The Disabilities Trust

Ernest Kleinwort Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 5 and 6 October 2016 and was unannounced.

Earnest Kleinwort Court belongs to a national charity that provides care, rehabilitation and support for people with profound physical impairments, acquired brain injury and learning disabilities, as well as children and adults with autism. Earnest Kleinwort Court provides accommodation for up to 35 people, who require support with their personal care. The service specialises in supporting younger adults with physical disabilities. On the days of the inspection there were 31 people living at the service, the majority of who were wheelchair users who also had other complex needs, such as learning disabilities, autistic spectrum conditions and communication difficulties. Two people also had a mental health diagnosis.

The accommodation was purpose built and comprised of a main building which contained 21 rooms and six bedsits, plus a further three bungalows within the grounds, all of which had ensuite facilities. There was a communal dining and social area in the main building and a dedicated activities room in a separate building. The service is based in Burgess Hill, West Sussex.

We carried out an unannounced comprehensive inspection on 14 and 19 January 2016. Breaches of legal requirements were found and following the inspection the provider wrote to us to say what they would do in relation to the concerns. These included the management of medicines, the assessment of risk, safeguarding people from abuse, staffing levels and access to staff training and development. Further concerns related to care plans that did not accurately reflect people's needs and those which contained out-of-date information. People, who were unable to take part in meetings, were not always asked their preferences with regard to the activities that were provided. There was also a lack of oversight of the service to enable the provider to ensure the quality of service being provided. At this inspection on 5 and 6 October 2016 we found that significant improvements had been made and the provider was no longer in breach of regulations. However, although systems to improve staff's access to training and development and oversight of the service had improved, we were yet to see these sustained and embedded in practice.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The last registered manager stopped working at the service at the end of October 2015. A new manager was recruited in December 2015, but left the service in June 2016. The service was then managed by a registered manager from one of the provider's other services until the end of September 2016. Following this, another of the provider's registered managers, a deputy manager and an assistant manager had been seconded to manage the service for three months. They were supported by two permanent assistant managers, an administrator and team leaders and there were plans in place for a new manager to be recruited. It was evident that the changes in management over the last year had been disruptive for people who lived at the service as well as staff that worked there. However, everyone spoke positively about the leadership over recent months and felt things

had changed for the better. Comments from staff included, "Everything is good, in general they are all on the ball" and "Management are amazing now. They are looking out for the residents and putting things in place to keep the residents safe and happy. We used to be left to do everything, but they've come in and made this place much better."

Staff had access to the training which the provider considered essential, as well as training that was specific to the needs of people they were supporting. The manager had identified that some staff had not yet completed all of the training. Provisions had been made to ensure staff were provided with support and guidance whilst they waited for their training to be completed, 'ten minute teaching sessions' had been implemented during staff handover meetings to ensure that staff were updated on current good practice in relation to their roles. A visiting healthcare professional, who had been invited to attend one of the sessions, told us, "They really made me feel included. The staff really seemed to take on board what I told them. I think it gave them more confidence to follow the guidance".

Mechanisms were in place to assure the quality of the service being provided. Quality assurance systems as well as regular audits were conducted to enable the manager to have an oversight of the service to identify areas that required development. There were systems in place to enable people to raise concerns and complaints and those that had been received had been dealt with in accordance to the provider's policy.

People told us that they felt safe, one person told us, "The staff help me stay safe. I haven't had a fall or anything like that. I trust them to look after me properly". Another person told us, "I've always felt safe, secure and comfortable here". People were protected from harm and abuse. There were sufficient quantities of appropriately skilled and experienced staff who had undertaken the necessary training to enable them to recognise concerns and respond appropriately. When safeguarding concerns had been recognised the appropriate action had been taken to ensure peoples' safety. People's freedom was not unnecessarily restricted and they were able to take risks in accordance with risk assessments that had been devised and implemented. People received their medicines on time and according to their preferences, from staff with the necessary training and who had their competence assessed. There were safe systems in place for the storage, administration and disposal of medicines.

People were asked for their consent before being supported and staff had a good awareness of legislative requirements with regard to making decisions on behalf of people who lacked capacity. One staff member told us, "We always assume people can make decisions for themselves". One person told us "They don't restrict me, which is great. I can do whatever I want". People and their relatives', if appropriate, were fully involved in the planning, review and delivery of care and were able to make their wishes and preferences known. Care plans documented peoples' needs and wishes in relation to their social, emotional and health needs and these were reviewed and updated regularly to ensure that they were current.

