Autism Sussex Limited

The Warren

Inspection report

23-25 The Warren
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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Inadequate
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

We inspected The Warren on 17, 18 and 22 June 2015. The Warren provides accommodation and support for up to three people. Accommodation is provided in two semi-detached houses at the end of a residential cul-de-sac. There were three people living at the service during our inspection. Two people were living in one of the houses and one person lived on their own on the other side of the house. There was a small shared garden at the rear of the properties. The age range of people living at the service was 23 – 37. People either had limited or no verbal communication. They communicated by vocalisation or the use of body language and picture/ flash cards.

The service provides care and support for people living with autism and other learning disabilities.

People presented behaviours that could challenge along with self-harming behaviour. Two people had been living at the service for over five years and one person had lived there for twelve months. Records and staff identified that the day after our inspection finished one person was

Summary of findings

scheduled to move out of the service to another service provider and this vacancy would not be filled. The provider leased the properties from a third party and the lease was scheduled to end in December 2015. The provider informed us the lease was not being renewed. There were transition plans in place for the two remaining people to move to other services the provider ran locally.

A registered manager was not in post. 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 and associated Regulations about how the service is run. However the service did have an acting manager in post who over saw the day to day running of the service and was currently going through the CQC Registration process.

The provider had not protected people's safety by ensuring there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed.

We found incidences where previous accidents and incidents had not been reported in line with the providers own policies and procedures. However, the acting manager had taken steps to ensure these were now being followed and relevant external agencies informed where appropriate.

Mental capacity assessments had not consistently recorded the steps taken to reach a decision about a person's capacity for decisions. Not all staff had completed MCA training however were able to confirm how they sought consent.

The provider had not taken steps to ensure people's privacy or dignity was respected. The premises did not provide people with the opportunity for personal space or a suitable communal area. One person's sleep routines had negatively impacted on other people living at the service, the provider had not taken steps to respond in a timely manner to prevent this.

The provider had not ensured the service met people's individual care needs. Care for one person was not responsive to their needs. There were not clear strategies in place to manage behaviour that challenged and care management for this person was not planned but reactive.

The Warren did not have a Registered Manager with the CQC however an acting manager was in day to day control of the home and was undertaking the registration process. However they were not clear on all functions of their role such as notifying the Care Quality Commission of incidents where injury, harm or abuse had occurred to people.

There were limited quality assurance processes in place and these had not effectively identified the shortfalls in quality of care being provided.

Risk assessments had been completed for a broad range of areas. They provided clear descriptions and guidance for staff to deal with perceived and apparent risks.

The provider had taken steps to ensure appropriate checks and routine servicing to the building and equipment were undertaken to keep people safe.

Medicines were managed safely in accordance with current regulations and guidance. Medicines had been stored, administered and reviewed appropriately.

Checks were undertaken to ensure staff were safe to work within the care sector. Staff had completed training on safeguarding and knew what action they should take if they suspected abuse was taking place.

People told us they liked the food and relatives spoke highly of the meals and snacks provided. Systems were in place to ensure there were sufficient quantities of fresh food available that catered for people's preferences.

Staff were having regular supervision and told us the acting manager listened and responded to their concerns and they felt supported.

People were supported to access health care professionals routinely and as required as a result of changes in health. Staff were aware of the processes they needed to follow to raise concerns about people's health.

We heard staff offering clear explanations to people in ways they understood. Staff were seen to be kind and caring to people.

Summary of findings

Some people were supported to have clear structured involvement in activities that were appropriate and engaged them effectively.

Care plans provided clear guidance for staff on supporting people with routine living needs.

People's family were made welcome and relatives spoke positively about the welcome they received. One told us, "I can pop in anytime and know I will be made welcome."

Staff meetings were used as a forum to share key operational information about the running of the service and provide updates on individual people.

People spoke positively of the acting manager and told us they had made a positive contribution to staff morale and identifying where things needed to improve.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

We found breaches in Regulations. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

The provider had not protected people's safety by ensuring there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed.

