidents were viewed. We also 'pathway tracked' three people living at the home. This is when we looked at their care documentation in depth and made observations of the support they were given.

Following the inspection, we spoke with three relatives and two professionals to gain their views of the service provided at Wentworth Close.

Good

Is the service safe?

Our findings

Although people could not tell us they were safe, we saw they were comfortable and relaxed around staff they knew well. Relative's told us that they thought people were kept safe. One relative said, "They've got a very good system for giving medicines to him, the times of day and how much, it is a very secure system. There's been no errors or mistakes." Another relative said, "My son has to have his medicines at a specific time for a health condition. He always gets them on time."

Two relatives expressed some concerns that there had been a lot of changes to staffing in recent months. The interim manager told us that they had been brought into the service a month ago as a result of staff leaving. Within this time, the interim manager had already amended the management structure to include two seniors instead of one. Three additional care staff had been recruited and were due to start imminently. Although agency staff were being used to cover hours, they worked regularly at the service and knew people and their routines well. A staff member from another Aspens Charities care home was also supporting people until new staff were settled into the service and their roles. We viewed staff rotas and saw that there was always a core staff member working with agency staff, as well as the deputy or a senior on duty to support. We observed that people were responded to quickly and efficiently and that there were enough staff to meet their needs. One person required two staff to support them when leaving the building and this happened. Another person required staff to sit with them when they ate or drank and this also happened consistently. A staff member told us, "For a while things weren't good but I am so glad I stayed. The new structure is working well and people are absolutely getting the support they need."

Assessments of risks, both personal and environmentally were undertaken for people who lived at the home. This included risks associated with activities, going out, using public transport or choking. For people with epilepsy, there were guidelines on what their seizures looked like, early indicators that the person may be unwell and actions staff should be take. This included specific information regarding any emergency medicines. For people that could display behaviours that challenged, there were clear protocols for what the behaviours were and actions to take. These included stress factors, the impact on the person and others, how staff should support people, and things that helped or should be avoided.

Incident and accident reports detailed information of the incident, immediate and on-going actions taken and reflected on lessons learned. Each month, incidents were analysed for patterns or trends. The interim deputy manager told us there had been an increase in challenging behaviour for one person. Staff sought advice from medical professionals, the mental health team and from a positive behaviour specialist. The person's medicines were reviewed and reduced by their GP. New risk assessments were introduced to address new behaviours and staff met weekly to discuss incidents and ways to manage them. It was identified that specific times of the day could make the person more anxious and therefore more staff were made available at those times. A plan was also designed which gave staff guidance in how to support the person in times of crisis. This included alerts being made to hospitals and other health professionals so the person could be responded to more quickly. The interim deputy manager told us, "With all the new protocols and support for the person, we have had no incidents in the last month and the person is almost back to their usual self." A professional told us, "The interim deputy manager seems very keen on making

sure positive behaviour support is implemented throughout the service and this would certainly have a positive impact on people."

People's medicines were safely managed. Staff were not able to support people with medicines unless they had received relevant training. Staff also had their competency to administer medicines assessed regularly. This was achieved through review of training, written tests and observations by a member of the management team. Some people took medicines on an 'as and when required' basis. Records detailed why the medicine was prescribed, the dose, maximum use within 24 hours and when the GP may need to review. There were medication risk assessments that detailed how the person may show they were in pain and when to offer pain relief medication. People's medication was stored in locked cabinets in their bedrooms which promoted their privacy and independence with managing their own medicines. We observed staff giving medicines to people in a calm, patient and caring manner. People were given explanations of what the medicines were and stayed with until all medicines were swallowed. Two staff checked Medicine Administration Records (MAR) and signed to confirm medicines had been taken. We viewed the MAR records for people and found they had been given their medicines as prescribed. Medicines were also given in line with people's preferences. For example, one person preferred to take their tablets in yoghurt and this had been agreed by their GP. Staff asked the person to choose which yoghurt they wanted and then gave their medicines this way. Another person had to take their medicines at a specific time and staff had set an alarm to remind themselves of this.