Staff worked in accordance with peoples' wishes and people were treated with respect and dignity. It was apparent that staff knew peoples' needs and preferences, as well as their interests and hobbies, and were able to support people to access and enjoy these. Positive relationships had developed between people and staff. One staff member commented, "It's a jolly place to work and spending time with people is what it's all about". One person told us, "The staff are good. I get on well with my key worker".

Peoples' health needs were assessed and met and they had access to medicines and healthcare professionals when required. Healthcare professionals explained that if people were unwell then healthcare professionals were contacted promptly. People's privacy and dignity was respected and maintained, one person told us, "They leave me alone when I want to be left, like this morning". Another person told us "They never come into my room without knocking, it may seem minor but it means a lot to me and they will always

ask my permission to go into my room if I'm not in. Staff always keep very good manners, a simple please and thank you is always followed". People had a positive dining experience and told us that they were happy with the quantity, quality and choice of food. One person told us, "I love the food. It's brilliant". Another person said, "The chef is a genius. The food is so good and there is a lot of choice".

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.

Safeguarding concerns had been recognised and reported when suspected abuse had occurred.

Robust arrangements were in place for the management, storage and administration of medicines.

People were supported by sufficient numbers of suitably qualified and experienced staff. Risks to peoples' health and safety were assessed and managed effectively without restricting their freedom.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported by a majority of staff who had the skills, knowledge and experience to support them effectively. Although the provider had made improvements with regard to staff's access to training and development, this was yet to be fully embedded into practice.

Staff were aware of the requirements under the Mental Capacity Act (MCA) 2005 and responsibilities with regard to Deprivation of Liberty Safeguards
(DoLS).

People were provided with a nutritious and varied diet that met their individual needs and preferences. People were supported to access health care support when needed.

Is the service caring?

Good

The service was caring.

People were supported to be independent by kind and caring staff.

People were treated with dignity and respect and were involved in their care.

People were supported to live the lifestyle of their choice and visiting was not restricted.

Is the service responsive?

Good

The service was responsive.

Staff were knowledgeable about peoples' support needs, interests and preferences and supported them to participate in activities that they enjoyed.

There were systems in place to respond to complaints and those that had been received had been dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Although the provider had made improvements with regard to the quality assurance processes to enable them to have oversight of the service and ensure the delivery of high quality care, this was yet to be fully embedded into practice.

People and staff were positive about the management and culture of the home. They felt they were treated as individuals and their opinions and wishes were taken into consideration in relation to the running of the service.

Ernest Kleinwort Court

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 5 and 6 October 2016 and was unannounced. On the first day of our inspection there were two inspectors and a pharmacy inspector. On the second day of the inspection there were three inspectors. The service was last inspected on 14 and 19 January 2016 where we found the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns in relation to the management of medicines, the assessment of risk, safeguarding people from abuse, staffing levels and training. Further concerns related to care plans that did not reflect peoples' current needs, people not always being asked their preferences with regard to the provision of activities and the lack of oversight and quality assurance processes for the service. The service received an overall rating of 'Requires Improvement' and after our inspection the provider wrote to us to say what they would do to meet the legal requirements in relation to these breaches.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. During our inspection we spoke with 14 people who used the service, the manager, the head of quality assurance, the deputy manager, three assistant managers, the administration assistant, an activity organiser, the maintenance person, the chef and kitchen assistants, seven members of the care staff team, two visiting health care professionals and two visiting social care professionals. We looked at seven people's care plans and medication records, the staff duty rota, five staff recruitment files, meeting minutes, the complaints log, accident and incident records, an overview of training that staff had completed and an overview of the supervisions and annual appraisals that had taken place. We also looked at some of the provider's own quality assurance audits and the results of the provider's customer satisfaction survey.

Good

Is the service safe?

Our findings

At the previous inspection on 14 and 19 January 2016 we found that people were at risk of receiving unsafe care. The provider was in breach of Regulations 12, 13 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns found with regard to the management of medicines and the assessment of risk, safeguarding people from abuse and staffing levels. After the inspection, the provider informed us of what they would do to meet the legal requirements in relation to these regulations. At this inspection we found that improvements had been made, sustained and embedded in practice and that the provider was no longer in breach of the regulations.

