Autism Care (Bedford) Limited

Autism Care UK (Bedford)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Autism Care UK (Bedford), (also known as Larchwood House), is a residential care home providing personal and nursing care to people with a learning disability and autistic people. The service also supports one person with physical disabilities. The service can support up to nine people. The home comprises of five flats and four ensuite bedrooms with shared communal spaces on each floor. There is also a shared garden at the front and back of the house. At the time of the inspection eight people were living at the service.

People's experience of using this service and what we found
The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right Support
•Staff supported people to have choice and control over their own lives. However, independence and choice were not always promoted when people were being supported by agency staff. This meant people were not always encouraged to be as independent as they could be and opportunities for learning were missed.
•People were supported by staff to pursue their interests but opportunities were mainly limited to known preferences with little chance to explore new interests or work placements.
•People had a choice about their living environment and were able to personalise their rooms and communal spaces.
•The service worked with people to plan for when they experienced periods of distress so that their freedoms were restricted only if there was no alternative.
•Staff enabled people to access specialist health and social care support in the community.

Right Care
•People had individual ways of communicating, such as using body language, sounds, Makaton (a form of sign language), pictures and symbols. However, they could not interact comfortably with staff and others involved in their care and support because staff did not have the necessary skills to understand them. This also put some people at risk of becoming distressed unnecessarily if communication was unclear.
•People did not always receive care that supported their needs and wishes and was focused on their quality of life and future. This did not promote opportunities for people to experience growth or new skills and independence.
•The service did not always have enough appropriately skilled staff to meet people's needs, to enable them to follow interests. This meant not all plans happened on the day and people were not always supported by

staff who understood how to interact positively with them.
•Staff understood how to protect people from poor care and abuse. The service had started to improve the way it worked with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
•People received kind and compassionate care. Staff protected and respected people's privacy and dignity.

Right culture
•Staff vacancies meant there was regular reliance on agency staff who did not always know people as well as permanent staff. This impacted people's ability to be supported consistently by staff who knew them well.
•The ethos, values, attitudes and behaviours of the management and staff had improved since the last inspection. However, this still required further development to ensure people led inclusive and empowered lives.
•The risks of a closed culture were reduced by the newly empowered staff team and their wish to understand how to provide care that promoted inclusion and respect. This was further reduced by staff and managers willingness to work with and be guided by external professionals to make improvements.
•Most people and those important to them, including advocates, were involved in planning their care.
•People mostly received good quality care, support and treatment when supported by staff and specialists who could meet their needs and wishes.
•Staff were more confident and more responsive to people's needs and this had resulted in the reduction of periods of distress experienced by people. This also meant there had been a significant reduction in the use of physical and chemical restraint. As and when needed medicines were used only in a supportive manner and in-line with the person's agreed plans.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was Inadequate (published 14 September 2021) and there were eight breaches of regulation. We imposed conditions to help drive improvement at the last inspection and the provider has been providing us with their improvement plans in accordance with the requirements of the conditions. At this inspection we found there had been a number of improvements but these were not sufficient and the conditions remain in place.

This service has been in Special Measures since 14 September 2021. During this inspection the provider demonstrated that while the improvements were not sufficient to remove the conditions, the service is no longer rated as inadequate overall or in any of the key questions and were therefore enough for this service to no longer be in in Special Measures.

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support right care right culture and to follow up on action we told the provider to take at the last inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safety, record keeping, personalised care, staff deployment and quality monitoring at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement

Autism Care UK (Bedford)

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two Inspectors, a member of the Care Quality Commission (CQC) medicines team and two Experts by Experience carried out the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Autism Care UK (Bedford) is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. At the time of our inspection there was not a registered manager in post. However, a manager was appointed and had submitted their application to the Commission to become registered. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection

We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We communicated with seven people who used the service and eight relatives about their experience of the care provided. People who used the service who were unable to talk with us used different ways of communicating including Makaton, pictures and their body language.