People were protected against the risk of abuse because staff knew what steps to take if they believed someone was at risk of harm or discrimination. Staff received safeguarding training regularly and gave us examples of signs a person may be at risk of harm and who they would contact in this situation. There was a 'Serious Incident' checklist on the office wall to remind staff what documentation needed to be completed and where to send it to. We found that all potential safeguarding concerns were reported appropriately and advice sought where needed.

Staff were recruited safely. We were told by the interim deputy manager that informal interviews were held initially, so that potential new staff could meet people and staff and learn more about the role. If this went well, then a second, more formal interview was offered. For candidates that were successful, the provider had completed thorough background checks. This included applications to the Disclosure and Barring Service (DBS) that checked for any criminal convictions, cautions or warnings. Evidence of their previous experience and training was required before working at the service. Agency staff also had employee profiles sent by their agencies. These included photo ID, DBS checks, training history and experience. The interim deputy manager advised that experience with autism was essential before working with people at Wentworth Close. "We also look at personal experience of supporting others, we want to know that they have the right personality to meet all our resident's needs."

People lived in a safe environment. Regular health and safety checks included fire safety, maintenance of the building, electrical equipment, room temperatures and water temperatures. Legionella and asbestos safety checks were also up to date. There was a maintenance team that supported all services run by the provider. Requests for works to be completed could be sent online. We viewed previous requests made and these had been actioned.

People had Personal Emergency Evacuation Plans. (PEEP'S) These identified fire risks, behaviours of concern, individual means of escape and how people had reacted to previous fire alarms. In an emergency, staff would take a fire safety folder which contained all fire procedures and the service disaster plan. This contained emergency contacts and who to phone in different scenarios. Fire drills were completed weekly with people to ensure they understood what to do in the event of an emergency. The interim deputy

manager told us these used to be done at the same time every week, however they changed this as they were concerned this could just become a part of people's routines. "People with autism need routine and structure. We didn't want them to only be expecting this on one day a week as a real emergency could happen anytime." Therefore, fire drills had now changed to different days and times each week.

We saw good practices with regard to infection control. Staff told us they received regular training and knew how to prevent the spread of infection. We found the building to be clean, tidy and well-maintained. Staff washed their hands regularly. Any substances that were hazardous to people's health, were stored safely. There was Personal Protective Equipment (PPE) such as gloves and aprons readily available throughout the building. We observed staff using this when supporting people with personal care or when preparing food.

Good

Is the service effective?

Our findings

Relatives told us they thought the service was effective because staff had the skills and knowledge of people to meet their needs. One relative said, "Certainly the ones I've seen are good, my son's keyworker and the acting manager are both very knowledgeable and on top of his care."

Staff told us they had received training in numerous areas including safeguarding, health and safety, mental capacity, first aid, medicines management and food hygiene. They had received more specialised training in autism and epilepsy to meet some people's specific needs. Staff had also had Non-Abusive Psychological and Physical Intervention (NAPPI) training which focussed on understanding behaviour rather than using physical restraint. The deputy interim manager told us, "We have had training in physical interventions but this is not restraint, more of guidance away from danger. This would always be used as a last resort after all other options had been looked at." There were opportunities for staff to complete a National Vocational Qualification (NVQ) in Social Care for those who wished to develop their skills and knowledge. An NVQ is a work based award that is achieved through assessment and training. To achieve an NVQ, candidates had to prove that they had the ability (competence) to carry out their job to the required standard.

Staff told us that since the new provider, induction for new staff had improved. It now included a five-day corporate induction training, where staff were introduced to the company, its polices and given the opportunity to start workshops for the Care Certificate. The Care Certificate is a nationally agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is comprised of 15 minimum standards that should be covered for staff who are new to care. Following this, staff were provided with in-house training, where they learned specifically about the home and the people living there. This included shadowing more experienced staff so that they had full understanding of people and their routines before they worked on their own.

In addition to induction and training, staff were supported with supervisions and annual appraisals, where they could reflect on their own practice and set personal goals. Staff told us, that during a period of staffing issues, supervisions had not happened as regularly but this had improved with the new interim management structure. One staff member said, "It's time with a manager to talk about concerns, what I've done well, how I'm feeling and where I can improve. With everything that's been going on, it feels good to be able to voice concerns and hear how improvements are being made."

