National Autistic Society (The)

National Autistic Society - Prospect House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Prospect House on 25 and 26 July 2018.
Prospect House is a 'care home' which is registered to provide care and accommodation for up to seven adults with autism. The care service had been developed and designed in line with the values that underpin the CQC policy 'Registering the Right Support' and other best practice guidance.

People in care homes receive accommodation and nursing care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection. Nursing care is not provided at Prospect House. At the time of our inspection seven people were using the service.

At the time of the inspection there was no registered manager at the service. However, the manager in post had applied for registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection in the service was rated Requires Improvement. We found the provider was in breach of one regulation of the Health and Social Care Act (Regulated Activities) Regulations 2014. This related to the provider having unsafe processes for the management of medicines. At this inspection we found sufficient action had been completed to make improvements.

During this inspection we found there were no breaches of the regulations of the Health and Social Care Act (Regulated Activities) Regulations 2014. We found evidence to support the overall rating of Good.

We found there were management and leadership arrangements in place to support the effective day to day running of the service. The manager had made several improvements and staff morale had improved.

There were processes in place for dealing with complaints. However, we found there was a lack of information to show how concerns had been dealt with and resolved. The manager took action to rectify this matter and we will check for further progress at our next inspection.

Processes were in place to provide people with safe support with their medicines.

People were safe at the service. Risks to people's well-being were being assessed and managed.

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

Processes were in place to make sure all appropriate checks were carried out before staff started working at the service.

There were enough staff available to provide care and support; we found staffing arrangements were kept under review.

Systems were in place to maintain a safe environment for people who used the service and others.

Arrangements were in place to gather information on people's backgrounds, their needs, abilities and preferences before they used the service.

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

We found people were effectively and sensitively supported with their healthcare needs and medical appointments. Changes in people's health and well-being were monitored and responded to.

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

We received positive comments about the staff team. We observed positive and respectful interactions between people using the service and staff.

Staff expressed a practical awareness of promoting people's dignity, rights and choices. People were supported to develop skills and engage in meaningful activities at the service and in the community.

Beneficial relationships with relatives and other people were supported.

Each person had detailed care records, describing their individual needs, preferences and routines. This provided clear guidance for staff on how to provide support.

People's needs and choices were kept under review, with the involvement of other people involved in their support.

People had communication profiles with plans in place, to highlight ways of sharing their feelings, needs and preferences.

There were systems in place to consult with people who used the service, relatives, staff and others, to assess and monitor the quality of their experiences. Various checks on quality and safety were regularly completed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were safe processes in place to support people with their medicines.

Processes were in place to maintain a safe environment for people who used the service.

Staff recruitment included the completion of relevant character checks. There were enough staff available to provide people with safe care and support. Staff were aware of safeguarding and protection matters.

Is the service effective?

Good

The service was effective.

Processes were in place to find out about people's individual needs, abilities and preferences.

People's health and wellbeing was supported and they had access to healthcare services when necessary.

People were supported to eat healthily; their preferred meal choices were known and catered for.

People were encouraged and supported to make their own choices and decisions. The service was meeting the requirements of the Mental Capacity Act 2005. Arrangements were in place to develop and supervise staff in carrying out their roles and responsibilities.

Is the service caring?

Good

The service was caring.

We received positive comments about the supportive and caring attitude of staff. We observed positive, respectful and sensitive interactions between people using the service and staff.

Staff were aware of people's individual needs, backgrounds and

personalities, which helped them provide personalised support.

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

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some complaints and concerns, were not properly recorded and managed.

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

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

Is the service well-led?

Good

The service was well-led.

There was a management team providing effective leadership and direction.

Staff were knowledgeable and positive about their work. They indicated the management, team work and staff morale had improved.

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

National Autistic Society - Prospect House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

We visited Prospect House 25 and 26 July 2018 to carry out an unannounced comprehensive inspection. The inspection team consisted of one adult social care inspector and one inspection manager, who attended on the first day.

