CareQuality Commission

CAS Care Services Limited

Devon Lodge

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Devon Lodge is a care home. People in care homes receive accommodation and their care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and both were looked at during this inspection. Devon Lodge provides care for up to twelve young adults with autism and severe learning difficulties often accompanied by complex needs, behaviours which might challenge others and self-injurious behaviours. The accommodation is arranged over two self-contained units. A main house and a smaller four bedded annex. At the time of our inspection there were twelve people living at the home. The service is located in a residential area close to local amenities. There is a large safe and secure garden and parking on site. The main objective of Devon Lodge was to provide a transition service where people with complex needs could be supported to develop, with enhanced support, life skills enabling them to move on to other more independent settings.

This was the first comprehensive inspection of this service under the provider CAS Care Services Limited. We have rated the service as overall Good. This was because, although we found some areas where the service could improve upon, people overall experienced good care and support.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Some aspects of medicines had not always been managed safely. Overall staff had a good understanding of the risks associated with people's care; however, records showed that in some instances, risk management protocols were not being effectively implemented.

Planned staffing levels were not always been achieved. At such times, people's planned activities were adjusted to ensure safety. Recruitment remained a priority for the registered manager and the provider was undertaking an urgent review with the commissioners of people's care to reassess the staffing requirements within the service.

Overall the home was clean although one person's room had a strong odour of urine which the staff had not yet managed to control. Policies and procedures were in place to protect people through effectively preventing and controlling the risk of infections.

The provider had appropriate policies and procedures for reporting abuse. This ensured staff had clear guidance about what they must do if they suspected abuse was taking place.

Accidents and incidents were investigated to make sure that any causes were identified and action was taken to minimise any risk of reoccurrence. Lessons learnt were communicated effectively with the staff team and throughout the organisation through a lessons learnt group.

People's rights were protected because the registered manager ensured that the requirements of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) were embedded within the service.

People's dietary needs were met and they were supported to make meal choices.

There were systems in place to support effective joint working with other professionals and agencies and to ensure that people's healthcare needs were met.

In general the environment was suited to people's needs, but we have made a recommendation that the provider continue to review the design and layout of the home and the number of people accommodated to further support the delivery of person centred care.

Staff had built strong relationships with people and knew how best to support them. They knew what was important to people and what they should be mindful of when providing their support. Staff interacted with people in a caring, good humoured and when needed, in a tender manner.

People's individuality and choices were respected and where necessary advocates were involved to ensure the person's views were represented and their rights protected throughout a decision making process.

Staff supported people in a way that maintained their independence and they spoke with, and about, people in a respectful manner.

People received care and support that was personalised to their individual needs and wishes. This helped to ensure that people lived in an inclusive environment where they were encouraged to express their views and choices.

People's relatives were involved in planning their care where appropriate. The support provided was, in most cases, achieving positive outcomes for people.

Staff effectively monitored aspects of the care and support people received to ensure it remained relevant and purposeful.

People were able and encouraged to take part in a range of leisure activities and follow their own interests. They were supported to maintain relationships with people that mattered to them.

Staff had taken innovative steps to provide information to people in a way in which they could understand allowing them to be as involved as possible in decisions about how their care was provided.

The registered manager used complaints or concerns to understand how they could improve or where they were doing well.

The registered manager demonstrated a thorough knowledge of each person living at the home and of the staff team. They fostered a positive and person centred culture within the home and helped staff provide care which was in keeping with people's needs and wishes.

There were systems in place to assess and monitor the quality and safety of the service and these were an integral part of the way in which the registered manager and provider identified shortfalls, learning and innovation to drive improvements in the service.

The registered manager had a clear vision for the service which was underpinned by key values which included inclusion, choice, independence and the reduction wherever possible of any restrictive practices.

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

The service was not always safe.

Medicines had not always been managed safely. Action was being taken to address this.

Overall staff had a good understanding of the risks associated with people's care however; records showed that in some instances, risk management protocols were not always effectively implemented.

Overall the home was clean although one person's room had a strong odour of urine which the staff had not yet managed to control. Policies and procedures were in place to protect people through effectively preventing and controlling the risk of infections.

Planned staffing levels had not always been achieved. At such times, people's planned activities were adjusted to ensure safety.

Staff had clear guidance about what they must do if they suspected abuse was taking place.

Accidents and incidents were investigated to make sure that any causes were identified and action was taken to minimise any risk of reoccurrence.

Is the service effective?

Good

The service was effective.

The support provided was, in most cases, achieving positive outcomes for people and ensured their dietary and healthcare needs were met.

People's rights were protected because the registered manager ensured that the requirements of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) were embedded within the service.