At the previous inspection we found that staff had not always recognised or acted on suspected abuse when it had occurred and not all staff had received up to date training on what constituted abuse. At this inspection all staff had received up to date training with regard to safeguarding adults at risk and staff were able to describe to us the different types of abuse and the actions they would take if they suspected abuse had taken place. Records showed that following our inspection there had been an increase in the amount of referrals to the local authority safeguarding team, as well as notifications submitted to CQC, in relation to instances of suspected abuse. Management and staff explained that this was due to staff having an increased awareness of what constituted abuse and of the reporting procedures they needed to follow. One staff member told us, "I do feel that the understanding of safeguarding has improved. We have significantly more safeguarding, but that's because we're reporting in properly". Records showed that appropriate action had been taken to safeguard people from abuse. For example, where allegations of abuse had involved a member of staff, disciplinary action had been taken and where the allegations had involved agency staff the agency had been informed and the staff had not worked at the service again. The provider had taken appropriate steps to respond to concerns raised by staff in relation to poor practice. Staff told us and records confirmed that when staff had witnessed or suspected any poor practice, they had reported this to their manager and completed the relevant documentation. As a result and where necessary safeguarding referrals to the local authority had then been made.

At the previous inspection medicines were not managed safely. This was because the medication administration records (MAR) had not been completed accurately, some medicines were out of date and there were no specific guidelines as to the administration of 'as and when needed' medicines. In addition to this, some medicines that needed to be returned to the pharmacy for disposal were not stored securely until their collection. Following the inspection the provider wrote to us to tell us they had taken immediate action to address these issues. This included arranging for an external pharmacist to undertake a medicines audit and with immediate effect, two members of staff who were trained to do so would administer medicines. At this inspection the provider had followed their action plan, the issues had been addressed and the improvements had been sustained.

There were safe systems in place for the administration and management of medicines. Staff ordered prescriptions according to what was needed. Most peoples' medicines were supplied in 28 day monitored dosage system blister packs (MDS) and printed medicines administration record charts (MARs) were provided. Medicines were stored in locked cabinets in peoples' rooms, the keys for which were held by the

team leader. There were no expired medicines stored in people's rooms and no medicines required refrigeration. Administration of some medicines were witnessed and counter-signed by a second member of staff in line with legal requirements. People leaving the home to attend activities took their medicines with them in the blister pack; this made it easy for staff to see if the medicines had been taken when people returned to the service. An example, further confirming the safe systems for medicine administration, was given for two people whose places of work had additional MAR charts that were signed when the medicines were taken; these were then returned to the service at the end of the month for monitoring. Staff signed MARs when medicines were administered and there were no missed doses. There was evidence in the care plans that topical creams had been applied and to which area(s) of the body. Medicines errors and near misses (near misses are errors that are identified before the medicine reaches the person) were reported by staff and action had been taken to reduce the risk of re-occurrence. Medicines no longer required or those that had expired were stored separately and returned to the pharmacy for destruction. There were protocols in place for staff to follow when administering medicines that were prescribed to be taken on an 'as and when needed' basis. A comprehensive medicines policy detailed all processes for managing medicines. Administration of medicines was carried out by staff who had received training and whose competencies had been checked.

At the previous inspection we found that risks to people had not always been assessed and managed effectively. At this inspection we found risks to people's safety had been assessed and planned for. Each person's care plan was supported by risk assessments which detailed the extent of the risk, when the risk might occur, and how to minimise the risk. For example, pressure risk assessments had been completed to identify people at risk of developing pressure wounds. This assessment took account of risk factors such as nutrition, age, mobility, illness, loss of sensation and cognitive impairment. Additional risk assessments were added was needed, such as the risk of choking and risks associated with people who needed assistance to move and position. These allowed staff to assess the risks and then plan how to manage the risk. One person told us, "The staff help me stay safe. I haven't had a fall or anything like that. I trust them to look after me properly". Another person told us "I've always felt safe, secure and comfortable here".