Before the inspection, we reviewed the information we held about the service, including notifications and previous inspection reports. A notification is information about important events which the service is required to send us by law. We contacted the local authority contract monitoring team, the local authority safeguarding team, commissioners of care, social workers, learning disability nurses, care coordinators and a consultant psychologist.

The provider sent us a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to decide which areas to focus on during the inspection.

We used a number of different methods to help us understand the experiences of people who used the service. During the inspection visit, we spent some time talking with people, observing interactions and the support provided by staff. We talked with two people living at Prospect House about their experiences at the service. We spoke with three support workers, a team leader, the manager, a team leader, deputy manager and the quality manager.

We looked at a sample of records, including three care plans and other related care documentation, two staff recruitment records, training records, menus, complaints records, meeting records, policies and procedures, quality assurance records and audits.

Good

Is the service safe?

Our findings

We looked at the way people were supported with the proper and safe use of medicines. At our last inspection we found there were some shortfalls with medicines management processes which resulted in a breach of the regulations. At this inspection we found improvements had been made and processes were in place to provide people with safe support. We also noted medicines audits and checking systems had been carried out to identify shortfalls and make improvements.

We checked the procedures and records for the storage, receipt, administration and disposal of medicines. We noted proper records had not been kept of one item being returned to the pharmacist, however this was amended during the inspection. Medicines storage areas were found to be clean, tidy and secure. Appropriate storage and administration was in place for controlled drugs, which are medicines which may be at risk of misuse. Appropriate records were kept to monitor the temperature of the medicines storage areas. We noted the temperature had increased towards an unsuitable level; we therefore advised appropriate action be taken to maintain the optimum storage conditions.

The medicines administration records (MAR) we reviewed were appropriately kept, complete and accurate. Each person had a 'medication profile' which included, prescribed medicines, known allergies, risk assessments and person-centred instructions for staff to follow on supporting people safely with their medicines. There were individual protocols for the administration of medicines prescribed "as necessary" and "variable dose" medicines. These were to ensure staff were aware of the individual circumstances when this type of medicine needed to be administered or offered.

There were processes in place to complete weekly and monthly audits on aspects of medicine management practices. The service had medicine management policies and procedures which were accessible to staff. Records and discussion showed staff providing support with medicines had completed training. There were arrangements in place to assess, monitor and review staff competence in providing safe, effective support with medicines.

We checked how the service protected people from abuse, neglect and discrimination. One person said, "I have no major concerns or worries. I generally feel safe living here." A healthcare professional told us, "I Definitely feel [name of person] is safe at the service" and a commissioner of services, commented, "No real concerns."

Prior to the inspection, we reviewed the information we held about the service relating to safeguarding incidents and allegations of abuse. We reviewed some of the concerns with the manager. Systems were in place to record and manage safeguarding matters. We found action had been taken to liaise with local the authority in relation to allegations and incidents. Staff spoken with expressed an understanding of safeguarding. They were aware of the various signs and indicators of abuse and were clear about what action they would take if they witnessed or suspected any abusive practice. The service had policies and procedures to support an appropriate approach to safeguarding and protecting people. Staff spoken with were aware of the service's 'whistle blowing' (reporting poor practice) policy.

Each person had a 'keeping me safe' assessment and a 'positive behaviour' support plan in line with their needs. One person told us, "They have gone through the risk assessments with me." There were person centred risk assessments and risk management strategies in place, to guide staff on minimising risks to people's wellbeing and safety. The risk assessments included safely supporting people with personal care, anxieties, their individual routines and activities in the community. A healthcare professional said, "They have supported some positive risk taking, they have been very proactive." The underpinning support plans were sensitively written and reflected people's specific needs, behaviours and preferences. Processes were in place to review risk assessments six monthly or more often if needed. Staff spoken with had an awareness of the risk assessments and told us how they were shared with the staff team and kept up to date. A social worker commented, "The service has been quick to identify any risks and worked with professionals to establish plans to mitigate these risks."

