Autonomy Healthcare Limited

Victoria & Elizabeth

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection that took place on 7 February 2017.

Victoria and Elizabeth provides care and accommodation to up to nine younger adults. The service specialises in the care of people diagnosed with learning disabilities, autistic spectrum disorders, and mental health needs. Accommodation is provided in a range of one- to six-bedded apartments situated on a private residential estate. At the time of our inspection there were eight people using the service.

The service has a registered manager. This 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.

People said they felt safe using the service. There were enough staff on duty to keep people safe, meet their needs, and enable them to take part in activities. The staff were experienced, well-trained, and knowledgeable about the needs of the people they supported. People told us the staff were caring and kind.

Staff supported people to be independent. People had progressed since coming to the service, for example some people had begun to use public transport independently. Records showed that activities were central to the support provided and people took part in educational and leisure pursuits on a daily basis.

Staff were knowledgeable about people's emotional states and any triggers that might cause their anxiety to increase. They worked closely with mental health, learning disability, and other relevant professionals to provide people with consistent ongoing support. They understood people's healthcare needs and enabled them to access healthcare services when they needed to.

Each person had their own individual food and drink budget and chose, shopped for, and prepared their own meals with staff assistance where necessary. We observed one staff member assisting a person to prepare their own meal. The atmosphere was calm and the setting homely and domestic. The staff member and person appeared to have a good, trusting relationship and to enjoy each other's company.

Staff treated people with dignity and respect. The design of the environment helped to ensure people's privacy was promoted. Each person had a spacious bedroom with a double bed, an ensuite toilet with a shower or bath, and a large television set. This meant that if people wanted to spend time away from others they could do this in comfort with the facilities they needed at hand and private to them.

People were involved in how the service was run. They had the opportunity to talk with managers and staff every day and share their views with them. The service had an open and friendly culture. Managers and staff were welcoming and enthusiastic about their work. They were keen to discuss 'best practice' and to listen to people's suggestions about the service. This had led to a number of positive changes being made to the

environment, activities, and access to the wider community.

Some improvements were needed to the service. Staff supported people to manage risks but appropriate risk assessments were not always in place. Care plans provided good information with regard to people's behavioural issues but needed more detail when non-behavioural issues were being addressed. Improvements were needed to the way medicines were managed and how staff recorded incidents.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was mostly safe.

People using the service felt safe and staff knew what to do if they had concerns about their welfare.

Staff supported people to manage risks but appropriate risk assessments were not always in place.

There were enough staff on duty to keep people safe, meet their needs, and enable them to take part in activities.

Some improvements were needed to the way medicines were managed.

Is the service effective?

Good

The service was effective.

Staff were appropriately trained to enable them to support people safely and effectively.

People were supported to maintain their freedom using the least restrictive methods.

Staff had the information they needed to enable people to have sufficient to eat, drink and maintain a balanced diet.

People were assisted to access health care services and maintain good health.

Is the service caring?

Good

The service was caring.

Staff were caring and kind and treated people with respect.

They communicated well with people and knew their likes, dislikes and preferences.

People were encouraged to make choices and involved in decisions about their care.

Is the service responsive?

Good

The service was responsive.

People received personalised care that met their needs.

Staff encouraged people to take part in a range of activities.

People knew how to make a complaint if they needed to and support was available for them to do this.

Is the service well-led?

Good

The service was well led.

The service had an open and friendly culture and the staff and managers were approachable and helpful.

People were encouraged to share their views about the service in a way that suited them.

Improvements were made to the service in response to feedback from people and relatives.

Victoria & Elizabeth

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 inspection took place on 7 February 2017 and was unannounced.

The inspection team consisted of an inspector, a specialist advisor, and an expert by experience. A specialist adviser is a person with professional expertise in care and/or nursing. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the 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.

We looked at information received from local authority and health authority commissioners. Commissioners are people who work to find appropriate care and support services for people and fund the care provided.

We reviewed the provider's statement of purpose and the notifications we had been sent. A statement of purpose is a document which includes a standard required set of information about a service. Notifications are changes, events or incidents that providers must tell us about.

We spoke with four people using the service and one relative. We also spoke with the managing director, the registered manager, the assistant manager, the engagement co-ordinator, and two support workers.

We looked at records relating to all aspects of the service including care, staffing, and quality assurance. We also looked at four people's care records.

Requires Improvement

Is the service safe?

Our findings

All the people we spoke with said they felt safe using the service. One person told us, "I would speak to staff if I felt unsafe." Another person said they had a call bell by their bed so they could call for assistance if they needed it and this made them feel safe. A relative said they thought their family member was safe.