People were given choice and control over their own lives. We saw staff asking people about their preferences and wishes using objects of reference and pictures. Staff gave people time to make decisions and double checked that these were correct. Staff had a good understanding of the mental capacity act and how this applied to the people they supported. One staff member said, "You must always assume people have capacity and support them to make decisions only when they can't do themselves."

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). All people had applications made for DoLS where it was deemed they lacked capacity, however none had been officially granted at the time of inspection.

The interim deputy manager had a good understanding of mental capacity and had implemented changes since being in post. They gave an example of a person who was at risk when using the kitchen. "The kitchen used to be locked all the time to reduce this risk but this wasn't fair on other people living here. The kitchen is now unlocked but we have other measures in place to ensure the one person doesn't come to any harm." Peoples care plans reflected on decisions people could make and highlighted how they should be supported to make choices.

People's nutritional needs were met. Every week people met to talk about their food preferences and this information was used to formulate menus. The interim deputy manager had identified that previously, people were only asked their choice of menus for the weekend. This had now been changed so that people chose what they wanted to eat all week. Menus were varied and promoted healthy eating. There were lots of alternatives if people changed their minds and didn't want what was on the menu. One person had a Speech and Language Team (SaLT) assessment that provided staff guidance due to being at risk of choking. We saw staff following this guidance by preparing food in the ways suggested and sitting with the person.

People were supported to see health and social care professionals to improve their well-being. One person told us that if they felt unwell they, "Spoke to staff and they help me." We saw evidence of involvement from people's GP, psychiatrists, positive behaviour specialists, neurologists, learning disability nurses and chiropodists. One person used to be underweight and had support from their GP and eating and drinking specialists. Guidance stated to eat little and often and we observed staff supporting with snacks throughout the day. This had achieved a positive outcome for the person and they had put on a significant amount of weight since moving into Wentworth Close. One professional said, "The interim manager and deputy manager are on the ball and proactive in identifying changes. They took my guidance and made sure staff understood what was needed and made the team work more effectively with the person."

Wentworth Close was a purpose-built bungalow that had been designed to meet the needs of people. One person had behaviour risks associated with stairs which were no longer an issue. Some people required space and privacy if they felt anxious. Bedrooms were large and there were numerous communal areas as well for people to have time alone if they needed it. There was also some pictorial signage around the home to direct people.

Good

Is the service caring?

Our findings

Although people couldn't tell us they thought staff were caring, we observed that positive relationships had been built between people and staff. Staff talked to people cheerfully and engaged them in conversation about how they were and what they had been doing during the day. One staff member joked with a person and they smiled, resting their forehead against the staff member. We were told this was the person's way of expressing they were happy and liked staff.

Although some relatives were concerned about recent staff changes, they told us staff were and had always been kind and caring. One relative said, "Staff are very warm and efficient, and caring. They are very loving to my relative, he doesn't speak much, they are efficient in letting us know what is going on." Another said, "I think it's a very pleasant atmosphere there. Staff have been very good, my relative has an excellent keyworker who knows him well and that is what he needs." Professionals were also positive that good relationships had been built between people and staff. One professional said, "I could see the person felt safe and confident with staff. Communication was positive and they respected people's rights. The home itself feels like a nice place to be."

Staff told us that they enjoyed working at the service and with people. One staff member said, "I like working here and with the residents very much. It feels like a second home." Another said, "When I see people happy, I am happy." Staff acknowledged that there had been a lot of staffing changes in previous months but told us they had stayed because, "People were important" and, "I couldn't bear the thought of them not having familiar staff around. I stayed for them and am so glad I did."

Staff had a good understanding of people's preferences and respected what made them different. They had all received equality and diversity training and applied the principles to people they supported. They gave examples of this, such as people choosing and buying their own clothes. One person had an item they always carried with them and staff ensured they always had it to prevent them from feeling anxious. One person had an item of clothing that was very important to them and staff ensured they had it with them when they were admitted into hospital. Another person does not like to go to the hairdressers and so staff organised for the hairdresser to come to the house instead. A staff member said, "People's preferences and routines are all different, but it is important to them and therefore it is important to us."