We looked at the processes in place to maintain a safe environment for people who used the service, visitors and staff. Records showed arrangements were in place to check, maintain and service fittings and equipment, including electrical safety and fire extinguishers. We found health and safety checks had been carried out. Fire drills and fire equipment tests had been carried out. There were contingency plans to be followed in the event of emergencies and failures of services and equipment. People had personal emergency evacuation plans, which meant their specific support needs in the event of fire had been identified and planned for. Arrangements were in place for the safe storage of peoples records to promote confidentiality of information.

We reviewed how people were protected by the prevention and control of infection. We found the environment to be clean in the areas we looked at. Suitable equipment including, protective aprons, gloves and hand sanitizer was available. Records and discussion indicated staff had completed training on infection control. We were advised the provider was in the process of introducing a specific audit tool for monitoring and managing infection prevention and control.

Staff recruitment procedures protected people who used the service. We reviewed the recruitment records of two newest recruits. The process included candidates completing an application form and attending an interview. Character checks including, identification, references and qualifications and employment histories had been completed. A DBS (Disclosure and Barring Service) check had been carried out. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. All new employees completed a probationary period to monitor their work conduct and competence. The service had disciplinary procedures in place to manage unsafe and ineffective staff conduct.

We looked at how the service managed staffing levels and the deployment of staff to support people to stay safe and meet their needs. We looked at the staff rotas, which showed arrangements were in place to maintain consistent staffing levels. Although some people spoken with had concerns about staff turnover and the use of agency staff, they did not express any concerns about the availability of staff at the service. One healthcare professional said, "There have been some staff changes but there is a core team of staff for consistency." The manager said staffing levels were under review and explained that if agency staff were necessary, the same person was requested to promote continuity of support. At the time of our inspection the recruitment of permanent staff was ongoing.

Good

Is the service effective?

Our findings

We reviewed how people's needs and choices were assessed and their care and support delivered to achieve effective outcomes. There had not been any new people moving into Prospect House for a few years. However, the manager described the process of assessing people's needs and abilities before they used the service. This would involve the completion of a comprehensive 'support design plan' assessment tool. People would be encouraged to visit, this was to support the ongoing assessment process and provide people with opportunity to experience and become familiar with the service. Consideration would be given to the individual's compatibility with people already using the service.

Arrangements were in place to review people's changing needs and preferences on continuing to use the service. The manager described their role in sensitively supporting people in their transition to other services. This was carried out in consultation with other agencies, who were responsible for leading the process.

We looked at how consent to care and treatment was sought in line with legislation and guidance. During the inspection we observed staff engaging with people on their individual needs and lifestyle choices. One person commented, "I'm able to consent. They always ask me and I sign things to say I consent."

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions or authorisations to deprive a person of their liberty were being met. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Prior to the inspection we received mixed comments from stakeholders, around the service's processes for assessing people's capacity, supporting their rights and providing care in their best interests. When we reviewed these matters with the manager, it was apparent actions were being taken to progress specific circumstances in consultation with other professionals. We found processes were in place to assess and monitor people's capacity to make decisions. We saw the assessments were being reviewed and developed, to be more decision specific and be clearer on the support to be provided. Staff spoken with said how people made their wishes and preferences known and gave examples how they involved people in making decisions.

There was information to show appropriate action had been taken to apply for DoLS authorisations by local authorities in accordance with the MCA code of practice. There were applications which had been assessed and authorised by the relevant local authority. Policies and procedures were available to provide guidance and direction on meeting the requirements of the MCA. Staff spoken with said they had received training on

the MCA, they indicated an awareness of DoLS and the legal status of the interventions and agreements in place.

We looked at how people were supported to live healthier lives, had access to healthcare services and received ongoing healthcare support. People had the opportunity and support for physical exercise, including cycling, walking and swimming. Each person had an 'anticipatory health calendars' to promote the daily observation of their health and wellbeing and any changes. There were health passports which included past and present medical conditions. This information was shared with other professionals when people accessed healthcare services. Records were kept of healthcare appointments, the outcomes and any actions needed. The service had liaised with a number of health care professionals, including GPs, dentists, chiropodists' mental health professionals and speech and language therapists. One person told us, "If I need to see a GP we book an appointment. I have eye tests two yearly and visit the dentist three monthly."