We found the service had not consistently reported and recorded accidents and incidents in line with their own policies and procedures.

Medicines were managed safely and in line with policies and procedures.

The provider had carried out appropriate employment checks on staff to ensure they were suitable and safe to work with people at risk.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider had not taken steps to ensure all staff who worked at the service had appropriate skills and training to support people effectively.

Mental capacity assessments had not consistently recorded the steps taken to reach a decision about a person's capacity for decisions.

People's nutritional needs were met and people could routinely choose what they ate and drank.

People were supported to routinely access services from health care professionals.

Is the service caring?

Inadequate

The service was not always seen to be caring.

The provider had not taken steps to protect people's privacy and dignity.

One person's sleep routines had negatively impacted on other people living at the service, the provider had not responded in a timely manner to prevent this.

The home's equipment was maintained and checked regularly.

Is the service responsive?

Requires Improvement

The service was not responsive.

Not all people's individual care needs were being met. Care for one person was not responsive to their needs; their care management was not planned but reactive.

Complaints had not been recorded and collated in line with the providers own procedures.

Summary of findings

Some people were supported to have clear structured involvement in activities that were appropriate and engaged them effectively.

Is the service well-led?

Inadequate

The service was not consistently well-led.

Effective management arrangements had not been established and a registered manager was not in post.

Statutory notifications had not always submitted to the Care Quality Commission.

There were some systems to assess the quality of the service provided in the home, however not all areas had been considered and were not used to drive improvement.

People spoke positively about the management and staff told us they were well supported.

The Warren

Detailed findings

Background to this inspection

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

We inspected the service on the 17, 18 and 22 June 2015. This was an announced inspection. We provided 24 hours' notice, this was because the service is small and we wanted to ensure that people we needed to speak to were available. The inspection team consisted of one inspector and an Expert by Experience who had experience of learning disability residential care homes. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. We last inspected The Warren in August 2013. We found the provider was meeting all the regulations we inspected against.

We focused on speaking with people who lived in the home, speaking with staff and observing how people were cared for. We looked in detail at care plans and examined records which related to the running of the service. We looked at three care plans and three staff files, staff training records and quality assurance documentation to support our findings. We looked at records that related to how the home was managed. We also 'pathway tracked' people living at The Warren. This is when we look at care documentation in depth and obtain views on how people found living there. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

We looked at areas of the service, people's bedrooms, bathrooms, lounges and dining areas. During our inspection we spoke with one person who lived at The Warren, four care staff, three relatives and the acting manager.

We reviewed the information we held about the service. We considered information which had been shared with us by the local authority, members of the public, relatives and healthcare professionals including a social worker and community practice nurse. We requested information from a GP. We spoke with various representatives of the Local Authority including the contracts and monitoring team. We reviewed notifications of incidents and safeguarding documentation that the provider had sent us since our last inspection. A notification is information about important events which the provider is required to tell us about by law.

Requires Improvement

Is the service safe?

Our findings

Relatives provided mixed responses when asked if they felt people were safe living at The Warren. One said, "They do their best and whenever we visit we haven't seen any problems." Another said, "I have not had confidence in the staff being able to keep them safe."

Rotas indicated staffing levels were in line with people's support plans. However, the service had experienced significant difficulty in sourcing care staff who were suitably skilled and confident to support one person with complex behavioural care needs. This had resulted in the provider employing the services of staffing agencies to supply staff. The acting manager identified what they saw as the reasons for having difficulty in recruiting staff that were suitably trained to support this person. They told us factors such as the remote location of the service and finding staff who had the skills, training and confidence to support this person. This person's care plan identified that a 'consistent and familiar staff team' was an important factor in providing care and reducing their anxiety. The acting manager told us staff who knew the person well and their potential 'triggers' were able to support them more effectively. Incident reports indicated that when staff did not have the skills and confidence to support this person the outcome for them was increased anxiety which resulted in their and staffs safety being placed at greater risk. For example, this person had managed to leave the service on two occasions without the staff's knowledge. The acting manager said, "We have had challenge in finding staff who are able to support them." They went on to say, "Simply because staff have had training in challenging behaviour does not make them the right person to support them, staff also need to be confident." Risk assessments had been updated and reviewed in an attempt to reduce the risks; however the service was not able to ensure this person's safety. Safeguarding concerns raised directly by the person's family member had been investigated by the Local Authority and action plans put in place. As a result of not being able to meet this person's needs and protect their safety the provider had served notice. This meant they were required to find an alternative place to live. They were scheduled to move to another service provider the day after our inspection was completed. This person had been living at the service for 12 months and during this time the provider had not ensured consistently that this person was safe by having suitability skilled and experienced staff in place to support them. The acting manager said, "This has been a learning opportunity for the whole organisation. From ensuring a comprehensive pre-assessment is completed through to ensuring a stable, suitably skilled staff team is in place."