Staff were trained in safeguarding (protecting people who use care services from abuse) and knew what to do if they were concerned about the welfare of any of the people using the service. The provider's safeguarding policy and procedure told staff what steps to take if they believed a person had been abused or was at risk of being abused. This included reporting the concern to management who would then inform the local authority safeguarding team. A contact telephone number was provided for them to do this.

During our inspection we were made aware that on occasions people using the service had obtained staff members' personal mobile numbers and in one instance a person had viewed inappropriate content on a staff member's phone. This was in breach of the provider's policy on mobile phones at work which stated that they shouldn't be used. This failure of staff to observe professional boundaries could confuse the people using the service about their relationships with staff members. We discussed this with the managing director and registered manager who said this matter had already been addressed with staff and would be reiterated at future staff meetings and in supervision sessions.

We looked at how are risks to people and the service were managed so that people were protected and their freedom supported and respected. The risk assessments we saw were thorough with clear instructions to staff on how to minimise risk when supporting people. However not all had been regularly reviewed so it was unclear whether the risks identified remained current. We discussed this with the provider and registered manager who said they were in the process of setting up a more formal system of review for risk assessments which would be dependent on the changing needs of the person in question.

Risk assessments for behavioural issues were of a good standard and included input from other health and social care professionals. They ensured that staff had the information they needed to keep people safe in a variety of circumstances. However risk assessments for non-behavioural issues, for example mobility, continence, and nutrition, were not always in place, although these areas did feature, to varying extents, in care plans. We discussed this with the provider and registered manager who agreed to review risk assessments with a view to ensuring that all areas of risk were covered.

Following our inspection visit the provider contacted us to say they had commenced work on improving people's risk assessments and had taken steps to ensure they were regularly reviewed and updated. This will help to ensure that staff have the information they need to protect people from harm.

We saw evidence at the inspection visit that the provider and registered manager would only admit people to the service if they believed they could safely meet their needs. For example, one person who was referred and assessed was not admitted as the managing director and registered manager felt they would pose a risk to themselves and others if they came to the service. This was an example of the service being managed so

as to protect the people using it and others.

The design of the premises helped to contribute to people's safety and one person told us they thought the building was safe and well-maintained. The areas we saw were secure, uncluttered and spacious. Each person had a call bell in their bedroom to summon staff if they needed them.

Where safe, low lighting had been installed to help cultivate a calm and soothing environment for people. Any items hazardous to health, for example cleaning fluids, were kept locked away. Staff told us they followed the provider's health and safety policies and procedures and made improvements where necessary. For example, when we visited the assistant manager was in the process of checking and re-filling the service's first aid boxes to ensure their contents were complete.

People told us there were usually enough staff to support them safely. One person told us they 'always have [enough] staff'. A relative said 'on the whole [there are] enough staff'. One person said they would like extra staff so they could go out in community more frequently. Records showed this person did have regular trips out. The managing director and registered manager said they understood that this person would like to go out more and they would discuss this with them to see if any improvements could be made.

The staff we spoke with said they thought the service was well-staffed. One staff member told us, "I've never worked anywhere with such good staffing." They told us that the staffing levels at the service enabled them to work safely with people and ensure those who needed staff to accompany them when they went out were able to do so.

At the time of our inspection visit the service employed between nine and 10 care workers on each shift and three care workers at night. The managing director and registered manager told us that if there was ever a reduction in these numbers due to staff sickness or leave, the registered manager, assistant manager, or engagement co-ordinator provider cover as all three were supernumerary. The service had not had to use agency staff which meant people had continuity of care. A member of the management team was also on call 24/7 to support care workers as necessary.

The provider operated a robust recruitment procedure. This included interviewing staff and obtaining police checks and references. All staff recruited had prior experience in providing care and support to people with learning disabilities, autistic spectrum disorders, and mental health needs, before coming to work at the service.

The managing director and registered manager told us recruitment was driven by the specifics requirements of the people using the service. For example, staff able to communicate in BSL (British Sign Language) had been employed to meet the communication needs of one of the people using the service.

All the staff we spoke with were knowledgeable about the field of care they worked in and the people they supported. They were keen to emphasise that, as far as possible, the service was 'user-led' and that their role was to support people to determine their own lives while at the same time staying safe. One staff member told us, "We support the residents in doing what they want."

We looked at how people's medicines were managed so they received them safely. Medicines were kept securely in purpose-designed storage facilities that only authorised staff had access to. The provider and registered manager told us they were in the process of considering the implementation of an extra security measure and were taking advice on this from commissioners and their contract pharmacist.