We checked how people were supported to eat and drink enough to maintain a balanced diet. Comments from people included, "The food is okay" and "It's not spectacular, but its edible!" We saw that people had access to drinks and snacks throughout the day and we observed people making their own breakfasts. People's specific dietary needs and preferences were known and catered for. The menu was planned to include known favourites, offer choices and help provide a balanced diet. One person told us, "We have menus, they recently asked everyone for suggestions." Mealtimes were flexible in response to group and individual living patterns.

Staff had an awareness of nutrition and healthy eating. They described the support they provided people with in relation to food, diet, meal preparation and cooking. Records were kept of nutritional needs, likes and dislikes. People's general dietary intake was monitored and their weight was checked at regular intervals, to help monitor risks and support people with their diet and food intake.

We looked at how the service made sure that staff had the skills, knowledge and experience to deliver effective care and support. One person told us, "The staff here know what they are doing." A healthcare professional said, "They are very, very proactive. They are good to work with. I have found [name of staff] is brilliant." Staff spoken with confirmed they had completed an initial induction programme. This included two weeks of classroom learning and incorporated the Care Certificate training modules. The Care Certificate aims to equip health and social care workers with the knowledge and skills which they need to provide safe, compassionate care. Staff were also introduced to the framework – SPELL. This had been developed by the National Autistic Society (NAS) to understand and respond to the needs of people with autism. SPELL stands for Structure; Positive (approaches and expectations); Empathy, Low Arousal and Links (links with other health and social care agencies and families). The induction training also included 'shadowing' existing staff and there was a 'systems orientation' file for new starters, including agency staff, to work through.

There was a programme of mandatory refresher training. This included safeguarding vulnerable adults, safe handling of medicines, health and safety, food safety and first aid. Specialist training was provided to help staff positively respond to people's behaviours. We saw records confirming that learning and development needs had been identified, planned for and achieved. Any gaps were in training were monitored and managed. Staff at the service had either attained an NVQ (National Vocational Qualification) in care or equivalent, or were due to complete a QCF (Quality and Credit Framework) diploma in health and social care.

Staff spoken said they received one to one and group supervisions with a member of the management team. We saw records of the supervisions and noted plans were in place to schedule further meetings. Staff

also received an annual appraisal of their work performance; this included a self-evaluation of their skills, abilities and development needs.

We reviewed how people's individual needs were met by the adaptation, design and decoration of the premises. People had been supported to personalise their bedrooms and keep them as they preferred. "I can have my room how I want it," explained one person. The care planning process took into consideration each person's specific needs and preferences relating to their personal space, including their sensory needs, behaviours and lifestyle choices. There was a 'sensory room,' 'games room' 'cinema room' and a 'quiet room.' People had access to an enclosed garden with furniture and equipment for outdoor leisure activities. We noted improvements had been made in communal areas, including new furniture, furnishings, decoration and lighting. The rooms were decorated with subdued colours and there were soft furnishings, artwork and photographs. People had been involved with choosing new colour schemes and floorcovering. One person told us, "It feels more homely now."

Good

Is the service caring?

Our findings

We reviewed how the service ensured that people were treated with kindness, respect and compassion and that they were given emotional support when needed. Comments from people included, "The staff are fine," "I am happy with the staff" and "I like to talk to them." One healthcare professional commented, "Staff are respectful and considerate of the views of the residents." We observed positive and meaningful interactions between people using the service and staff. Staff showed sensitivity and tact when responding to people's emotional needs and behaviours. We saw that staff were respectful and kind, when supporting and encouraging people with their daily living activities and lifestyle choices.

The SPELL learning programme, had given staff the underpinning knowledge and skills around supporting people with consistency and in response to their specific needs, choices and routines. This and reflective staff supervision, aimed to embed staff knowledge and understanding of autism within their everyday working role.