We are improving how we hear people's experience and views on services, when they have limited verbal communication. We have trained some CQC team members to use a symbol-based communication tool. We checked that this was a suitable communication method and that people were happy to use it with us. We did this by reading their care and communication plans and speaking to staff and the person themselves. In this report, we used this communication tool with two people to tell us their experience.

We spoke with eleven members of staff including the manager, the deputy manager, two members of the quality improvement team and care staff.

We sought the views of Healthwatch England and spoke with four other health and social care professionals who work closely with the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We reviewed a range of records. This included six people's care records and eight medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Requires Improvement

Is the service safe?

Our findings

Our findings
Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection

At our last inspection, we found evidence systems were not effective enough to demonstrate safety. There were concerns with safe management of medicines and fire prevention. We also found concerns in the failure of staff to follow current guidance about the safe management of COVID-19 risks This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider was still in breach of regulations 12

- Prescribed medicines were not always recorded accurately. Staff did not always document changes to medicines clearly on medicine administration records. This meant people were at risk of not receiving the correct dose of their medicines and this had led to a recent medicines error. Medicine administration errors had been reported but there was no evidence of a thorough investigation. The manager told us the investigation was still in progress.
- Information in one person's care plan about the dosage of emergency medicine in the event of a seizure did not match the information in the medicines protocol. Staff were not all aware which was the correct dosage. This could lead to vital medicine not being administered in the event of multiple or prolonged seizures.
- Staff had assessed risks to people in relation to moving and handling and pressure care and choking. However, the information did not provide staff enough guidance. For example, whether any equipment was used to transfer a person or quantities of food and fluid requirements. Records about risks were not always completed and health professional guidance for one person in relation to choking was unable to be located.

We found no evidence that people had been harmed however, a medicine administration and records error had occurred resulting in an overdose of medicine for one person for three weeks and this placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took immediate action and confirmed since the inspection, that some of the above concerns have been addressed and made safe.

● Staff managed the safety of the living environment and equipment well through checks and action to minimise risk. The provider had taken action to ensure all fire risk management procedures were in place and fire doors had been made safe.
● People's freedom was restricted only where they were a risk to themselves or others, as a last resort and for the shortest time possible. Each person's care plan included ways to avoid or minimise the need for restricting their freedom.
● People told us they felt supported by staff when taking their medicines. The service ensured people were not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured that people's medicines were reviewed by prescribers in line with these principles. As and when required medicine for supporting people's anxieties had not been required since December 2021 as staff were more confident in how to better de-escalate situations.

● The service used effective infection, prevention and control measures to keep people safe, and staff supported people to follow them. The service had procedures for admitting people safely to the service.
● The service supported visits for people living in the home in line with current guidance and prevented visitors from catching and spreading infections. They followed shielding and social distancing rules where possible. People told us they were supported to have visits with their relatives and stay in touch in other ways. One person told us, "I have a mobile (phone) and my [relative] calls every day. I go home every week and at Christmas." A relative told us how much they appreciated the provider giving them official letters they could show to police if stopped during lockdown in order to maintain visits with people who required them for their mental well-being.
● Staff used Personal Protective Equipment (PPE) effectively and safely and were tested for infection along with people using the service.
● All staff had completed food hygiene training and followed correct procedures for preparing and storing food.
● The service promoted safety through the layout of the premises and staff's hygiene practices and had schedules in place for ensuring the premises were cleaned regularly. The service had good arrangements for keeping premises clean and hygienic. A relative told us, "[It is] always nice and clean and when we last went there, we asked if they had decorated it was so clean."
● The service made sure that infection outbreaks could be effectively prevented or managed. It had plans to alert other agencies to concerns affecting people's health and wellbeing. There was an up to date infection prevention and control policy.