Staff demonstrated a good understanding of promoting independence and supported people to do as much on their own as possible. We observed that staff encouraged one person to pour their own cereal and milk when preparing their breakfast. Other people were encouraged to take their plates out to kitchen and load them into the dishwasher themselves. One person could display behaviours that challenged and risks had been identified with using the kettle. Instead of making drinks for them, staff had introduced a hot water urn which the person could use themselves without being at risk. People were encouraged and supported with cleaning the bungalow and taking out the recycling. One staff member said, "Most people can do things on their own with a bit of verbal encouragement and praise." They gave an example of a person who had recently learned to use the self-service at their local supermarket. "It can take time but you have to do it at people's own pace because they can do so much and they are so proud of themselves when they achieve."

Staff ensured people's dignity and privacy was respected and promoted. Staff respected that people's bedrooms were their own private space and asked permission before entering. We saw staff closing the office door before talking about people to ensure confidential information could not be overheard. Staff gave examples of supporting people with personal care and standing outside the door to allow privacy. One staff member said, "Although they have been risk assessed as needing staff with them, we are subtle about it and give them privacy by standing outside the door." Another staff member said, "I would never talk about a person in front of others who didn't need to know." When staff were not in the office, they kept the door locked. We were told this was because two people could go in and read information. People's care documentation was locked in filing cabinets that only staff had access to. The service had a confidentiality policy that staff were aware of and they had also received confidentiality training.

People were involved in making their own decisions and encouraged to express their views. We observed staff continually asking people how they were, their opinions on what they wanted to do and when they wanted to do things. Each week, a resident's meeting was held, where people chose the following week's menu and activities. Any health and safety related matters were also discussed. One staff member told us, "Sometimes people don't want to come which is fine. If people don't attend the meeting, we bring it to them on an individual basis so we can still find out their choices."

Requires Improvement

Is the service responsive?

Our findings

Relative's thought that staff were responsive to people and their changing needs. They told us they were involved with annual reviews and informed of any changes. One relative told us, "Yes, we see his care plan and suggest changes. We are musicians, we had asked for him to have music therapy and they have continued to do so." Another said, "Yes, we have an annual review and we give quite a bit of input, we tell them what things we would like our relative to do or try." Despite this positive feedback, there were some areas we found not to be responsive.

Staff told us that activities for people had lapsed due to the difficult staffing period, however the interim management team were working hard to improve this. One staff member said, "We're starting to share ideas and plan again. It's exciting." There were lots of in-house activities such as games, hand massages, art and craft and film nights. People walked to the local shops to buy items they needed and some had been fruit picking. People also received singing and music lessons each week, where a professional musician played their favourite songs. We observed this activity taking place and people were smiling and singing along. However, activities outside the home were not as frequent. A staff member told us that a person used to go bowling but didn't anymore. Another person used to go swimming but this had stopped. The relative told us, "I questioned whether he should carry on swimming, and now they are going to do that again." The interim deputy manager was keen to organise holidays for people and was already planning funding so this could happen. They had also started to implement 'Opportunity days'. These were where people could choose what they wanted to do as a day trip. One person had already visited local caves for their opportunity day. A relative said, "They used to hire a hotel and have a Christmas party for everybody and now they don't." The interim management team had already started planning for events they could have, such as a Christmas party for people and their relatives. Another relative said, "They built a sensory garden in the garden but no one cares about it now, no one maintains it anymore." Although we could see this was an area for improvement, the interim management team were aware of this and more time was needed to implement and imbed planned changes.

From August 2016, all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard (AIS). The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively.

Some people's support plan's informed staff that they required pictures to communicate, however we saw there were some missed opportunities to develop documentation. People's care plans, menus and review documentation were written, with minimal pictures. There was a lack of evidence to demonstrate people were involved with their care planning and reviews, nor was documentation adapted to encourage their involvement. We were advised that people were no longer having monthly keyworker meetings so it was even more important to include them in six monthly reviews. The interim deputy manager advised they were in the process of developing an easy read complaints form for people, however this had not been implemented yet. The interim deputy manager also had plans to implement choice boards for people. These would hold pictures of a variety of items, for example to do with food, clothes or activities and could

be used to support people to make decisions. They would be small enough to be carried around by people. We discussed this with the interim manager and deputy manager. They agreed this was an area for improvement and more time was needed to implement and imbed changes.