People had support plans which identified their individual needs and preferences and how they wished to be supported. One person commented, "I'm working through my care plan with [the deputy manager] it's getting there." The information was written in a sensitive and person centred way. There were 'one page profiles' and 'life histories' which provided an overview of people's routines and expectations and how they wished to be supported. Included were important details on people's backgrounds, personal relationships, family contact, specific preferences, cultural heritage and spiritual needs. There was also in-depth information on how each person's autism influenced them. The information was very thorough and personalised; therefore an 'essential support' guide providing a concise overview was available for staff to access and refer to.

Staff spoken with knew people well and understood their role in providing people with person centred care and support. They were aware of people's individual needs, specific routines, preferences, backgrounds and personalities. They described how they provided support in response to people's needs preferences and behaviours. Staff had received equality and diversity training. Equality is about championing the human rights of individuals or groups of individuals, by embracing their specific protected characteristics and diversity related to accepting, respecting and valuing people's individual differences.

Records and discussion showed people were enabled to maintain meaningful relationships. They were actively supported to have contact their family and friends. Provider Information Return (PIR) told us the service was running a sexuality workshop with people, to help them communicate, understand and rationalise their sexuality or relationship needs.

There was a keyworker system to promote trusting and beneficial working relationships. The system linked people using the service to a named staff member who worked more closely with them, their families and others involved in their support. We received some comments around a lack of consistent keyworker support. We discussed this with the manager, who agreed to review the arrangements in place. We also noted that PIR identified the provision of consistent keyworker teams as an area for improvement. There

were daily 'shift planners' which identified which staff member was working with each person, to help support preferred routines and continuity of support. Consideration was given to the desired characteristics of staff people needed to provide their support. One person said, "They know I am most happy with staff who enjoy computer games."

We reviewed how the service enabled people to be independent and be actively involved in making decisions about their care and support. People were enabled to develop independence skills, by accessing the community resources and doing things for themselves and others. One person told us, "I'm quite independent. I do some cooking. I get my own food and make things." Staff gave us practical examples of how they supported and promoted people's individual life skills, independence and choices. We discussed some specific circumstances with the manager and staff around the delivery of care and support for individuals. We noted examples where people had been enabled to do things for themselves and make their own decisions and choices. It was apparent supporting this approach could be complex. One healthcare professional explained, "Staff are continually having to manage providing support that is person centred and promotes independence, alongside managing complex risks and using restrictive practices appropriately. I have noticed it can be challenging for staff to balance an individual's need for choice against their duty of care to ensure their basic needs are being met."

We looked at how people's privacy was respected and promoted. People had free movement within the service's communal areas and the rear garden; they could choose where to spend their time. All the bedrooms were single occupancy and had en-suite bathrooms. This promoted privacy of individual space and dignified support with personal care. People could spend time in their rooms whenever they chose. Bedroom doors were fitted with suitable locks to promote privacy of private space and people had keys to their rooms. We observed examples where staff respected people's private space and ensured confidentiality of verbal discussions. Staff described practical examples of how they upheld people's privacy. One staff member said, "We always knock and wait for a reply before entering rooms."

There were notice boards at the service which provided information for people and their relatives. Included were previous inspection reports, fire procedures, forthcoming events, and details of local advocacy services. Advocates are independent from the service and can provide people with support to enable them to make informed decisions. There was a display board with staff photographs so people knew who would be on duty to support them. The provider had an internet website which provided information about the service.

Requires Improvement

Is the service responsive?

Our findings

We reviewed how people's concerns and complaints were listened and responded to and used to improve the quality of care. One person we spoke with confirmed their awareness of the complaints procedures and described how they had previously raised concerns which had been effectively resolved. They said, "Any issues can be sorted."

At the time of the inspection the complaints procedure for people who used the service was under review and therefore was not on display. The procedure had been produced in different formats, to help make it accessible to people. There were complaints forms available for people using the service to use. The service had a policy providing guidance on managing complaints; this referred to proactively supporting people who used the service to make their views known. Staff spoken with expressed an understanding of their role in supporting people to make complaints and described how they would respond should anyone raise concerns.