In general the environment was suited to people's needs, but we have made a recommendation that the provider continue to review the design and layout of the home and the number of people accommodated to further support the delivery of person centred care.

Is the service caring?

Good

The service was caring.

Staff had built strong relationships with the people and knew how best to support them. Staff interacted with people in a caring, good humoured and when needed, in a tender manner.

People's individuality and choices were respected and where necessary advocates were involved to ensure the person's views were represented and their rights protected throughout a decision making process.

Staff supported people in a way that maintained their independence and they were cared for with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People received care and support that was personalised and relevant to their individual needs and wishes.

People were able and encouraged to take part in a range of leisure activities and follow their own interests. They were supported to maintain relationships with people that mattered to them.

Staff had taken innovative steps to provide information to people in a way in which they could understand allowing them to be as involved as possible in decisions about how their care was provided.

The registered manager used complaints or concerns to understand how they could improve or where they were doing well.

Is the service well-led?

Good

The service was well led.

The registered manager demonstrated a thorough knowledge of each person living at the home and of the staff team. They

fostered a positive and person centred culture within the home.

There were systems in place to assess and monitor the quality and safety of the service and to identify shortfalls and promote learning and innovation to drive improvements in the service.

The registered manager had a clear vision for the service which was underpinned by key values which included inclusion, choice, independence and the reduction wherever possible of any restrictive practices.

Devon Lodge

Detailed findings

Background to this inspection

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

This unannounced comprehensive inspection took place on 30 November and 5 December 2017 and was carried out by one inspector.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is used by registered managers to tell us about important issues and events which have happened within the service. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, such as what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection.

Most of the people using the service were non-verbal or had other communication difficulties and so they were not able to speak with us and so we spent time observing interactions between people and the staff supporting them. We spoke with the registered manager, the regional manager, deputy manager, the provider and quality director, three support workers and an agency worker. We reviewed three people's care records, staff training records, recruitment files for four staff and other records relating to the management of the home such as audits, complaints and meeting minutes. Following our inspection, we spoke with four relatives and five health and social care professionals to obtain their views on the quality of care provided.

This was the first comprehensive inspection of this service under the provider CAS Care Services Limited.

Requires Improvement

Is the service safe?

Our findings

People were unable to tell us whether they felt safe living at Devon Lodge, but our observations indicated that they seemed comfortable in the presence of their support workers. There were a number of occasions when we observed staff support people in a tender manner indicating that they were genuinely concerned for the person's wellbeing. All of the relatives we spoke with felt their family members were safe at Devon Lodge. One relative said, "I am more than happy it is a very safe environment and an honest environment too". This was a reflection on what they felt was clear communication about how incidents or events that had the potential to impact on people's safety were managed by staff and the leadership team. Another relative told us, "[The person] seems to feel safe at Devon Lodge. He has regular staff members working with him; he trusts them and engages well". A third relative said, "We believe [the person] is generally kept physically safe from harm from external influences, and in a secure environment".

We looked at how the service managed people's medicines. Medicines were only administered to people by staff who had been trained to do this and who underwent an annual review of their skills, knowledge and competency to administer medicines safely. Suitable systems were in place to order people's medicines. A medicines lead worker and a colleague were given protected time to check these on arrival and book them into the home. Medicines, including controlled drugs were kept safely in a locked cabinet, in a locked treatment room. Controlled drugs are medicines that require a higher level of security in line with the requirements of the Misuse of Drugs Act 1971. The temperature of the treatment room was monitored daily to ensure the medicines were being stored within recommended temperatures. We reviewed each person's medicines administration record (MAR). These contained sufficient information to ensure the safe administration of medicines. Some people's MARs included person centred protocols for the use of 'as required' or PRN medicines. For example, one person had a clear escalation for the use of emergency or lifesaving medicines used to treat seizures.

We did note some areas for improvement. It was the provider's policy was that each administration of medicine was witnessed by a second support worker and a check of the MARs showed that this was not consistently happening. One person's emergency medicine had passed its expiry date. This could make the medicine less effective. Medicines awaiting disposal were not being stored appropriately and had not been recorded in the returns book meaning there was no record of their presence within the service. Action has now been taken to address these concerns.

Overall staff had a good understanding of the risks associated with people's care and how to support them to maintain good health and to stay as safe as possible. People had risk assessments in relation to their health and wellbeing, maintaining independence and daily routines. These assessments recognised the risks associated with these activities and gave staff guidance on how to support people to develop their independence without being overly risk adverse. Staff demonstrated an enabling approach and proactively encouraged people to have the most meaningful life possible. For example, one support worker told us, "We do take some risks, for example off site trips, we took [person using the service] to the Harvester for breakfast, it went well, you just have to push a little bit more, be mindful, reintroduce things slowly and always be flexible". We noted that one of the people living in the annex, where the front door was secured

with a code, was given access to the code so that they could move freely between the annex and the main house. These approaches helped to ensure that restrictions were minimised and that people had the most freedom possible. When new or increased risks were identified, staff had usually acted to address these. For example, prior to our inspection, one person had managed to abscond from the home. Remedial measures had been put in place to help prevent this from happening again.