The medicines records and regimes we looked at were mostly in order. The provider and registered manager, who had an overview of medicines safety at the service, told us the results of their latest annual medicines audit. This showed there were just four errors found in 5,096 medicine administration events over the course of the previous year. In each case appropriate action was taken to address the error, learn lessons, and continue to improve medicines safety at the service.

However some improvements were needed. One person had a complex medicines regime with multiple changes, instigated by more than one prescriber, recorded. This presented a challenge to staff at the service in terms of obtaining and administering the person's medicines in a timely manner and ensuring accurate records were in place. The registered manager and provider were working to ensure this was always done safely,

Some PRN (as required) medicines were listed on the same sheet as regular medicines with no clear definition between the two. Not all PRN records specified the actual time the medicine had been given and in what dose. This meant that we couldn't be sure how much PRN medicines people had had and when.

One person's instructions for their PRN medicines were unclear. This was because records stated they could have 1-2mg up to four times a day. However the maximum daily dose was 4mg per day so there was the potential here for overdosing.

One person had declined a regular medicine for four days but there was no reason or explanation recorded for this.

One person had a medicines record that had been completed in pencil when it should have been completed in black pen which is more permanent and cannot easily be altered.

We discussed these issues with managing director, registered manager and assistant manager. They agreed to make immediate improvements were necessary and to contact their pharmacist for advice on how to improve medicines management at the service to ensure it was as safe as possible.

Following our inspection visit the provider contacted us to say they had made a number of improvements to their medicines systems. They told us: the systems for recording and administering PRN medicines had been strengthened; if medicines were refused staff would record the reasons and outcomes; and the importance of using black pen when recording administration had been communicated to staff. These actions will help to ensure medicines are always managed safely at the service.

Good

Is the service effective?

Our findings

People told us the staff provided effective care. One person, who had specific communication needs, told us three of the staff were able to communicate with them. This was because the staff in question had had specialised training to enable them to do this. A relative told us, "Some [of the staff] are really good at motivating my [family member]."

Staff told us they were satisfied with the training they'd received and felt that the service provided good learning opportunities for them. One staff member told us, "I am learning every day I work here."

All new employees undertook an induction and a period of shadowing (working alongside an experienced member of staff). This was followed by a series of courses appropriate to their work, for example, food hygiene for catering staff. All employees received annual training in health and safety matters such as moving and handling, fire awareness, and safeguarding.

As the service supported people with complex and challenging behaviours all staff completed a three-day 'conflict management' course. This helped to ensure they had the skills and knowledge they needed to work effectively with people in a positive way that protected their dignity and rights.

At the time of our inspection visit the managing director and registered manager were in the process of reviewing staff training. They told us that from April 2017 they would be launching a new series of bespoke specialist courses for staff having sourced a new training provider. This would help to ensure staff had the skills they needed in a range of specialist areas, for example working with people diagnosed with personality disorders.

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 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 managing director and registered manager were aware of their role and responsibilities in relation to the MCA and had made referrals to the local supervisory body, where they believed an application for DoLS should be considered. This might be because a person lacked capacity to make safe decisions in some circumstances and/or they were subject to high levels of supervision from staff.

At the time of our inspection we found that where people had DoLS authorisations in place. The conditions for these were being met. For example, one person needed to be accompanied by staff whenever they left the service. Records showed that staff did accompany them when they went out. This meant effective care and support was being provided and the risk of harm to the person reduced.

A relative told us that in their view there were 'no restrictions [in place] that aren't necessary at the time'. One person said they didn't like the restrictions they were subject to but records showed these were necessary for the person's and other's safety. Staff were trained in the use of the MCA, DoLS, and the use of restraint and breakaway techniques. The staff we spoke with understood that de-escalation, distraction and calming techniques were the most effective methods to use in order to keep people safe, with restraint and safe holds being the last resort.

People told us they were supported to eat and drink enough and could choose what they wanted. One person told us, "I buy my own food and drink, have what I want." Another person told us they got enough to eat and drink, had a weekly plan for their meals, and could have snacks when they wanted them. A relative told us their family member 'picks his own food.'

Each person using the service had their own individual food and drink budget and chose, shopped for, and prepared their own meals, with staff assistance where necessary. If people needed extra support with their meals this was provided. For example, one person needed their food cut up or mashed to enable them to swallow it safely. Another person needed prompting to encourage them to choose healthy items when they shopped. This information was in people's care plans which staff followed to help ensure people ate and drank safely and maintained a balanced diet.