We looked at the complaints records which provided a good indication that people were confident in raising concerns and voicing their opinions. We noted specific examples where the response to complaints and concerns had resulted in improved practice. However, we found there was a lack of clarity in some of the records to show the action taken to investigate the concerns and resolve matters. We noted the provider's complaints recording systems had not been used and the manager was not fully aware of the processes in place. We reviewed the progress of some of the complaints with the manager, we were satisfied appropriate action had been take or was progressing, in response to the concerns raised. Following the inspection, we received confirmation that action had been taken to ensure the complaints processes were robust and fit for purpose. We will check the progress made to make improvements at our next inspection.

We looked at how people received personalised care that was responsive to their needs. We discussed with the manager and staff, examples of the progress people had made, resulting from the service being responsive and developing ways of working with them.

We received mixed views from stakeholders on the provision of support individual people were experiencing at Prospect House. Their comments included, "They provide individualised care [name of person]'s quality of life has certainly improved," "They have managed to bring about a significant reduction in challenging behaviour for this person" and "I feel the service has responded positively to psychological consultation." We also received views from stakeholders which suggested people's needs and preferences were not always successfully responded to. We reviewed some specific circumstances with the manager and staff. We found processes were ongoing, to monitor, review and respond to people's individual circumstances in consultation with them and other stakeholders.

People had individual care and support plans, which had been developed in response to their needs and preferences. There was evidence to confirm people had been consulted on the content of their care plans and ongoing reviews. One person said, "We have been reviewing and updating some information in my care plan." A health care professional told us, "We have reviewed the care plans, they are up to date."

The care and support plans and other related records we reviewed, included people's needs and choices. The plans contained person centred details on how people's care and support was to be provided. This information identified people's needs and provided in-depth and detailed guidance for staff on how to respond to them. The care plans were written in a person centred way and included pictures and symbols to help make them more understandable to the person. There were 'essential support' care plan summaries, providing more accessible information for the staff team.

People's support needs, lifestyles and circumstances were regularly monitored. We observed a 'hand over' discussion meetings between staff to communicate and share relevant information. Records were kept of people's daily living activities, their general well-being and the care and support provided to them. There were also additional monitoring records as appropriate, for example relating to behaviours and other identified needs. These processes were to enable staff to monitor and respond to any changes in a person's needs and well-being. A social worker commented, "The service has good communication between staff. Information discussed during MDT (multi disciplinary team) meetings and review meetings, is always fed through to the frontline support staff, ensuring positive and effective support provision."

We saw people accessing the community and taking part in activities during our visit. One person told us, they had a part time job working in a café. Their skills had also been proactively utilised in the house. They told us "I recently did a floor plan for the premises." Staff described the range of meaningful activities on offer, to support people in experiencing new ventures, developing skills and confidence building. The activities included, swimming, walks out, cinema, meals out, cycling, shopping, computer games, DVDs and visits to places of interest. We saw agreed activity planners which confirmed each person had a varied programme of daily activities. Each activity had a learning objective to focus upon the person's individual life-skill development and recognise their achievement. There was an album of photographs, to provide a reference journal of people's experiences with individual and group activities.

We checked if the provider was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. We found personalised methods were used to communicate and engage with people, using ways which were best suited to their individual preferences and abilities. This included the use of pictures and computer tablets. There were individual 'communication profiles' and 'sensory profiles' with support plans to highlight people's ways of sharing their feelings, needs and preferences.

The service did not usually provide end of life care. However, we discussed with the manager ways of sensitively planning for people's needs and preferences, also the processes in place to support people who may experience family bereavement.

Good

Is the service well-led?

Our findings

We reviewed how the service's management and leadership processes achieved good outcomes for people. At our last inspection we received comments from people who used the service, which implied changes in the management team had resulted in some instability and this had an impact on how Prospect House was run. At this inspection we found improvements had been made and were ongoing. Comments from people who use the service included, "The managers are on the floor a lot more" and "Things have got better."

Since our last inspection there had been some developments in the management team. There was a new manager in post, who had applied for registration with the Commission and there was a new deputy manager. Throughout the inspection the manager expressed a commitment to the ongoing developments at the service and demonstrated a proactive response to the inspection process. There had also been changes in senior management arrangements. Furthermore, the NAS had introduced a quality manager role to lead on governance and auditing processes.