This was in breach of the Health and Social Care Act 2008 Regulation 18 (Regulated Activities) Regulations 2014.

The acting manager told us that following any accident or incident care staff completed head office documentation. Dependant on the seriousness of the incident, and in line with the provider policy, senior staff would be informed of the incident immediately or have sight of the documentation when they were next in the service. However, we found examples where agency staff had not followed the providers' policy therefore creating a delay in the acting manager being aware of incidents. This meant there had been occasions where incidents had not been identified in a timely manner to senior staff. The acting manager acknowledged that proper communication processes had previously not been adhered to with regard to internal and external reporting of incidents. We saw internal meetings minutes that indicated actions plans had been put in place to address these shortfalls. The registered manager told us, "I now have oversight of all accidents and incidents within the service." Staff told us that they always complete incident documentation and ensure the acting manager is notified. All recent incident forms had been reviewed and signed by the acting manager and where appropriate actions put in place as a result. For example, one person had their usual daily routine adapted as a result of a change in behaviour this was in an attempt to re-establish consistency and in line with their care plan.

Risk assessments were in place for a broad range of areas such as self-harming behaviour, cleaning products, stairs and fire. They provided clear descriptions and guidance for staff to deal with perceived and apparent risks. Where risks were linked to people's behaviours there were additional details regarding triggers, early warning signs and early intervention strategies. Where risks or strategies had changed there was evidence that the documents had been updated. Staff told us these were useful documents and particularly helpful to new staff.

The provider leased the properties from an independent company. This company had responsibility for some aspects of the property maintenance. For example, PAT

Requires Improvement

Is the service safe?

testing, servicing of the boiler and fire alarm. We saw documentation that identified checks and servicing were taking place. Routine maintenance was undertaken by the provider's maintenance staff. Care staff told us they would identify broken, faulty equipment to the acting manager who would email a request identifying the specific works required. We saw evidence that the manager was in regular liaison with the providers maintenance staff and requests were actioned promptly. On the day of our inspection we saw repairs being undertaken on an area of ceiling where water damage had occurred. Routine health and safety checks were undertaken by care staff on a daily and weekly basis. For example both houses had fire checks such as alarm testing on a weekly basis.

The home had appropriate arrangements in place for the safe receipt, storage and disposal of medicines. There were records of medicines received, disposed of, and administered. We looked at people's medicine records and found that recording was clear and accurate. Any anomalies recorded were followed up by senior staff, such as when staff signatures were missing. One person when asked if they got their medicines on time each day they said, "Yes." We observed a member of care staff checking medicines that had returned with a person after a weekend stay with relatives. There was clear guidance for staff for people who had medicines which were required occasionally.

Staff described different types of abuse and what action they would take if they suspected abuse had taken place. There were policies in place to ensure staff had guidance about how to respect people's rights and keep them safe from harm. Records confirmed all care staff had received safeguarding training however two staff required refresher training. The acting manager was referring all incidents to the Local Authority.

We looked at personnel files for three staff; they contained the appropriate information including completed application forms, two employment references, Disclosure and Barring System (Police) check, interview records and evidence of their residence in the UK. This meant that the service had taken steps to ensure staff that worked at The Warren were suitable to work within care.