We did identify some concerns though about how certain risks were being managed. For example, in the case of one person, records showed that they had experienced a significant loss of weight in a short period of time. Their care plan stated that they should be weighed on a weekly basis but this had not been happening. The registered manager told us the weight loss had been discussed with the person's GP, but this had not been documented. One person could experience seizures, but from reviewing rotas, we could not be confident that each shift had a suitably trained member of staff on duty that was able to administer emergency medicines in response to a person experiencing a seizure. We brought this to the attention of the registered manager who took action to ensure that this training was booked for relevant staff.

Overall the home was clean and policies and procedures were in place to protect people through effectively preventing and controlling the risk of infections. Following a recent environmental health assessment, the service had been awarded the highest rating for its food hygiene practices. We did note though that one person's room smelled strongly of urine. The deputy manager told us that the room was cleaned throughout the day on a regular basis and that the flooring had been replaced on a number of occasions and the bathroom refitted; however none of this had been successful at managing or reducing the odours due to the person's ongoing reluctance to urinate in their bathroom. We remained concerned that the room was not a pleasant place for the person to sleep or spend time and have asked the registered manager to continue to investigate individualised solutions for addressing this effectively.

Some of people within the service could at times express themselves through displaying behaviours which could challenge others which included physical aggression towards others or towards objects. Where this was the case people had positive behavioural support plans which had been developed with the input of the provider's psychology team. Plans included a description of the potential behaviours, the possible triggers, justification for intervention, and the agreed techniques to be used. Where physical interventions or restraints were required, staff used a nationally accredited approach. The support plans viewed were clear and stressed the importance of taking the least restrictive actions first and of applying the restrictive interventions for the shortest length of time necessary to reduce risk and bring the situation under control. Staff told us they felt confident in the use of these techniques and that the registered manager and therapy team were very good at listening to them and incorporating into plans strategies staff had found worked effectively. We did however note that following the use of physical interventions, there was no documented evidence that staff were being debriefed in line with the provider's policy or with best practice guidance. This is a supportive tool for staff but also contributes to reflection which can help lead to the reduction in the use of physical interventions.

Environmental risks were managed. Regular checks were undertaken of the fire safety within the service and fire drills took place periodically. People had personal emergency evacuation plans (PEEPS) which detailed the assistance they would require for safe evacuation of their home. The PEEPs were stored in a 'grab pack' which was readily available in case of an emergency. A business continuity plan was in place which set out how the needs of people would be met in the event of the building becoming uninhabitable or an emergency such as a fire or flood or loss of power. Checks were made to ensure that gas and electrical appliances were safe to use and of the water temperatures. Window restrictors were also checked weekly to ensure they were in good working order. Daily and monthly health and safety checks also took place which included checks to make sure the perimeter fencing was free from damage and fire exits and escapes clear.

Checks were made to ensure that people were protected against the risks associated with legionella.

Prior to the inspection, we had received information telling us there were not always enough staff deployed to care for people safely and to meet their needs. Our observations during the inspection indicated that there were sufficient numbers of staff available to meet people's needs and to provide meaningful interaction and engagement. The registered manager used a staffing analysis to plan staffing levels. Planned staffing levels during a day shift were a team leader, 11 support staff, an activities co-ordinator and an activities assistant. A review of rotas for November 2017 indicated that these planned staffing levels were not always being met. For example, on three days and two nights, the number of daytime staff deployed was at levels which the staffing analysis deemed should only be used in 'an emergency involving unforeseen circumstances'. We also noted that on 13 days in November 2017, there were only two staff deployed in the annex to support the four people living there, when the staffing analysis identified there should be three.

On days when minimum staffing levels were deployed, the registered manager told us that staff might have to amend people's planned activities but that the staffing levels remained safe. Both she and her deputy would step in to assist the staff team although she acknowledged that they did not work at weekends. Radios allowed staff in the annex to quickly seek assistance from the main house should this be needed. They explained that agency staff were used to fill gaps in the rotas but that using too many agency workers could in itself have a negative impact on people's support as they did not have such a good understanding of people's needs. Staff instead adapted the way in which they worked, by for example, one member of staff supporting two people, keeping one of these in 'line of sight' rather than through the direct provision of one to one care.