People's freedom was not unnecessarily restricted. Equipment, to ensure people's safety and enable them to move independently was made available to them and was safe to use. People who needed assistance to move were supported to the dining room at lunch time and provided with the equipment they needed to eat and drink safely and independently. Lifting equipment and wheelchairs were checked regularly to ensure they were functioning correctly and there was a 'charging' room where wheelchairs and other equipment could be charged overnight so they were available for people to use when they needed them. The provider ensured people were supported to take positive risks that enhanced their quality of life, for example, some people were supported to go sailing. Risk assessments had been completed which clearly identified the risks associated with this activity, however, the peoples' enjoyment of the activity had also been considered as had the fact that people fully understood the risks associated with it. One person told us, "I can do what I like here. I always feel safe".

At the previous inspection we found appropriate steps had not been taken to ensure that, at all times, there were sufficient numbers of skilled and experienced staff deployed to meet people's needs and assure their safety. At that time the service had frequently operated with less staff than the provider had assessed was required to safely meet people's needs. In addition to this, staff absences and vacancies had not always been covered and staff that were on duty did not always have the skills they needed to meet the needs of the people they were allocated to support. At this inspection we found that this issue had been resolved.

There were sufficient numbers of staff deployed at all times to meet peoples' assessed needs. Following the last inspection the provider took immediate action to increase the staffing levels at the service and

commissioned the services of more agencies so that they were able to cover staff vacancies and sick leave. A dependency tool had been used to calculate people's dependency levels which had been analysed to establish the number of staff needed on each shift. A member of the management team told us, "I went and observed the shifts based on the analysis to recognise the busy points. I recognised that certain times were busier than others, for example, Sunday morning when people want to go to church. We identified points throughout the day and engaged with staff to get feedback around staffing numbers". Management told us they used regular agency staff to cover shifts to ensure consistency. Records and staff confirmed this. Comments from staff included, "We ask for specific agency staff now, for continuity and their skills", "We finally have a steady staff team, and our agency staff we use, I can't fault them" and "I think it has improved a lot since the last inspection. The staffing is much better. We are working at a comfortable number".

People were supported by staff that had the skills to support them. Staff told us that some people displayed behaviour which challenged, including being verbally and physically aggressive towards other people. Staff that had the skills and experience to support these people were pre-allocated to work with them, and, where possible people's preferences with regard to who they wanted to receive support from was accommodated. One staff member told us, "We have enough staff to deliver safe care. We have people on one to one and two to one care and that is being met".

There was a senior member of staff on duty and a member of the senior management team on call at all times. People, staff and visiting healthcare professionals told us that they felt there were enough staff to meet people's needs. Domestic staff were also employed to undertake cleaning and food preparation. Other staff were employed to complete the gardening and maintain the building and office staff were employed to complete administration tasks. This meant that staff that were employed to support people did not have to engage in these other tasks and were allocated to solely support people and meet their needs.

The provider had taken steps to ensure that the environment and equipment within the service was safe. A personal evacuation plan was in place for each person in case of an emergency. This provided staff and the emergency service personnel with guidance as to how to safely and effectively support people to evacuate the building in the case of an emergency. Safety checks and regular servicing of the equipment within the service had been completed. There was a secure door entry system in place to ensure unauthorised people did not gain entry to the service. Accident and incidents had been recorded and an analysis had taken place to help identify any emerging themes or trends.

The provider followed safe recruitment practices and relevant pre-employment checks. These included criminal records checks, proof of staff's identity and their right to work in the United Kingdom. References from their previous employers had also been obtained prior to starting work at the service. Appropriate checks had also been undertaken for staff that were working through other agencies. These included identity and security checks as well as ensuring that they had received appropriate training to undertake their role effectively and safely. A member of the management team told us, "We use regular agency staff and we look to take them on, on a permanent basis, if they are working well."

Requires Improvement

Is the service effective?

Our findings

At the previous inspection on 14 and 19 January 2016 we found that people were not consistently receiving effective care. The provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns with regard to staffs' access to training to enable them to fulfil their role and meet peoples' needs. After the inspection, the provider informed us of what they would do to meet the legal requirements in relation to these regulations. At this inspection we found that improvements had been made and the provider was no longer in breach of the regulation. However, we found that these improvements needed to be sustained and embedded into day to day practice.