Requires Improvement

Is the service effective?

Our findings

Staff accessed and undertook the majority of their training via online computer courses. Staff had individual training accounts and once a course was completed the acting manager received notification and the training spread sheet was updated. Areas staff covered by this method included, safeguarding, infection control, medicines and person centred care. Although the training spread sheet identified there were specific courses available related to autism no staff working at The Warren had completed these. To support staff to manage behaviour that challenges all Autism Sussex staff used one specific training method. The initial training was completed over two days in a classroom setting. This training was aimed at providing staff with de-escalation strategies. One staff member told us this training was, "Useful, but mainly focused on prevention and only a small part on physical intervention." We asked the acting manager how they assured themselves agency staff had the appropriate training to support people living at The Warren. They told us that they had established clear guidelines with the agencies on the 'type of staff' that would be suitable and use only agency staff that had undergone training in managing behaviour that challenges. However we reviewed two agency staff 'employee profiles' it stated they had completed 'Lone Worker / Managing Aggression' training. The acting manager could not identify the content of this training and whether it was compatible and consistent with their own training techniques in this area. This meant the provider had not taken steps to ensure all staff working at The Warren had appropriate skills and training to support people effectively.

This was in breach of the Health and Social Care Act 2008 Regulation 18 (Regulated Activities) Regulations 2014.

The MCA states assessment of capacity must be decision specific. It must also be recorded how the decision of capacity was reached. We found reference to people's mental capacity did not consistently record the steps taken to reach a decision about a person's capacity. We asked the acting manager to talk us through how they completed mental capacity assessments. They were unable to tell us who undertook the assessments or the steps needed. We were informed, "It's about choosing the most appropriate communication method to determine if it is what they want." However we did find reference to a mental capacity assessment related to medicines within one person's care plan.

Training schedules showed us that not all staff had received Deprivation of Liberty Safeguards (DoLS) training or MCA 2005 training. Care staff we spoke to had a basic understanding of mental capacity and informed us how they gained consent from people. One care staff told us, "We offer a choice for as much as possible such as clothing or food. Another staff member said, "We get to know people really well and work with them closely so they are able to let us know what their decisions are."

DoLS protect the rights of people by ensuring that any restrictions to their freedom and liberty have been authorised by a supervisory body, to protect the person from harm. One person currently had a DoLS authorised. However another person was routinely restricted from accessing a communal stair well area. The risk assessment which had resulted in this had not considered whether this was a deprivation of their liberty. There was a historic document from 2009 within this person's care plan that demonstrated that a best interest meeting had taken place regarding a coded lock on the front door but this was prior to the additional locked being fitted. There was no current assessment evident for this person on how their freedom may be restricted or what least restrictive practice could be implemented. During the course of our inspection the acting manager was seen to take action to liaise with the supervisory body regarding this issue. This is an area that requires improvement.

All people's food and drink was prepared in one of the kitchens. Meals were chosen by staff in line with peoples identified preferences and choices. People told us that they liked the food and we saw within some people's routines they were regularly involved in food preparation. Care staff undertook the responsibility for purchasing food and groceries. We saw the fridge was full and a wide selection of ingredients was available. One relative told us, "The food has always been good, lots of it." One staff member said, "The residents enjoy their fruit so we always make sure there is a fresh supply in."

The service had systems in place to provide staff with supervision. We looked at minutes from supervision meetings and saw a range of areas had been discussed such as, training, updates on specific people they

Requires Improvement

Is the service effective?

supported, and developmental areas. One staff member told us, “The manager makes times for us; we talk about how to ensure things work well.” All staff told us they felt supported in their roles.

People received effective healthcare support from external health professionals. Relatives told us GP appointments were scheduled when required. We saw other health care appointments such as chiropodist and dentist were booked by staff on behalf of people on a regular basis. Staff recognised that people’s health needs could change quickly. One staff member told us, “If we spot anything has changed health wise I will raise it with a senior carer or the manager.” A GP who had regular contact with people told us, “I have always found The Warren staff helpful and well organised.”