The staff we spoke with were generally positive about the staffing levels and felt that these did ensure that people received safe care. One staff member said, "Yes there are generally safe staffing levels" and another said, "There are days when the staffing is lower, we adapt, change trips, focus on other activities". People were unable to tell us their views about the staffing levels but feedback from their relatives was mixed. One family member said, "From our experience…there does appear to be enough staff on duty to ensure the residents are kept physically safe….. We do know that there have been occasions when [person] has not been able to go out due to constraints on staffing numbers". Another relative said, ""There are always enough staff available to keep [the person] safe. He is offered a range of activities each day, both on and off site. I am not aware of any occasion where activities are limited due to staff shortages". A social care professional told us that when they visited, "You can be falling over staff, sometimes they use economy of staff, I'm ok with that". In summary, it was evident that planned staffing levels were not always being met. At such times, people's planned activities were adjusted to ensure safety. Recruitment remained a priority for the registered manager and two new night staff had recently been recruited. The regional manager told us that the provider had plans to undertake a project at the service to review with commissioners the level of support each person needed and assess whether this would be better managed with fewer staff. They felt that this could bring benefits as some of the people using the service could become more agitated or display behaviours which might challenge if over stimulated through large numbers of staff being present in their home. They also felt that this would help support the reduction of restrictive practices. They told us this piece of work was an organisational priority.

Relevant checks were completed before staff were employed. Each staff member had provided an application form, a full employment history and proof of identity and attended a competency based interview to check their suitability and competency for the role. In most cases satisfactory references from previous employers had also been obtained. We did note that in the case of one staff member, both of their references were character references despite the fact that they had previously worked in health and social care positions. Disclosure and Barring Service (DBS) checks had been completed. DBS checks alert the

provider to any previous convictions or criminal record a potential staff member may have which helps them to make safer recruitment decisions.

The provider had appropriate policies and procedures for reporting abuse. Staff received annual face to face safeguarding training and observations of their practice following which they received feedback about their performance. This ensured staff had clear guidance about what they must do if they suspected abuse was taking place. Staff had a positive attitude to reporting concerns and to taking action to ensure people's safety. Safeguarding people from harm was discussed at staff supervision and was also explored at the interviews of prospective staff members. People were supported to understand how to stay safe. For example, information had been made available in a range of formats to ensure that people knew how and with whom they should raise any concerns about their safety. Whistleblowing procedures were in place, although staff were confident that the leadership team would act on any concerns they might have about a person's safety.

Accidents and incidents were investigated to make sure that any causes were identified and action was taken to minimise any risk of reoccurrence. For example, we saw that following a medicines error, the support worker had repeated their medicines training and been reassessed as competent. Lessons learnt were communicated effectively with the staff team and throughout the organisation through a lessons learnt group. The registered manager told us learning from any safeguarding investigations or incidents that had occurred was shared with staff at team meetings to improve the quality of care provided at the home.

Good

Is the service effective?

Our findings

Most of the social care professionals told us that the service provided effective care. For example, one said, "Staff know [the person] well, they handle his needs well, it's pretty good, it's one of the homes I am least worried about, the attention to service users is good". Another, however, told us, that they felt more could be done to ensure that compatibility was given more when new people were admitted to the service. They were now in the process of finding an alternative placement for the person who they felt needed a calmer and quieter environment than that which was now available at Devon Lodge. They acknowledged that staffs at Devon Lodge were working closely with the new care provider to achieve an effective transition for the person from their service. This was being led by the person as much as possible with their visits to the new service being carefully planned. The person's relative told us that staff at Devon Lodge had been very supportive throughout this process and both they and the social care professional were clear that staff cared for the person and wanted the best for him and were open about the challenges of caring him for him at Devon Lodge.

Care plans provided information to ensure staff knew how to meet people's individual needs. Each person had a support plan, a positive behaviour support plan and risk assessments. Alongside this they also had a health plan which included information about how their physical health needs were being met. People's support plans were currently being redesigned and updated but were generally person centred and contained information about the support they needed with areas such as personal care, eating and drinking and with domestic tasks or leisure opportunities.

In general the environment was suited to people's needs. Each person had a single ensuite room. In some cases, the room reflected the person's individual tastes and choices. For example, one person had a sensory board in their room and stars glowing on their ceiling. Others had limited furniture in their rooms due to the risks these posed or because the person's complex needs meant they could not tolerate these or because the person might damage these or harm themselves. Some people's rooms did not have curtains. We were told that this was because they kept pulling these down. To protect the person's dignity privacy screening had been put in place. The deputy manager told us that efforts continued to introduce items into people's rooms to make them more homely and that recently they had been able to put pictures up on the wall in one person's room which they were tolerating well. Where people were still not able to tolerate the pictures or perhaps might destroy these, the maintenance person had drawn pictures on the walls to help enhance the environment for people.