People were supported by staff that had access to a range of training to enable them to develop their skills and knowledge to meet peoples' needs and staff told us that the training they received was effective. The majority of staff had either completed, or were in the process of undertaking, training which the provider considered essential. In addition to this, training, to meet peoples' specific needs such as catheter care, epilepsy and supporting people who displayed behaviours that challenged, had also been undertaken. One member of staff told us, "We had de-escalation and intervention training". They explained this had provided them with the skills they needed to provide appropriate support to people who displayed behaviour such as physical aggression towards others. People told us that they felt the staff were skilled and provided them with the support they needed. One person told us, "I need some help to get in and out of bed. They know what to do".

However, the manager explained that they had identified that some staff had not yet completed all of the training the provider considered to be essential and some of the training certificates for some staff were not current. They told us that there were plans in place for these gaps to be addressed and training had been booked. However, in the meantime 'ten minute teaching sessions' had been introduced during staff handover meetings to update staff on current good practice in relation to a wide range of subjects relevant to their role. Staff confirmed this and told us that they found the teaching sessions useful and informative. A visiting healthcare professional told us that they had been invited to attend one of the teaching sessions to provide staff with additional information and specific guidance on how to support some individuals. They told us, "They really made me feel included. The staff really seemed to take on board what I told them. I think it gave them more confidence to follow the guidance".

Newly recruited and agency staff were supported to complete an induction programme before working on their own. One new staff member told us, "Definitely the induction was good and useful. It was about three weeks and included shadowing, observations and training". An agency worker told us "I had an induction. It was useful and showed me how to evacuate the residents from the building, plus information about them. They won't place us agency staff with any residents without an induction and won't let us work with any residents that we haven't worked with before". Newly recruited staff were also required to complete the care certificate. The care certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It is designed to give confidence that workers have the skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

The provider had systems in place for staff to receive one to one supervision meetings with their manager, during which they could privately discuss their personal and professional development. Staff also had an annual appraisal of their performance. One staff member told us, "I get one to one supervision". Another staff member told us, "I have no problem with training and supervisions". The manager told us that although all staff had received some supervision sessions, the majority of staff had not received supervision as regularly as the providers' policies and procedures specified and this was an area of practice that they had identified they need to improve upon. Despite this, staff told us that they felt supported by management and could approach them for advice and guidance or to request training at any time. One staff member told us, "I've not had too many written supervisions, but it doesn't worry me. I'm supported and can approach my supervisor any time. It's not an issue for me". Another staff member told us, "I couldn't ask for a better management team, they are a shoulder of support and the manager is excellent. They listen and get things done". Another told us "The managers are very good and approachable. We've done lots of work around PDR's (Personal Development Reviews)".

People liked the food on offer and were able to make choices about what they had to eat. They were very complementary about the standard and variety of food provided. One person told us, "I love the food. It's brilliant". Another person said, "The chef is a genius. The food is so good and there is a lot of choice". Staff provided people with the support they needed to eat and drink during meal times and to have access to drinks throughout the day. Specialist equipment such as plate guards and beakers with a drinking spout were provided for people that needed them. Peoples' dietary needs and preferences were documented and known by the chef, kitchen and care staff.

People were referred appropriately to the dietician and speech and language therapists if staff had concerns about their wellbeing. People's nutritional needs had been assessed and relevant support had been sought for people who required specialist diets, such as soft food, for people who had swallowing difficulties. One person, who had been identified as at risk of malnutrition, had a food and fluid chart in place to enable the provider to monitor their food and fluid intake. This had enabled them to assess that although the person's food and fluids had not increased, the person was gaining weight and so a referral had been made to the relevant healthcare professional.

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

The manager demonstrated a firm understanding of the MCA and told us that an application to deprive one person of their liberty, in specific circumstances, had been submitted to the local authority and had been authorised. Staff had undertaken recent training in this area and had a good understanding of the implications of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. Records confirmed that mental capacity assessments had been undertaken appropriately, such as peoples' understanding of the reason they needed to take medicines.

Staff told us and our observations confirmed that they gained consent from people before supporting them

and delivering care. We were told the principle of assuming people had capacity to make their own decisions was followed. Staff told us that everyone was able to make their own day to day decisions and that if they were not able to make a decision, for example, whether to receive medical treatment, then their family members and the person's social worker would be consulted. One staff member told us, "We always assume people can make decisions for themselves". One person told us "They don't restrict me, which is great. I can do whatever I want". Consent had also been sought and obtained from people, and where appropriate their relatives or representatives, in areas such as information sharing and photography for identification purposes.