Inadequate

Is the service caring?

Our findings

People told us they liked the staff they were supported by. One relative said, "The carers are very good, know our daughter well." Although we observed staff showing kindness and supporting people in a positive manner we found that the service was not consistently caring and people's dignity and privacy was not assured.

In one of the houses a person was living in what was previously a communal lounge. This person had been moved into this area since sustaining serious injuries from falling down the stairs. The lounge was now serving as this person's bedroom. This person had been living with this arrangement for over two years. This room was a thoroughfare for staff, visitors and another person who lived at the service when they required access to the kitchen. The person was supported to use the stairs once a day to access the bathroom for a bath or shower and at other times used a commode that was in their room. We noted that when this person required use of the commode staff drew the curtains and withdrew into the kitchen. This did not afford this person dignity. In addition, as the room acted as a thoroughfare this meant that this person was not provided with suitable private space. One staff member told us that since this person had their bed in this area another person spent more time in their room in the evenings and generally came downstairs less often.

One person had disturbed sleep patterns. This meant they were frequently awake for extended periods through the night. Staff told us this person's vocalisation could be loud and due to the thin walls caused a noise disturbance for other people in the house next door. A staff member said, "If next doors resident is awake then it will often mean everyone has a disturbed night this side." Another staff member said, "It has a negative effect on the residents who were kept awake." We asked staff how being kept awake affected people's behaviour. They told us their behaviour was more erratic and it could affect their usual routines. One staff member said, "One resident has refused to go to their day centre because they were tired after a noisy night."

These issues were a breach in Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed these issues with the acting manager. They told us due to the person with disturbed sleep patterns imminently moving out, and no one would be replacing them, the risk of continued noise disturbance at night would be removed. There were also plans to open up a previous connecting arch way between the houses. This meant a temporary toilet and shower could be installed next door, down stairs. This would result in the person not requiring the use of a commode downstairs. We saw evidence that these temporary works were booked to take place within ten days.

One person enjoyed using a lap top computer. They used it whilst sitting on a sofa. However, the combination of a low sofa and a higher table on which the lap top sat made it awkward to reach the keys and whilst sitting in this position the person was afforded no back support.

We heard staff taking time to explain things clearly and with patience to people in a way they understood. An example was explaining the flow of the day to a person so they were aware why they were waiting to go out. People's likes and preferences were documented in their care plans.

One staff member told us, "I find the key element to supporting residents is to know them well, knowing when they may need support and their triggers and when you can promote their independence."

Care records were stored securely. Information was kept confidentially and there were policies and procedures to protect people's confidential records. Visitors were welcomed during our inspection. A relative told us they could visit at any time and were always made to feel welcome. They said, "We are always made welcome and given a cup of tea and updated on anything that has been going on."

Requires Improvement

Is the service responsive?

Our findings

For one person who had been living at The Warren the provider had made the decision that they were unable to meet their care needs. They had served a notice period on them; this meant they were required to find an alternative care provider. On coming into post in November 2014 the acting manager identified that this person was not receiving effective 'person centred care' and took steps to engage the support of external health care professionals. These included assessments from an occupational therapist and Speech and Language Therapist (SALT). The acting manager told us the sensory assessment had assisted care staff to have a better understanding of this person's needs and engage in a more positive way with them. They said, "Since the assessment we have designed an activity timetable that has more emphasis on meeting their high sensory needs." This person's care plan had been updated to incorporate the outcomes from these assessments. The SALT team had provided new communication flash cards; staff told us these were proving a more effective way for the person to identify their needs. However due to the providers difficulty in establishing a stable, consistent staff team to support this person the service had not been responsive to their individual care needs as not all staff were familiar enough with their complex needs to support them appropriately. A relative said, "The failure to put in place a consistent core team of staff has been very negative on them." The provider had not met this person's needs by providing carefully planned care in a structured methodical manner but instead had been reactive to this person's behaviour that challenged. For example there was evidence that some female care staff had previously effectively supported this person. However due to female staff sustaining injuries the acting manager had stopped all female staff supporting this person within the house.