At our last inspection there was some discontentment and low morale amongst the staff team. During this inspection all the staff spoken with told us the service had progressed and that staff morale was improving. Their comments included, "It's a much better place now, staff have got their heads up higher," "The manager has given us confidence, individually and as a team," "We now work in teams, which is helping the situation" and "Things have been put in place to make things more organised." During a hand over meeting, we observed positive and friendly interactions amongst the staff team.

One healthcare professional wrote, "My experience of working with the management team at Prospect House has been very positive; they have welcomed my support and facilitated access to information, meetings, arranged staff sessions and invited me to attend handover and key worker meetings……They have a focus on improving the service for residents and staff supporting them. They are open to ideas and different ways of thinking."

We reviewed how the service promoted a clear vison and approach, to deliver high-quality care and support. Prospect House is registered to provide care and accommodation for up to seven adults with autism. This meant the service did not comply with the principles of the CQC policy 'Registering the Right Support' in respect of accommodating no more than six people. However, we found the service had been developed and designed in line with the values that underpin 'Registering the Right Support' and other best practice guidance. These values include choice, promotion of independence and inclusion, with the aim that people with autism using the service can live as ordinary a life as any citizen.

Staff expressed a good working knowledge of their role and responsibilities. They had been provided with job descriptions, contracts of employment which outlined their roles, responsibilities and duty of care. They had access to the service's policies, procedures and any updates. The service's vision and mission statement was on display and was reflected in the service's written material. There were regular staff meetings We reviewed records of the most recent staff meetings and noted various work practice topics had been raised and discussed. One member of staff told us, "We have weekly team meetings. I feel comfortable speaking

up, sharing ideas and making suggestions."

There were systems in place to monitor the quality of the service, included various daily, weekly and monthly checks. The NAS had a quality monitoring audit tool kit. This was to monitor and achieve adherence to the regulations. Quality monitoring visits were carried out by the quality manager. Reports following visits included any recommendations and follows up on previous reports. We received a copy of the last visit report which showed some matters had been identified for improvement; these were to be monitored for progress within a time specific action plan. The manager had also completed a 'self audit' this had resulted in a realistic plan of action to develop the service.

We looked at how people who used the service, staff and others were consulted on their experiences and shaping future developments. People were actively encouraged to share their views and opinions on a day to day basis and during their reviews. They had recently been supported to complete feed-back forms on their experience of the service and their response were to be collated. A consultation 'inclusion event' was also being planned. These were informal gatherings in various settings, to enable people to share their views and experiences on the service and make suggestions for improvements. A 'suggestion box' had been provided, which gave people an ongoing opportunity to make comments and put forward ideas.

Relatives and other stakeholders had also been contacted for feedback on the service. The manager described the action taken to develop telephone interviews and e-mail questionnaires. We saw evidence of this process in practice. Plans were in place to evaluate all the survey responses, share the outcomes and identify plans for development.

Staff had opportunity to share their views annually via a national computer based staff survey within the NAS organisation. We had sight of the results survey carried out in within the provider's services in the North. There were action plans to respond to the issues staff had raised. An online 'whistle blowing' portal was available for staff to access.

There were strategic development plans available to provide direction and oversight of the service and the wider organisation.There were development plans for Prospect House which were directed by CQC's framework to ensure services are safe, effective, caring, responsive and well-lead. Information within the Provider Information Return (PIR) showed us the manager had identified several matters for development within the next 12 months.

Prospect House along with the other NAS services in the region had achieved Autism Accreditation status in February 2017. Autism Accreditation is an internationally-recognised process of support and development for all those providing services to autistic people.

There were procedures in place for reporting any adverse events to the CQC and other organisations, such as the local authority safeguarding and deprivation of liberty teams. Our records showed that notifications had been appropriately submitted to the CQC. We noted the service's CQC rating and the previous inspection report were on display at the service; the rating was also displayed on the provider's internet website. This was to inform people of the outcome of the last inspection.