There was a comfortable lounge and a large activities room, equipped with a computer, an exercise bike and games and crafts. There was also a basic sensory room, dining room, a kitchen and laundry and a communal bathroom with mood lighting. A continuous improvement plan was in place to develop and enhance the environment. The flooring on the stairs had been replaced and new furniture for bedrooms was on order. New chairs were also planned for the dining room. A new worktop had just been fitted throughout the kitchen and other planned improvements included replacing the hot tub which had been broken for some time but had been enjoyed by a number of people using the service.

The environment could at times be noisy due to some people's preferred way of communicating or because they might be distressed or anxious. Whilst staff responded promptly to provide support, we observed that people were able to move freely around the home should they feel the need for a more private or quiet space. We did note that there was limited space available for people to have to private time with their families when they visited and one of the relatives we spoke with felt that at times the communal areas were too crowded and noisy. They told us that this had been one of the key factors in their decision to find an alternative placement for their family member. The registered manager was aware of best practice guidance which has found that it is best for young people and adults to live in smaller settings.

We recommend that the provider continue to review the design and layout of the environment in line with current guidance and review the number of people accommodated to ensure this fully supports the needs of people using the service.

People's rights were protected because the registered manager ensured that the requirements of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) were embedded within the service. The MCA 2005 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. Where people were able to express their wishes and choices it was evident that staff respected these and had involved them in planning their care. A staff member told us, "You cannot assume they lack capacity, it's important to give them options". They told us how they had used a talking mat with one person to try and ascertain their preferred holiday destination, they said, "After 15 meetings with them, Disney became a clear winner". Talking mats are mats to which pictures which can be attached and re-arranged as required. They help people communicate their choices. To check whether people were able to make more complex decisions about their care, the senior staff had, when required, completed and documented mental capacity assessments in relation to day to day decisions such as personal care, attending healthcare appointments and their dietary needs. We did note that the best interest's consultations had not always been fully documented. We spoke with the registered manager about this, who advised that going forward this would be fully documented.

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 2005. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where potentially restrictive care practices were in place, relevant authorisations had been obtained.

Procedures were in place to ensure that new staff received an induction into the service and the needs of the people they would be supporting. This helped to ensure that staff knew people well and were confident, safe and competent in their role. The induction lasted for two weeks and included a period of shadowing experienced staff and a session on understanding the impact of living with autism on people's lives. New staff were provided with a buddy who mentored them and modelled best practice. The induction was mapped to the Care Certificate. The Care Certificate sets out the competencies and standards of care that support workers are expected to demonstrate.

Staff were positive about the training available and told us it helped them to perform their role effectively. Face to face training was provided in a number of subjects such as; safeguarding, administering medicines, emergency first aid, and in recognised and accredited strategies for managing behaviour that challenges, including the use of physical interventions. Online training was undertaken in additional subjects such as responding to emergencies, equality and diversity, food safety, health and safety, Mental Capacity Act 2005

(MCA 2005) and infection control. The training provided was designed to support staff to develop a good understanding of the challenges of living with autism and this was a theme running through all of the training sessions. The registered manager also held a number of reflective practice sessions on a range of topics relevant to the needs of people using the service such as communication, positive behaviour support and care planning. We did note that agency staff working within the service were not required to have training on how to safely use physical interventions. The registered manager told us that agency staff were only allocated to support people who did not present 'high challenges'. In addition they advised that should an incident occur trained staff would step in to provide the required support. We spoke with an agency worker who was on their seventh shift in the home. They told us they felt well supported and had been provided with a full induction which had included reading each person's profile.

Ongoing support for staff was achieved through individual supervision sessions and an annual appraisal. Staff told us they received regular supervision which was useful in measuring their own development and identifying additional training needs. One staff member said, "I have supervision every three months, it's good to know whether you are doing a good job or a bad job".

Staff supported people with their dietary needs. People were encouraged to exercise genuine choice about what they ate and drank. Each day there was a choice of two main meals. Pictures of these were displayed and the person picked up the picture of the meal they preferred and showed this to the cook or the staff member supporting them. Meal times were flexible and could be adjusted according to what activities people were doing but also in light of how the person was feeling or how settled they might be. Some meals were eaten as a group whilst others preferred or needed to eat separately to avoid over stimulation. We observed part of the lunch time meal on the first day of our inspection. Staff role modelled and supported and encouraged people in a friendly and respectful way. The food provided met people's dietary requirements and preferences and also where appropriate, their cultural and religious preferences.