One person's care plan identified car journeys could be used as a strategy to reduce anxiety; the provider had made arrangements to have a suitable vehicle and driver available each day. The acting manager told us this person went out in the car up to four times a day. They said, "The travelling and motion can reduce anxiety and provide sensory stimulus." The acting manager told us this person's relative also used this as a strategy to engage the person when on visits. It was not clear from discussion with staff or care notes how the provider intended on reducing this person's reliance on car journeys as a way to reduce their anxiety. The car journeys were being used as the primary tool to de-escalate behaviour that challenges without having clear strategies on engaging this person in other ways.

The above are a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The acting manager told us they did not believe the original assessment and transition of this person had been sufficient to enable a fully rounded decision as to whether The Warren was a suitable environment for them. This person had been visited once by Autism Sussex staff prior to their move to The Warren. We reviewed the original 'pre-assessment of needs' documentation that had been completed by the previous Registered Manager and it included limited information on strategies staff could use to effectively manage behaviour that challenges and how to meet their daily living needs.

The acting manager was only able to identify one recent complaint since they had worked at the service. This had come from an external source and was responded to appropriately and in a timely manner. The acting manager stated any complaints would generally be responded to by the 'head office' support function and they would be liaised with to provide context and background. At the request of the inspector the acting manager liaised with their head office support and located a spread sheet where complaints were required to be recorded. The acting manager had not been aware of this spread sheet prior to our inspection. People living at The Warren did not have any information displayed in any format on what they should do if they were unhappy about a situation. This is an area that requires improvement.

However we did have positive feedback and one relative said, "Since the new (acting) manager started I have been able to get hold of them whenever I needed to raise any issues, the previous manager did not spend much time at the home."

Other people living at The Warren who had lived there for a number of years had more established routines and strategies to respond to their needs. The provider runs a separate 'day care service' which both of these people attended on week days. One person told us they enjoyed going to the day service. We spoke to staff who supported

Requires Improvement

Is the service responsive?

these people at the day service and looked at the individual timetables they followed whilst there. Activities included trampoline, drama, use of a sensory room and bowling. Staff who supported these people whilst at the day centre provided The Warren care staff with a hand over when they returned home. One staff member said, "The day centre is a really nice place for them to be, very sociable and friendly." When one person returned from the day centre care documentation stated that care staff should initiate 'talk time' so they were able to talk about what they had done at the day service.

Care documentation contained personal profiles and routines. One staff member told us, "I found the care plans really helpful when I started to get an understanding of background." Care plans demonstrated assessment of people's individual living needs and identified how these could be met. Areas included personal hygiene, eating and dressing. Care plans identified people's likes and dislikes and their preferences for activities. Relatives told us they had been involved in providing information to inform care plans. Information on important friends and family within people's network were identified along with names and their relationships. We heard staff talking to people about their families and upcoming family events.

People were supported to access the local community. On the day of our inspection we saw two people were supported to visit a nearby park/recreation area. One person was looking forward to visiting the local shop to make a specific purchase of an item and to look at magazines. People's daily routines were recorded in 'daily logs' by care staff. These captured information on people's health, moods and behaviours and the activities they had taken part in. These were broken down into 'planned' versus 'actual.' Staff told us these were a useful tool when handing over information to other care staff.

Inadequate

Is the service well-led?

Our findings

A registered manager was not in post at the time of this inspection. A registered manager is a person who has registered with the CQC to manage the service. There were arrangements in place for the day to day management of the home which were currently being undertaken by the acting manager. The previous registered manager left in April 2015. The CQC has received an application for a new registered manager.

The acting manager knew each person well who lived at The Warren. One staff member said, "There are here a lot of their time." Another said, "Things have improved since they have been here." Staff and relatives spoke positively about the acting manager and commented that they would be happy to speak to them about any concerns. Despite people's positive comments we found the provider was not consistently notifying the CQC of incidents where injury, harm or abuse had occurred to people. Under the Health and Social Care Act 2008, providers are required by law to submit statutory notifications. A notification is information about important events which the provider is required to tell us about. We identified incidents which had not been notified to us. The acting manager who had been in post since November 2014 had been notifying the Local Authority. The acting manager acknowledged the requirement to submit notification following all future notifiable incidents.