People's health care needs were met. People told us they were supported to see healthcare professionals when needed. Staff handover sheets and daily records documented when health care support had been requested and details of the outcome of visits from healthcare professionals such as their GP, physiotherapist or district nurse had been recorded. Two visiting healthcare professionals both commented that they felt that peoples' health care needs were being met and that they were contacted when needed.

Good

Is the service caring?

Our findings

People were supported by kind and caring staff that knew them well and had a good understanding of their needs. Staff demonstrated an understanding of the preferences and personalities of the people they supported and with whom caring relationships had been developed. One person told us "The staff are good. I get on well with my key worker". A staff member commented, "It's a jolly place to work and spending time with people is what it's all about".

Staff took care to maintain and promote peoples' well-being and happiness, for instance, staff had taken steps to ensure one person who could not take food and drink orally, still derived pleasure from eating. Although they were unable to take large items of food, staff had given very small amounts as 'tastes for pleasure'. Staff made time to talk to people, asking how they were and sharing jokes and anecdotes with them. It was evident that staff knew people and people were happy to approach staff if they had concerns or worries. One person told us, "There's always someone to talk to if I want". Another person told us that one person used to become anxious every week before the fire alarm test because they were "terrified by the sound of the fire alarm bell". They explained how they'd shared this with management and told us, "They now make sure the person is out of the building whenever they do a test".

There were mechanisms in place to involve people in their care, such as meetings and care plan reviews. People were provided with information in a format that was meaningful to them. For example, posters informing people of the activities on offer were illustrated with pictures and symbols to aid their understanding. Staff understood peoples' communication needs and styles and were able to communicate with people effectively. We observed that staff communicated with people in a warm, friendly and sensitive manner that took into account their needs and understanding. For example, by using short sentences or using Makaton. Makaton is a form of sign language used by people with a learning difficulty. Staff had taken steps to implement a social story for one person with autism to help them understand the concept of death and prepare them for the eventuality of their pet dying. Social stories are short descriptions of a particular situation, event or activity, which include specific information about what to expect in a situation and why.

Peoples' privacy and dignity were respected and promoted. We saw that 'Please do not disturb signs' were displayed on people's bedroom doors when personal care was being delivered. Some people had other signs to hang on their doors as they wished, for example, one person's sign stated 'If my door is shut please will you open it' and another person's stated 'Please keep out!'. Staff demonstrated that they had a good understanding of the importance of maintaining people's dignity and treating people with respect. We observed they took care to ensure doors were closed when they were delivering personal care to people as well as when we were speaking with them about people's care needs. Staff knocked on peoples' doors and waited for a response before entering. One person told us, "They leave me alone when I want to be left, like this morning". Another person told us "They never come into my room without knocking, it may seem minor but it means a lot to me and they will always ask my permission to go into my room if I'm not in. Staff always keep very good manners, a simple please and thank you is always followed".

People received appropriate emotional support to meet their needs. Observations showed one person had

become distressed. The staff member allocated to work with them, immediately intervened, offering them reassurance. The person reacted positively to the staff member's intervention and within five minutes was observed to be calm and relaxed and socialising with others. We observed another person who was visibly upset, seek comfort from staff. Staff showed concern and listened to the person whilst reassuring them about their worries.

People were supported to remain independent. Some people had facilities in their accommodation for making their own hot drinks and snacks and others had their own kitchens in which they could prepare their own meals. The service was fully adapted for people who used wheelchairs. For example, door handles and work tops were at an appropriate level so that they were accessible for people and they did not need support from staff to use them. We observed people being supported to gain food preparation and cooking skills in the service's training kitchen. People told us that they had been fully involved in choosing the food they were preparing. One person, who was mixing ingredients, told us, "I like cracking the eggs" and "I've done it all by myself". People were supported to find employment and to arrange transport so they could travel independently to and from work and social events. One person told us, "It's great here. I've got so much more freedom than I had at the place before, I can do what I like here".

People were supported to maintain relationships with people that mattered to them. One person's partner often visited at weekends and stayed overnight. Another couple lived in a bungalow together and other people told us that they were visited by their family and that staff supported them to go to social clubs where they could meet up with friends. One person told us that their relative visited them every weekend and commented, "They always have lunch with me and they have commented on how caring the staff are". Each person had their own room, flat or bungalow, which had been personalised with their belongings and memorabilia. One person's room reflected their love of a particular sports team and memorabilia was displayed. Other people had pictures of their friends and family and of themselves on holiday, on display.