Most of the people who lived at Devon Lodge lived with complex health and social care needs and there were systems in place to support effective joint working with other professionals and agencies to ensure that these needs were met. For example, the provider had its own multi-disciplinary team which included psychiatrists, psychologists, nurses and speech and language therapists. Where necessary referrals were also made to the local NHS and local authority learning disability services for intensive support. There was evidence that staff also referred people to a range of other healthcare professionals such as GP's, dentists and opticians. People had annual health checks and medicines reviews and routine screening. Each person had a health action plan, which provided information about past and current medical conditions as well as records of all healthcare appointments.

Good

Is the service caring?

Our findings

Staff had built strong relationships with the people they supported. One staff member told us, "I really enjoy my job, working with the guys". They told us how even when a person achieved something as straightforward as tying their shoes laces, this made them feel happy and meant they went "Home with a smile". Another staff member told us, "The residents are interesting; you get to spend time with so many different characters". A third staff member said, "We are very lucky, even the new staff are taking to the role, everyone is being enriched". Staff were familiar with the content of people's support plans and how best to support them. They knew what was important to people and what they should be mindful of when providing their support. There was evidence that the support plans were underpinned by an ethos of providing care in a kind and compassionate manner and of supporting people to have the best possible day and experiences.

Our observations indicated that staff interacted with people in a caring, good humoured and, at times, tender manner. For example, we observed one person sitting alongside a staff member who was giving them a head massage. The person appeared to gain comfort from this and the interaction distracted the person for a period of time from their self-injurious behaviours. We observed staff encouraging a person to recite rhymes. The staff member said, "Well done, super" to the person. Staff told us that they were confident that all of their colleagues were kind and caring. One team leader told us, "Yes, they are all kind and caring, if they weren't I would address it. I keep a close eye on new staff and will pull them to one side if I feel they have not responded to a resident appropriately". We observed that where necessary staff maintained clear boundaries in an attempt to avert behaviours which might challenge or to try and promote a harmonious living environment. This was done in a kind but firm manner.

Where people were not able to verbally communicate their choices or emotions staff used alternative methods to try and assist them to make choices and express their preferences. For example, staff used the 'Picture exchange communication system' (PECS) with people to support communications. PECS allows people with little or no communication abilities to communicate using pictures. Other people used 'Now and next' boards to help people make choices about activities or tasks in stages throughout the day. It was clear that people's individuality and choices were respected in areas such as clothing, hairstyles and in the activities they took part in. Where families or others had voiced an opinion about how aspects of their family members care should be managed, staff had, or were, working closely with other professionals to ensure the person's views were represented and their rights protected throughout the decision making process.

The importance of supporting people to use and maintain their existing skills was referenced throughout their support plans and we observed that staff supported people in a way that maintained their independence. For example, we observed that people were encouraged to get involved in daily chores such as preparing elements of their meals or tidying their room. People brought their own meal to the table and cleared away afterwards. Some people got involved in taking in deliveries or tidying the garden. We observed one person folding their laundry with the support of staff. Staff role modelled to support people's independence, for example, one support worker told us, "[person] wouldn't put their shoes on, so I took mine off and showed him how".

People were cared for with dignity and respect. Staff spoke with, and about, people in a respectful manner and people's support plans were written in a manner that was respectful of people's individuality. Although most people were supported on a one to one basis for most of the day, we saw that this was delivered in a manner that was mindful of the person's need for privacy and for some personal space. One person had initially needed a staff member with them in their room at night., With time and with reassurance that the staff member would still be close by; staff were now able to sit outside the person's bedroom door allowing the person additional privacy.

Staff embraced people's diversity and this was reflected in the way in which care was delivered. For example, Staff had supported one person to celebrate a religious feast central to their faith. People were not discouraged from expressing their sexuality and were supported to have personal time in the privacy of their own room. Information about advocacy services was available and people were visited by both the provider's advocate and where appropriate by independent advocates or formal representatives, which helped to ensure that people's rights were protected and their views and wishes heard.

Good

Is the service responsive?

Our findings

Our observations indicated that people received care and support that was personalised to their individual needs and wishes. This view was supported by a social care professional who visited the service on a regular basis. They told us the service was "Very person centred" and that staff were "Always engaging and were proactive".

During the inspection we were told how the support being provided was achieving positive outcomes for some people. For example, we were told how one person's needs had meant trips into the community were difficult to achieve as they could become agitated or try to abscond. Staff persevered with offering a variety of trips out and through providing a calm, structured and flexible approach this person was now attending a range of external activities including trampolining and visits to the pub. Staff had supported another person to go on their first holiday. Although just a one night stay away, it had been a great achievement for the person. The person's relative praised the service for helping to prepare their family member for adult hood. They felt staff tried innovative ways of trying to encourage people to try new things or attempt new tasks. We were told about another person who had come to the service taking a range of medicines; they were now just taking one. They had often ripped or damaged their clothing. Staff had observed that they liked the fleeces worn by staff as part of their uniform and sourced similar fleeces for the person to wear. We were told that the person was very proud of their fleece and that this had resulted in a reduction in the person attempting to rip their clothing. It was evidence that staff were motivated to support people to develop their skills and abilities. A member of staff told us, "I love it when they [people using the service] achieve something…they have a sense of pride in themselves".