This is a breach in Regulation 18 of the Health and Social Care Act 2008 (Registration Regulations 2009).

We identified there were some routine quality assurance processes in place that care staff carried out on a daily and weekly basis. For example those related to infection control and health and safety such as fire alarm testing. However the current acting manager had not established systems or processes to drive up the quality of the service. Accident and incidents reports were being completed by staff however patterns and trends were not identified or analysed for future staff learning. The acting manager told us that since taking over the service they felt as if they had been 'firefighting'. They said significant amounts of their time was spent ensuring staff cover was in place, liaising with a concerned parent and social services, requesting and overseeing maintenance repairs and resolving vehicle issues. They stated they had been required to work as care staff on several occasions when no alternative staff could be sourced. As a result the acting manager did not have full over sight of the support offered by the head office function. Several times during the inspection they needed to liaise with head office for clarification on routine management issues. For example if and how often satisfaction surveys took place. The acting manager told us, "Prior to my arrival I do not think the service received enough support from the management."

The most recent service 'quality standard audit' had been undertaken by the previous registered manger in November 2014. The audit identified areas where 'corrective action' was required. Areas highlighted included, staff training, budget versus staff ratio, risk assessment requiring updating for one person and total number of incidents. Most but not all actions had a completion timescale identified however none of the actions had a completed date filled in. The document did not provide clear guidance on what specific actions were necessary to be completed and any further follow up steps that would be required. Each 'action' had a quality standard number however the acting manager was not able to identify what these numbers related to. The number and types of complaints or concerns received had not been identified within this document. The acting manager had not been using this audit as a tool to improve the quality of the service. The acting manager had taken steps to improve the quality of care for people living at The Warren however the extended period of time it had taken for action to be taken indicated the service had not been well led.

The issues identified with governance are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The acting manager said they were confident that impact of the person moving out from The Warren would have a significant effect on their workload and as such would allow additional time to be committed to implementing quality assurance systems.

The acting manager had been working at the service since November 2014. During their first few weeks they had a handover from the previous registered manager. The previous registered manager continued to remain as the registered manager until they left Autism Sussex in April 2015. However during this time they were no longer regularly at the service overseeing day to day operations.

Inadequate

Is the service well-led?

Once the previous registered manager left in April 2015 the acting manager was being supported by an operations manager. They told us they had received good support and guidance from them since the previous registered manager had left. The acting manager said, “We can discuss issues openly and they have been available when I have needed.”

Staff meetings were held monthly. These meetings provided an opportunity for staff to raise and discuss issues and for senior staff to remind colleagues about key operational issues. Staff commented they found these meetings useful and provided an opportunity to share ideas and provide each other with updates on individual people. For example, new routines for a person.

Staff told us they felt well supported by the acting manager. One told us, “I know I could approach them about anything and they would make time for me.” Staff had a clear understanding of their roles and the lines of accountability. One told us, “It has been much more straight forward to get things done since we have had our current manager.” A relative told us, “We have a lot more trust in the current manager, the previous one we were left guessing a lot of the time.” Another relative said, “The staff seem much happier now, the new manager has been positive.”

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There was not sufficient numbers of suitably qualified, skilled and experienced staff deployed in order to ensure people's safety and welfare. Not all staff had undertaken appropriate training to enable them support people safely. Regulation 18(1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Suitable arrangements were not in place to maintain people's privacy and dignity. Regulation 10(1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was not an effective system in place to assess and monitor the quality of service. Regulation 17(1)(2)(a)(b)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People's treatment and care must be appropriate to the individual. Regulation 9(1)(a)(b)

The enforcement action we took:
Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider had not fulfilled their statutory obligations to the CQC with regard to notifications. Regulation 18 (2)b(ii) 2e

The enforcement action we took:
Warning Notice.