Staffing and recruitment

At our last inspection the provider had failed to ensure there were suitably qualified, competent, skilled and experienced persons to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider was still in breach of regulation 18

● The numbers and skills of staff did not always match the needs of people using the service. This was, in part, due to the regular reliance on agency staff. While the provider tried to book the same agency staff for continuity of care this was not always possible. This impacted on people as some agency staff were not skilled in how to interact with people, how to safely support them or understand how they preferred to spend their time.

● Managers did not arrange shift plans so that staff were deployed in ways that ensured strong leadership on each shift. This left some agency staff unsure about what they should be supporting people with and how to do this.
● Staff told us deployment on the rota meant that there was not always enough staff on shift to act as a second staff member for people who required two staff to support them in the community. This resulted in some planned events not taking place.
● Relatives voiced concern about staffing levels and skills. One relative told us how there was not enough staff to encourage people to try new opportunities. They told us, "Staffing issues are crucial. Not enough planned activities. It is frustrating. There are no drivers." Another relative said, "I think staff know [my family member's] name. For agency staff this is not always the case."

We found no evidence that people had been harmed however, people were being supported by staff without the correct skills to meet their communication and support needs. This placed people at risk of experiencing distress and needs not being met. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we recommended the provider consider current guidance in relation to staff recruitment processes and requirements and take action to update their records. The provider had made improvements.

● Staff recruitment and induction training processes promoted safety. Pre-employment checks were robust and included staff's work history, references and making checks for any criminal records.
● Staff were supported with a thorough induction process and told us they were given time to read people's care plans as well as complete various training courses. One staff member told us, "I did five shadow shifts but [managers] did say if I wasn't comfortable with working on my own, I could have more shadow shifts." Another staff member said, "When I first started the care plans were a bit of a mess and there were things in them that I read and when I got to work with people it wasn't true. But recently I have read the new [care plans] and they seem to be a lot clearer and easier to understand. I do feel the 'how' to do things could still be improved."
● Each person had an 'at a glance' plan that gave staff essential information about do's and don'ts to ensure that staff could see quickly how best to support them.

Systems and processes to safeguard people from the risk of abuse

At our last inspection We found evidence that people had been harmed in the form of psychological abuse, causing unnecessary anxiety and sedation. Systems were not robust enough to demonstrate people were kept safe. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13

● People were kept safe from avoidable harm because staff knew them well and understood how to protect them from abuse. The service worked well with other agencies to do so and were able to evidence a reduction in the number of incidents related to people's distress.
● Staff had training on how to recognise and report abuse and they knew how to apply it. There were systems in place to report, record and monitor incidents or concerns.
● People and their relatives told us they were safe. One person told us, "I do feel safe in my room, nobody

comes inside if I don't want them, staff knock and I let them in." Staff could recognise signs when people experienced emotional distress and knew how to support them to minimise the need to restrict their freedom to keep them safe.

Learning lessons when things go wrong

● Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned.

● Staff were encouraged to learn from safety alerts and incidents. Staff told us they used learning to think of ways to improve practice.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Adapting service, design, decoration to meet people's needs

At our last inspection, we found concerns with the standards of maintenance and decoration as well as cleanliness of the internal and external environment. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 15

- The provider had completed all required maintenance in the service. There was now new flooring in the laundry room. The communal spaces had been re-decorated and cleaning schedules and audits ensured the service was clean and fresh. The garden had also been tidied and cleaned.
- People personalised their rooms and were included in decisions relating to the interior and exterior decoration and design of their home. The design, layout and furnishings in a person's home supported their individual needs.
- People had given their views on colour of decoration in shared spaces and had been allocated a budget by the provider to each choose some personal items for the lounge. Staff supported people to create a garden space that offered different textures and opportunities to grow plants.

Ensuring consent to care and treatment in line with law and guidance

At our last inspection, the provider had failed to ensure appropriate approval and processes were sought for depriving people of their liberty. This was a breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11

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. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

● Most staff knew about people's capacity to make decisions through verbal or non-verbal means and this was documented. For people that the service assessed as lacking mental capacity for certain decisions, staff recorded assessments for any best interest decisions. Assessments recorded by staff were decision specific but would be further enhanced by recording people's comments and nonverbal communication in place of summaries.