It was evident that staff had a good understanding of people's needs. It was clear that staff knew people's likes and dislikes and their communication methods well whether this be through words or other vocalisations that staff had become familiar with. This helped to ensure that people received person centred care and lived in an inclusive environment where they were encouraged to express their views and choices. Information was also available about their individual likes and dislikes and their preferred daily routines. Staff maintained journals which noted how each person had been, what they had eaten and what activities they had been involved in. These journals were written in a person centred manner and captured how people were feeling, for example, staff had written in one person's journal, 'Their favourite song came on and he smiled'. Records were also made of any incidents of behaviour which might challenge others and where appropriate, the number of seizures people had experienced, whether any PRN medicines had been required or physical interventions used. The journals were reviewed daily by the lead support worker. This helped to ensure that staff were able to effectively monitor aspects of the care and support people received. People's needs and support plans were reviewed regularly and people, their families and health and social care professionals were involved in reviews. This helped to ensure that each person's placement at the service and their support needs remained purposeful and relevant.

A communication book was used by staff to share information effectively, such as whether people had healthcare appointments they needed to keep. There was also a daily handover which helped to ensure staff all remained informed about any changes in people's needs. Most of the relatives we spoke with told us

that staff and the registered manager kept them well informed about any changes to their family members care. They told us they received weekly 'home contact' letters telling them how the week had been for their family member, what activities they had been involved in and progress made with goals or objectives. One relative told us, "I have always had good communication, this has enabled honest conversations and means we have not been stripped of the closeness with our child, we are all part of the same team, this is one of the strengths of the service". One relative did say that the contact letters had in recent months been spasmodic and that trying to make contact with the home at weekends when the registered manager or deputy were not working could be difficult.

The service had an activities team who oversaw the delivery of a range of leisure activities both within and outside the home. Within the home people engaged in activities such as games and crafts and sing and sign groups. We observed people spending time on their tablet or computer and playing games with staff. One person enjoyed a foot spa. Another person spent some time in the sensory room whilst another spent time relaxing on a bean bag, listening to music and using a weighted blanket to help calm and soothe them. Outside there was a large garden which including the 'Shack' a messy play area. People could use roller blades and bikes and until recently relax in the hot tub, although this was currently broken. Alongside these leisure activities, people were encouraged to focus on attaining certain goals or objectives. These were aimed at supporting the person to achieve independence with particular tasks such as hoovering, making their lunch or mopping their room. Some of the activities such as sing and sign sessions were focussed on developing communication skills such as using PECS or Makaton. The targets were developed in line with the principles of lifelong learning but also reflected the person's choices where this was possible to determine. One staff member told us how the targets could be small things such as handing out snacks to their peers. When targets were achieved, this was celebrated and the person was given a certificate.

Outside of the home, people were supported to attend football sessions run by the local premier league football club. A staff member told us how one person who attended these sessions had grown in confidence so much, they were tackling and had recently scored a goal following which they had given a high five. Some people went swimming, to the gym or for walks. People also attended trampolining and fitsteps sessions. One person had been on a holiday to Euro Disney and another for an overnight stay in Devon. A staff member told us, "They are doing something different every day; [activities coordinator] has done a fantastic job and brought another element". The relatives we spoke with were mostly positive about the activities provided but two felt that more could still be done to provide additional activities or leisure opportunities outside of the home.

A range of tools had been used to try and ensure that people were involved in choosing the activities they took part in. The activities staff had worked closely with the provider's speech and language therapist to implement 'choosing boards'. For some people, the boards might only contain a small amount of choices as this was all the person could cope with. A feelings board was also available and staff told us people were encouraged to pick a symbol which reflected their mood. If a person was feeling sad, staff could try and find out what was wrong. If the person was feeling agitated or perhaps angry then the activities schedule was amended to avoid activities known to triggers behaviours which might challenge others or lead to self-injurious behaviours. Social stories were used to try and ascertain an understanding of which activities people enjoyed so that their weekly activities planners could be tailored to these. Social stories are a tool that supports the safe and meaningful exchange of information between staff and people with autism. We were told how one person had indicated that they wanted to be a postman. To support this staff had bought the person a satchel and arranged for them to get involved in delivering the local newspaper.