Good

Is the service responsive?

Our findings

At the previous inspection on 14 and 19 January 2016 we found that staff had a good understanding of peoples' care and support needs. However, some care plans contained out of date information and did not accurately reflect peoples' current needs. We also found that people, who were unable to attend meetings, were not always asked their preferences in relation to the activities they wanted to participate in. Whilst these issues did not cause harm to people, we identified these as areas of practice that needed to improve. At this inspection improvements had been made. Care plans contained updated guidance for staff to follow in relation to supporting people in key areas of their care such as moving and handling and pressure area as well as their involvement in expressing their preferences when planning activities.

Peoples' needs had been assessed and planned for. Care plans provided specific guidance for staff to follow when supporting people with their individual needs, for example, they included step-by-step guidance of how to support a person with their morning routine and to transfer from their bed to their wheelchair. Additional information, such as the nature of the person's disability, their likes, dislikes and strengths were also included. It was evident from the information in peoples' care plans that individuals, and where appropriate, their family members and social workers, had been consulted when peoples' care had been reviewed. People confirmed that they had been involved in their care plan reviews. One person told us, "We sat down and chatted before the meeting about it and during it my aspirations and goals were noted. I am listened to and I have a voice".

People received care and support that was responsive to their needs. People could get up and go to bed at the times they wanted. One person told us, "Things are done to 'my' timetable not theirs. There's nothing regimented about this place and if I have a request, for example, if I want to get up early in the morning, they will accommodate my request". Another person told us, "I normally buzz when I'm ready to get up and they come across to help me. We agree the night before now what time I want them to come". Staff told us that when required they also worked flexible hours to accommodate peoples' preferences, for example, to attend social and sporting events.

At the last inspection we identified that there were no systems in place to gain the views of peoples' preferences in relation to the provision of activities. At this inspection we found that this had been addressed. The provider employed two activity organisers who held group and one to one meetings with people to ask them what activities they liked and which ones they wanted to partake in, as well as what guest speakers and entertainers they would like them to arrange. We observed that there was a poster on display advertising indoor cricket, it stated, 'This is an activity that service users asked for, so we hope to see everyone there'.

People were supported to take part in activities that they enjoyed and were meaningful to them. People told us that they took part in activities such as wheelchair football, bowling, arts and crafts, computer games, woodwork, gardening and cooking. One person told us "This week I've been in for the table cricket and the cooking and last week we had creepy crawlies". Some people, in the activities room, were working towards making a mosaic 'welcome' sign for the service, other arts and crafts were also on display. There was a

weekly gardening club where people were growing their own vegetables in raised beds which were accessible to people who used wheelchairs. Entertainers visited the service on a regular basis and we observed photographs of a pony that had visited people in their rooms. People were supported and encouraged to find new interests. One person told us, "On Saturday I was sailing down in Shoreham harbour. It's exciting in a small dinghy and a strong wind. It's something I never thought of attempting when I was able bodied". Themed evenings and social events took place. People told us that the 'Friday night bar' had been reintroduced, this was a social event that people enjoyed and looked forward to attending. Other social events that took place on a weekly basis included karaoke, bingo and a quiz. We were told that there were plans to hold parties to celebrate Halloween and Christmas.

Some people had been supported to find employment or voluntary work which they clearly enjoyed. One person told us "I'm pretty self-sufficient. I work and I'm out most days. I enjoy it". People told us that if they wanted to do something that had not been planned, they could do so. For example, one person told us that they had told staff they wanted to go shopping and this had been arranged.

Handover meetings were held at the start and end of each shift, so that staff were aware of any issues that had occurred during the previous shift. We observed a handover which was chaired by a team leader, information from the morning staff was passed across verbally and with the use of a handover sheet, to the afternoon staff, detailing any changes or updates to peoples' care needs. The activity organiser told us that they had recently been encouraged to attend the handover meetings and that this enabled them to be kept informed of how people were feeling and of any changes to people's needs. They told us that they also used the handover meetings to pass on information to the care staff about what people had been doing.