We did see some good practice with regard to AIS. Staff knew people's communication needs well. We saw staff rephrasing questions to one person so they understood what was being asked. Two people had white boards in their bedrooms which they used to write down what was planned for the day. One person had a visual timetable and staff were working on doing the same for other people. Another person had a social story regarding how to keep them safe when they went out. This was read to them before they left the building and helped them to understand risks and feel calmer about what was going to happen when they left the house. A relative told us, "They have tried to communicate with my relative with little pictures, maybe with pictures of a sandwich to allow him to make it."

No-one was receiving end of life care at the time of inspection. However, people had not been asked about their wishes nor had any advanced planning been considered. Their care plans stated they had limited understanding of death and bereavement and the interim management team wanted to improve that. Although people were young and well, the interim deputy manager had already started planning some easy read documentation to talk to people about their preferences for end of life care. The interim deputy told us, "A person from another care home by the provider died suddenly and it was a shock for all of us. It could happen at any time and therefore any preparation is good." When the person died, people at Wentworth Close had been given an easy read document to explain what had happened. The interim deputy manager was planning to implement similar communication tools to develop people's understanding of death and support with bereavement.

Staff were understanding of people, their preferences and anxieties and responded appropriately. We observed one person becoming anxious and displaying some challenging behaviours. Staff talked to the person in a calm manner, explained what was happening and why. This helped the person to feel calmer. When another person showed signs of becoming anxious, staff read to them and talked about things they liked. They joked about characters from their favourite television programme and the person laughed. A person had clear boundaries with regard to touching others. These were reinforced by all staff to ensure consistency for the person. Staff had also responded to health concerns for people and this had improved their wellbeing. They gave an example of a person who did not brush their teeth when they moved into Wentworth close. The person's key-worker bought a flashing toothbrush and different flavoured toothpaste and the person was now brushing their teeth every day.

Each person had a care plan that was specifically designed around their needs, goals and aspirations and was reviewed regularly by staff. People had their needs assessed before they moved into the home and the information gathered was used to develop their care plan. Each support file was specific to the person and emphasised their preferences and routines, which were important to them. There was 'Independent Living' assessments that explained what people could do independently and what they needed support with. Routine was an important aspect of people's lives and they had detailed care plans for each part of their routines. Care plans also included the parts of their lives affected by their autism and how they could be supported to overcome this. Each person had goals and a development plan for how these could be achieved. One person had a goal to call and write to their relative once a week and we saw this was happening.

The service had not received any complaints since changing to a new provider. Relatives confirmed they had not had to raise any issues but understood the complaints process. There was a clear complaints policy and a complaints/compliments book by the front door for people and visitors to write in. We saw in people's

weekly meetings that they were reminded of who they could talk to if they were unhappy. The interim management team were also working on a new easy read complaints document for people.

Requires Improvement

Is the service well-led?

Our findings

At the time of inspection, the registered manager was on extended leave. There was an interim manager and interim deputy manager managing the service together in their absence. Relatives were complimentary of the registered manager. One said, "They are good" and another, "The manager who is on leave was absolutely excellent in setting up the home." Regarding the new interim structure, relatives said, "I am always informed of what is going on" and, "They know people well." One relative said, "The registered manager there is on leave at the moment and the staff that are there are trying to work everything out. I suppose it was difficult for them, and they have had a struggle trying to get staff as well. I believe this is being sorted now."

Professionals also spoke highly of the new interim management team. One said, "The interim deputy manager was great. They were quick to put guidance we gave into practice and communicate with the team." Another said, "Both the interim manager and interim deputy manager were really professional and organised." One professional was aware of previous staffing issues and said, "It feels like things are really improving with new management." Despite this positive feedback, there were some areas we found not to be well-led.

Although staff showed understanding of choice and consent in day to day practice, people's care records did not always meet guidance in line with the Mental Capacity Act. People had specific decision-making forms related to managing their personal care. These included views from professionals and relatives. However, there was no evidence to demonstrate the person's views had been considered and how the decision for a lack of capacity was reached. People did not have specific decision-making forms related to practices which restricted their movements or privacy, such as locks on the front door. There was no documented evidence to suggest that the person's views or those that knew them best had been considered, or that their capacity to consent had been assessed. From what we observed and what staff told us, people did not appear distressed by these practices. However, it is important that the provider do all that is practicable to obtain and document the views of people as part of the decision-making process.