● Staff respected the rights of people with capacity to refuse their medicines. People told us staff supported them to make decisions about medical treatment. One person said, "I had all my (Covid-19 vaccination) jabs. The GP and staff explained to me why it's good to have my vaccine."

● People were offered the support of advocates where required and conditions attached to authorised DoLS were being met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Care plans reflected a good understanding of people's needs, including relevant assessments of people's communication support and sensory needs. However, this was repetitive in places with differing information in different segments and therefore unclear. The care plan guidance was not always followed by all staff, especially in relation to communication.

● Support plans set out current needs but did not always promote strategies to enhance independence. There was no evidence of planning and consideration of the longer-term aspirations of each person and how these would be met. People told us about things they would like to try or achieve but these had not been recorded or arranged. This meant people were not supported to spend their time meaningfully or develop skills and interests.

Staff support: induction, training, skills and experience

● Staff were knowledgeable about most aspects of their roles but some staff were less confident in understanding the principles of the Mental Capacity Act 2005 (MCA). While training records showed staff had received training about Autism awareness, one staff member told us they did not recall this training and they were not aware of sensory needs that people might have.

● Updated training and refresher courses helped staff develop their confidence and skills in certain areas such as ways to reduce restrictive practices and better communicate with people.

● Staff told us they received support in the form of continual supervision, coaching and appraisals and checks on competency were taking place.

Supporting people to eat and drink enough to maintain a balanced diet

● People told us they were given choice of food and drink and could have a drink or snack at any time. One person said, "I know what is for dinner today. It's tuna pasta bake, my favourite. I can change it if I want but I like pasta bake."

● Staff encouraged people to eat a healthy and varied diet to help them to stay at a healthy weight. One person told us they were following a low cholesterol diet. Another person was happy to have limited snacks as they understood it was to help manage a health condition and stay well.

● Mealtimes were flexible to meet people's needs and to avoid them rushing meals. People were able to eat and drink in line with their cultural preferences and beliefs.

Supporting people to live healthier lives, access healthcare services and support

● People told us staff supported them if unwell. One person said, "If I have a headache, I would tell someone and they will give me my paracetamol."

● People had health action plans in place, however these listed professional contacts but did not identify how people would be supported to promote healthy lifestyles. Further information could be found in other areas of the person's care plan but this was not signposted for staff to be aware.

● Hospital passports (a document to aid healthcare professionals understand people's needs) did not always contain people's full diagnoses. This meant in an emergency, care and treatment could be compromised.

● People were supported to attend health checks, screening and primary care services. People were referred to health care professionals to support their wellbeing and help them to live healthy lives.

● Health care professionals had been working to support the staff to develop their records and practices in relation to medicines. Another health care professional told us they did not have any concerns and the service was making referrals to specialists where required.

Requires Improvement

Is the service caring?

Our findings

Our findings
Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

At our last inspection, we found concerns about listening devices and staff language that did not promote privacy or respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 10

- Staff were using surveillance devices to listen to people as and when required such as night-time or when alone in their bedroom or flat. During this time the listening devices were kept with staff who ensured no-one else could overhear the person to maintain their privacy.
- The language staff used to describe or refer to people was positive in that they used people's names or 'people we support' rather than referring to people as acronyms.
- People told us staff treated them well and told us about things they could do for themselves. One person said, "Staff are nice, they do have time when I really need help, like my medications and if I need to go to shops."
- Some people were able to shop independently and make their own meals. One person told us, "I went to the shop for bits and pieces. I am cooking tomorrow in my flat and it's chicken curry." However, Staff did not always support people who needed it to be involved in preparing and cooking their own meals and this led to some missed opportunities for engagement and learning.
- Staff knew when people needed their space and privacy and respected this.