There were systems in place to respond to comments and complaints. People were provided with information about how to make a complaint when they first moved into the service and complaints that had been received by the provider had been recorded and responded to appropriately. People told us that they knew how to make a complaint. One person told us, "When I have taken my concerns to the management it's always been attended to".

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection on 14 and 19 January 2016 we found that the service was not consistently well-led. The provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was a lack of oversight in relation to the quality of service being delivered and to ensure that the provider's policies and procedures were being followed. After the inspection, the provider informed us of what they would do to meet the legal requirements in relation to this regulation. At this inspection we found that improvements had been made. However, we found that these improvements needed to be sustained and embedded into practice.

The provider undertook quality assurance audits to ensure a good level of quality was maintained. These audits included medication, care planning and health and safety audits as well as surveys that were sent to gain peoples' feedback. Results were analysed to determine trends and to identify shortfalls that needed to improve. The manager told us that through their observations and audits, they had identified that further improvements were needed in relation to staffs' access to regular supervision and training as well as in relation to the updating of peoples' care plans. They told us that each member of the management team had been allocated a specific area of responsibility and that this included implementing the improvements needed. In addition to this, the team leaders had been asked to solely concentrate on completing additional training to ensure that they had the skills they needed, for example, training on the concept of Positive Behaviour Support (PBS) and PBS planning for a two month period. The manager told us and records confirmed that each persons' care needs had been reviewed, however, the associated care plans had not all been updated accordingly and some contained inconsistencies and blank sections. These are areas of practice that need to implemented, sustained and fully embedded into day to day practice.

There was no registered manager in place. The last registered manager stopped working at the service at the end of October 2015. A new manager was recruited in December 2015 but left the service in June 2016. The service was then managed by a registered manager from one of the providers' other services until the end of September 2016. Following this, another of the providers' registered managers, a deputy manager and an assistant manager had been seconded to manage the service for three months. They were supported by two permanent assistant managers, an administrator and team leaders and there were plans in place for a new manager to be recruited. It was evident that the changes in management over the last year had been disruptive for people who lived at the service as well as staff that worked there. However, everyone spoke positively about the leadership over recent months and felt things had changed for the better. Comments from staff included, "Everything is good, in general they are all on the ball" and "Management are amazing now. They are looking out for the residents and putting things in place to keep the residents safe and happy. We used to be left to do everything, but they've come in and made this place much better." Two visiting healthcare professionals commented that the atmosphere at the service was calmer, the service was managed better and felt that staff morale had improved.

Staff felt listened to and valued. One staff member told us, "I can speak with the managers and I'm listened to. I like to think they act on what I tell them." Another commented, "I think the service is improving. There had been a lack of communication, but this is much better, they listen and get things done." A further staff

member told us "We're listened to and things get implemented. I raised something and the day after, it was done. It's been bad, but now we are a strong unit and support each other and pull together". Staff explained how management had trialled different start and finish times for their shifts in order to establish a staff rota that was effective and provided sufficient numbers of staff at key times of day to respond to peoples' needs. They told us that their views had been sought on this issue and were listened to. One staff member commented "We fed back that the shift starting at 8:00am didn't work as some of the residents want to get up early for work and activities, so the managers listened and it was changed to an earlier start".

Following the outcome of the last inspection the provider had undertaken a review of their organisational structure as well as the needs of the people using the service. As a result of their findings they assessed that the service, which had sat within the providers' physical disability directorate, should also sit within their autism directorate. The impact of this was that a range of expertise and resources, which were previously difficult for management to access, were readily available. These resources included input from healthcare clinicians and a wide range of training such as PBS and physical intervention techniques. Management and staff felt that these were positive changes which had led to improved outcomes and quality of life for people living at the service.

Mechanisms were in place for the manager and management team to keep up to date with changes in policy, legislation and best practice. They were supported by the provider and were able to share information and best practice with other managers within the disabilities trust. Up-to-date, sector-specific, information was also made available for staff, including guidance around positive behaviour support and the care of people who displayed behaviours that challenged. We saw that the service also liaised regularly with the Local Authority and learning around local issues and best practice in care delivery was cascaded down to staff.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The manager had informed the CQC of significant events when they occurred. This meant that we could check that appropriate action had been taken. The manager was also aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent as it sets out specific guidelines providers must follow if things go wrong with peoples' care and treatment.