In addition to the examples given above, there was other evidence that the service had taken innovative steps to provide information to people in a way in which they could understand allowing them to be as

involved as possible in decisions about how their care was provided. For example, buttons had been displayed in a number of key locations around the home. When pressed, a voice gave information about the activities that were planned for that day or the meals that were on offer. An easy read service user guide was available and easy read posters describing who people could speak with if they were unhappy, such as an independent advocate that visited the service on a regular basis. Similar posters were also available about how people could report bullying or abuse. This meant that the service was complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

The registered manager used complaints or concerns to understand how they could improve or where they were doing well. There had been four complaints since our last inspection. These had been investigated and responded to appropriately.

Good

Is the service well-led?

Our findings

The service had a registered manager who was registered with the Care Quality Commission. They were supported by a deputy manager and team leaders. The registered manager had been in post since the home opened and during the inspection they demonstrated a thorough knowledge of each person living at the home and of the staff team. They fostered a positive and person centred culture within the home and helped staff provide care which was in keeping with people's needs and wishes. They told us that working with people living with autism was their passion and that they were committed to nurturing people and bringing out their personalities. They demonstrated a clear value base and it was evident that people were at the heart of the service. Staff and relatives were complimentary about the service and of its leadership. A staff member told us the registered manager was "Very resident focussed" and another said, "They are very good with trying new strategies to support people…no matter how busy they are, they will come and help if you need it. They have an open door policy, the deputy is fantastic too, we are very well led, they are firm but fair". A relative told us the registered manager was, "A very caring and personable person who we feel is committed to trying to provide a service in the best interests of the residents".

There were clear lines of responsibility and accountability within the service. The registered manager understood her responsibilities and followed procedures for reporting any significant events which occurred within the service to CQC and to other organisations such as the local authority safeguarding team. Staff understood their responsibilities and each day a daily allocation sheet was used to clearly identify which staff member was in charge of the shift and who was responsible for supporting each person.

House meetings with people were held and were an opportunity for people to be involved in decisions about trips and other events. For example, we saw that people had been encouraged to indicate whether they preferred a trip to the panto or to the turning on of the Christmas lights. Staff meetings were also held during which they discussed issues affecting people using the service, staffing matters or concerns, the catering and training. There was also an 'open forum' during which staff could raise other issues.

We observed a good working relationship between the registered manager and staff. The staff we spoke with felt well supported and told us that morale and team work was improving following a difficult period during which there had been some challenges within the staff team. Both the registered manager and provider told us they were committed to ensuring that staff felt valued. One way in which they hoped to drive this was by encouraging team members to nominate colleagues who they felt had made a 'random act of kindness'. A monthly draw then determined which staff members were invited to a dinner with the board. The registered manager told us they were well supported by the provider and regularly met with other registered managers and the senior leadership team and board to share learning and information.

There were systems in place to assess and monitor the quality and safety of the service and these were an integral part of the way in which the registered manager and provider identified shortfalls and promoted learning and innovation within the service. The provider employed a head of quality and compliance whose team of auditors made regular announced and unannounced visits to Devon Lodge and reported on their findings. In particular one of the quality auditors were working with the team at Devon Lodge to look at ways

in which restrictions on people could be minimised. The registered manager undertook a range of audits throughout the year which included health and safety, medicines and infection control audits. Peer audits were performed by other local managers allowing an assessment of the quality of care to be made from a fresh perspective.

Each week the registered manager reported to their regional manager on the number of significant events which might have occurred such as safeguarding concerns, medicines errors and the number of physical interventions that had been used. If there was an unexpected increase in any of these areas, then the registered manager would be asked to complete a detailed report explaining the reasons for this. Reports were also made of the number of meaningful hours of interaction people had received each week. This helped to ensure that quality was also being defined from the perspective of people using the service. These quality and safety indicators were compared with the findings in previous weeks to help the provider identify emerging risks within the service. The findings were also shared with the provider's senior management team through clinical and operational governance meetings which helped to ensure that they too had an oversight of risks or concerns within the service.

The registered manager had a clear vision for the service which was underpinned by key values which included inclusion, choice and independence. They told us their aim was to reduce restrictions on people and said, "It's not about having control, it's about being in control, it's about taking safe risks….we don't assume if something fails that it's not worth trying again". Our inspection and the feedback we have received since, has indicated that both the registered manager and staff work in a manner that is in keeping with these values. Two of the health and social care professionals we spoke with did voice a concern about lack of communication by the provider about the change of ownership in 2016 and they raised concerns about the impact of this on staff and the future direction and focus of the service in light of this. We fed this back the provider who was clear that as an organisation they remained strongly committed to providing an enabling and inclusive person centred service.