Ensuring people are well treated and supported; respecting equality and diversity
- People told us they liked living at the service. They received kind and compassionate care from staff who used positive, respectful language which people understood and responded well to. One person told us, "I like to talk to [staff member]. They are good at listening."
- Most staff were patient and calm and used appropriate styles of interaction with people, they were attentive to people's emotions and support needs. However, this was inconsistent and some staff were not aware of people's protocols or guidance that would enable a continuity of care.
- The service had a warm atmosphere and people were relaxed in staff's company and comfortable to approach them.

Supporting people to express their views and be involved in making decisions about their care

●Staff did ask people their preferences but not all staff took the time to understand people's individual communication styles and develop a rapport with them.

● People were supported to access independent, good quality advocacy. People were empowered to make decisions about the service when appropriate and felt confident to feed back on their care and support. One person told us, "My care plan is in my room and I have all contacts and photos of my social worker, advocate and my consultant."

● Most people, and those important to them, took part in making decisions and planning of their care and risk assessments. One person said, "Next week is my CPA meeting. CPA means Care, Plan Approach meeting. We all sit and talk about me. This one is about my medicines."

● However, where people could consent to their relative's involvement in care planning, some relatives told us they were not involved or informed. One relative said, "We don't get involved in care planning. We're expecting a review soon." Another relative told us, "We have been to reviews at the beginning, a few years ago. A month or two ago a review was supposed to happen but didn't, it wasn't the home's fault, the social worker didn't turn up. A review should be next month, no date yet, it's three to four years since we had a review."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them; Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication needs

At our last inspection, the provider had failed to ensure personalised care that empowered people to develop their skills and interests in line with the Right support, right care, right culture principles. The provider had not made reasonable adjustments to meet specific communication needs. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider was still in breach of regulation 9

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Support did not focus on people's quality of life outcomes; goals were not meaningful and people were not supported to understand how they could achieve them. People told us about pastimes/hobbies interest they would like to achieve or try. These included learning to drive, becoming a Paralympic swimmer, joining a gym, the cinema, yoga and learning how to put on a duvet by themselves or to cook specific meals. While some of these had been identified in care records, no action had been taken by staff to make them happen. One relative said, "More work-based activities (needed). My [family member] loves being out in the community, any opportunity to be out in the community…it has been discussed numerous times and at reviews. It would be looked into but nothing happens."
● Each person had a plan which identified target goals. However, these were often not designed to support them to achieve greater confidence and independence or reflect longer term aspirations. The goals contained no steps for how they would be achieved or reviews of the success of the goal each time it was tried.
● Most people spent their time in the house or going to local shops or parks unless able to do things without staff support. One person told us, "I like to spend mornings in my room, after breakfast I come here and will soon go to town for some small shopping." Another person said, "Sometimes I go to the park but I don't need help with that. When I am on my own, I make my coffee, or play games on my iPad. I like going to the

library all by myself and then I go to the game shop. I found it myself."
● Some staff did support people to take part in learning skills such as cleaning, gardening, making snacks and drinks but these were not recorded or structured for a consistent learning approach and did not occur regularly. This led to further missed opportunities for people to develop skills and interests.
● British Sign Language training was considered the first language for one person. The provider was to ensure staff were trained in BSL to support communication. However, a recent review has suggested the person no longer uses BSL as their main form of communication and so this training for staff is yet to be sourced while awaiting a re-assessment of the person's communication needs
● Makaton (a form of sign language used to aid speech) was used by three people to support speech. Eight staff were in the process of completing training in Makaton. However, most of those staff did not feel comfortable to practice this and so staff were still not making reasonable adjustments to meet people's communication needs.
● Staff did not ensure people had access to information in formats they could understand. One person's care plan said they should use a 'Now and Then' board to help them to focus and understand options of how they were spending their time. However, this was not used, and staff told us it did not happen.
● Relatives told us about their concerns regarding communication. One relative told us, "Communication, engagement and clear programmes (are needed) so my [family member) knows what's going to happen and who will work with them." Another relative said, "Adherence to protocol and follow agreed care plan (is needed). (They need to have) person specific detail and be individualised."
● One person's care plan had good examples of how to use pictures to offer a choice of two things at a time to prevent them becoming overwhelmed and support their focus. This was not used by staff who instead asked open questions with unlimited choices which led to no choice due to confusion.
● People had communication support plans which described in detail for some people, how they communicated and how best to respond. However, these were not always followed by staff and were inconsistent. This meant in some cases they did not describe what signs and gestures the person used or an explanation of what they typically meant.