Even though the interim management team had only been in post for three weeks, they had recognised areas for improvement and started to make changes. For example, the interim deputy manager told us that they recognised improvements were needed for documenting handovers and had implemented a form to ensure all relevant information was handed over in-between shifts. They had recognised that activities had lapsed due to staffing issues and had started improving this again. Other ideas to improve communication documentation had been started but required more time to be fully implement. Staff knew people and their support needs very well. Following the inspection, the interim deputy manager completed and sent us pictorial communication documents and new mental capacity assessment forms. Therefore, we considered the impact on people to be low. However more time was needed to fully implement new ideas for improvement and imbed these into the service.

The PIR we received for the service stated that feedback forms were sent out to people, relatives and staff each year. Relatives were unsure whether they had completed these. One relative said, "I've not completed

anything, however I feel I know staff very well, they are almost like friends and I don't have concerns about raising anything." We were told by the interim manager that surveys from the new provider had only been sent out in October 2018 and therefore they had not the opportunity to receive feedback about the service and use this to improve. We did view various compliments that had been received from relatives and professionals. One relative wrote, "You clearly have a great relationship with my relative and I am impressed by your commitment." Following a meeting regarding support needs for one person, a professional had written, "Overall we were left with the impression that you are a dedicated and caring team. The person is able to enjoy a varied, good quality of life. The person is also supported by staff who like them and whom they are able to build trusting working relationships."

Staff were positive about the new interim management structure. They told us that since it had been implemented, lots of positive changes had happened. One staff member said, "Interim management team are very good. Things weren't in place but they have worked really hard to fix it." Another said, "We are back to being a team again and are working together to make improvements." The interim manager also told us they had received a lot of support from the company's head of residential services. They said, "We talk a lot and they are there if we need them." There were regular meetings with other managers of Aspen Charities services where positive outcomes and ideas could be shared. Staff also spoke highly about the new provider and incentives that had been introduced. For example, staff were given vouchers to reward good attendance. They also participated in team days each year, where activities and team building exercises were encouraged to build trust between staff.

Staff told us that during the difficult staffing period, team meetings had not happened as regularly, but this was now being rectified. We viewed the latest team meeting minutes for November 2018 and saw that company updates, new staffing structures and safeguarding incidents were discussed. There was an agenda on the office board where staff could add anything they wanted to discuss. There was also evidence to show that policies and procedures were reviewed with staff during meetings. As well as team meetings, staff told us they were kept regularly updated about the service and people in daily handovers. We observed a handover happening. Each person was discussed individually and included their psychological and physical well-being. One person had been to a hospital appointment and staff updated the next team on what had been said and any immediate actions. They had also updated the person's care plan and written in the communication book, so that staff working the following day could see updates.

Each month, the interim manager completed quality audits that looked at people's care plans, staff files, accidents, incidents, complaints and compliments. It was through this process that areas for improvement were identified and actions taken to improve. The quality assurance lead for the company also audited the service every three months. We viewed the latest report and found that all concerns identified had been actioned. The service was due another audit the week after inspection and were looking forward to demonstrating improvements they had made.

The interim deputy manager was passionate about working with people and providing the best service possible. They had recently become a positive behaviour lead and attended their first meeting with other leads for the company. The interim deputy told us that from this meeting, they had decided to implement positive behaviour competencies to assess staff understanding, during supervisions. They were also developing a staff assessment tool to evaluate staff understanding of person centred care.

The interim management team had a good understanding of the duty of candour and how this related to their service. The interim manager said, "We will always be open and honest about incidents and areas for improvement. This is the only way we can get better." We found that incidents were shared with relevant others such as local safeguarding teams and CQC. The interim deputy was aware of the need to share their

inspection report in the service and on the company website.

During inspection we found the interim management team to be very responsive to concerns we raised. Immediately following the inspection, they had made positive changes to documentation and advised of timescales for other actions. This demonstrated their willingness to improve.