We found no evidence that people had been harmed, however, people were not being supported in ways that met their emotional, social, developmental and communication needs. This placed people at risk of experiencing distress, needs not being met and not being listened to or understood. This was a continued breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider informed us after the inspection they had plans for further training for staff around goal setting and reviewing. They planned to discuss one key goal with people and support staff to focus on implementing this in a meaningful way. They told us this would then be built on once staff skills had been developed.

● Support had improved, people's care plans had been reviewed and updated. Two people had found or were being supported by social care professionals to find voluntary work placements.
● Staff worked closely with health and social care professionals and ensured people were assessed to see if they would benefit from the use of non-verbal communication aids and supported with interpreters where required during assessments.
● People who were living away from their local area were able to stay in regular contact with friends and family via telephone and social media.
● Staff had supported one person to build on their interest of football and attend a live football match. The person was very excited about this and told us they had enjoyed it, showing us their football scarf and souvenirs.

Improving care quality in response to complaints or concerns

● People told us they could raise concerns and complaints easily and staff supported them to do so. One person said, "[Staff member] is my keyworker but other staff are good and I can approach them when I need help."

● Relatives told us they could raise concerns but were less confident action would be taken. One relative told us, "I've complained to the home, not absolutely sure it was understood." Another relative said, "I'm confident we could make a fuss, not confident anything would get done. We raise concerns to immediate management."

● The service had a complaints policy in place. The provider told us this was also in accessible formats; however, they had not been able to produce this when asked. There was no record of complaints on file.

End of life care and support

● The service was not supporting anyone with end of life care at this time. For people and relatives who wished to, end of life and/or wishes in the event of illness had been considered and recorded.

● Relatives views were mixed, some relatives said they had been consulted about end of life wishes for their family member. Other relatives told us they had not thought about it but would like to start having he conversation. The manager had plans in place to review this area of care need with people and their relatives.

● Management of people's health needs had been recorded in their care plans.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection, staff had not understood the fundamental needs of people they were supporting. Records were incomplete or inaccurate and quality assurance systems did not identify concerns or allow for provider oversight of the quality of care provided. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider was still in breach of regulation 17

● Governance processes were not fully effective in helping to hold staff to account, keep people safe, protect people's rights and provide good quality care and support. Some records continued to be incomplete or inaccurate.
● There was current provider oversight of the service due to the input of specialist internal teams and external professional support to help drive the improvements. These were temporary solutions to support staff at the service to improve. However, the provider did not identify all of the concerns we found at this inspection.
● We were not assured that the provider level quality monitoring processes were sufficient to ensure future concerns or lessons learnt would be identified and actioned in a timely manner as the same systems remain in place that were in place prior to the previous inspection where many concerns were not identified.
● Staff were not aware of the principles of the Right Support, right care, right culture policy or how this applied to the way they support people in practice. Not all staff knew how to promote people's rights or their specific communication needs. Good quality support was inconsistent.
● There was a new manager in post who was not yet registered with CQC. However, they had submitted their application and this was in the process of being reviewed by CQC registration inspectors.
● The provider had provided continued training and coaching for staff but this had not been effective in all cases.
● Not all staff said they felt empowered to promote new goals, work opportunities and interests with people for better outcomes and or had the confidence and skills to take positive risks. We discussed this with the manager and senior managers who confirmed they were in the process of providing training and support for

staff in this area.
● The deputy manager, staff and the internal quality team, worked hard to instil a culture of care in which staff truly valued and promoted people's individuality, protected their rights and enabled them to develop and flourish. However, this was not yet embedded into staff practice and required further development to ensure all staff had a consistent approach.
● Feedback from relatives was mixed. Overall, they were positive and told us they could see staff had been really trying and improvements had been made. They were still, however, concerned about people not spending their time in meaningful ways and poor communication between themselves and the provider.

We found no evidence that people had been harmed however, Systems and records were still not always accurate or effective in offering clear guidance to staff on how to safely meet people's needs. Reviews of records by the provider had not identified all of the issues found during this inspection. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The deputy manager and some support staff had the skills, knowledge and experience to perform their role and a clear understanding of people's needs and oversight of the services they managed.
● Staff felt respected, supported and valued by senior staff which supported a positive and improvement-driven culture.
● Some staff did have a good understanding of the needs of autistic people and how best to meet them.
● People told us they were happy living at the service and enjoyed what they did. They liked the staff team and felt supported by them. A relative told us, "[Staff] have improved a lot and are trying. They need to be given time. Need an experienced person on site to manage teams properly. The management of the place is a problem, the deputy manager was trying but they need more than one person to get on top of things. It may be getting better with the new manager."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● Staff gave honest information and suitable support, and applied duty of candour where appropriate.
● Where incidents occurred, there was reflection and lessons learnt identified but sometimes this was not effective.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The staff had installed a suggestion box in the home for people to submit comments and ideas and be more involved in the development of the service. This was to support people who were not comfortable to speak up directly or in groups. Opportunities were given to talk to staff at other times and people told us they were happy to do so. A recent group exercise during a house forum had helped some people think about what they would like for the future of their home.
● Staff felt valued and respected by managers and told us they appreciated the additional support. One staff member said, "[Deputy manager] has made such a difference. Things have really improved, better training, treated better and get much more support. The team are more confident." Another staff member told us, "At the minute, what we are asking for we are getting, communication and training were the main problems. Before we never got support, we were treated like rubbish. [Deputy manager] gives opportunities to try new things."
● The provider sought feedback from relatives annually in a formal survey and the staff spoke with relatives regularly less formally. However, relatives told us that they did not receive information on outcomes or changes as a result of the survey and so felt it was just a paper exercise. One relative told us, "There was a

survey done last year before the CQC inspection. We filled it out comprehensively, there was a box saying, 'Do you want management to get in touch?' We ticked it; they never did get in touch. It was a survey from Head Office."

● Some relatives were not aware of recent improvements and changes such as key worker systems, re-decoration of the interior and exterior of the home, recent staff training and updated care plans. This lack of awareness of the changes supported their view that communication was still a problem. This also left some relatives feeling like they were not fully informed when incidents occurred.

● The manager told us they had contacted relatives and intended to have a review with each relative to understand their communication needs and ensure this improved.

Continuous learning and improving care

● The staff team were supported to regularly reflect on things that had gone wrong and look at ways of improving the service. One staff member told us, "I was one of those people who didn't do it online but when CQC came in you change your mind on a lot of stuff and realise you can do better and do as much as you possibly can."

● This had had a positive impact on the service and they were able to evidence a reduction in the amount of times people became distressed and a reduction in the use of medicine or physical restraint during those times. Other people had now developed better sleeping patterns as a result of feeling more supported and less worried.

Working in partnership with others

● The provider engaged in local forums to work with other organisations to improve care and support for people using the service.

● The provider has worked with the Local Authority to help improve the quality of care at the service.

● The service worked in partnership with advocacy organisations and other health and social care organisations, which helped to give people using the service a voice and improved their wellbeing.