Staff supported people to maintain good health and enabled them to access healthcare services when they needed to. One person said they had had an ear infection and went to both their doctor and a dentist to have that treated. A relative said that their family member received appropriate healthcare support. They told us, "[My family member] or staff will contact the GP or the dentist. He [my family member] sees who he needs to see."

People's healthcare needs were documented in their records. Some people had complex healthcare needs so staff worked closely with a range of healthcare professionals including GPs, district nurses, physiotherapists, and learning disability experts. Specialist assessments and care plans from these healthcare professionals were on file and in use. These showed staff were following expert advice.

Not all the people using the service were able to tell staff verbally if they were in pain or otherwise felt unwell. To address this care plans included information about how people might behave if they had a physical health problem. This meant that staff could advocate for people to ensure their healthcare needs were met.

At the time of our inspection people did not have health action plans in place. A health action plan is a personal plan about what people need to do to stay healthy and describes what support they might need. The Department of Health state that all young people or adults with learning disabilities should have a health action plan. We discussed this with the managing director and registered manager. They told us they were in the process of introducing health action plans at the service and the assistant manager showed us a draft health action plan that had been completed. This showed that work was in progress to ensure people had health action plans in place.

Good

Is the service caring?

Our findings

People told us the staff were caring. One person said they got on well with the staff. Another person said the staff were always patient with them. They said, "When I am angry I tell staff; staff understand." A relative told us the staff had got to know their family member well and said, "The staff are always friendly."

The service had a policy of supporting people to maintain and extend their social network and activities. People's care records included details of their life histories, relatives and friends, and preferences for activities and hobbies. This meant staff were aware of these and could support people to maintain social contacts and make choices about how they spent their leisure time.

Staff had developed positive caring relationships with people. They took an interest in them and encouraged them to explore new opportunities. One staff member told us two people using the service initially did not want to do anything at all. They said they spent time getting to know them and found out that both liked animals. Staff were then able to find them activities involving animals which they enjoyed.

We observed one staff member assisting a person to prepare their own meal. Their approach to the person was warm and friendly. They encouraged the person to take the lead in the activity and supported them to do this safety. We could see that the person was enjoying this activity and they gave us a 'thumbs up' to confirm this. The atmosphere was calm and the setting homely and domestic. The staff member and person appeared to have a good, trusting relationship and to enjoy each other's company.

People told us they were involved in planning their own care and support and had seen their care plans. One person said their level of involvement was 'better than in some other places I've been'. People also said they had chosen what activities they wanted to do and discussed their future plans with staff. A relative said their family member 'says what he wants to do and has lots of choice'. A staff member said people were given copies of their individual support programmes, if they wanted these, to keep in their bedrooms so they could refer to them whenever they liked.

However it was not always clear from records whether people had been involved in all stages of the care planning and risk assessment process. We discussed this with the managing director and registered manager who said people were always consulted when their care and support was being planned, but this had not always been made clear in records. They said this would be remedied. They said they promoted a 'nothing about me, without me' approach wherever possible and in future staff would be using pictures and symbols to ensure people understood what was being written about them. This meant people would be more actively involved in making decisions about their care and support.

All the people we spoke with said staff respected their privacy and dignity. A relative said their family member was 'respected by staff' who gave him encouragement when he found it difficult to motivate himself in the mornings.

Both male and female staff were employed so people had a choice as to who supported them. All staff were

trained in promoting people's privacy and dignity and during our inspection visit we saw staff treat people with dignity and respect at all times.

The design of the environment helped to ensure people's privacy was promoted. Each person had a spacious bedroom with a double bed, an ensuite toilet with a shower or bath, and a large television set. This meant that if people wanted to spend time away from others they could do this in comfort with the facilities they needed at hand and private to them. People could also have keys to their own rooms if they were risk assessed as safe to do this. Some bedrooms had been personalised in line with people's preferences. For example, staff had purchased wall transfers for one person relating to their favourite celebrity.

One person and a relative told us there were no curtains on the windows in communal areas. We discussed this with the managing director and registered manager who said there was privacy glass on the windows which meant that people couldn't easily see in. However they also said that if people wanted curtains they could have them. They said they would discuss this with the people using the service and relatives to get their views on this matter and take action as necessary.

Good

Is the service responsive?

Our findings

People told us staff supported them to be independent which is what they wanted. A relative said, "Some [of the staff] are really good at motivating my [family member]." Records showed people had grown in independence and become more active since coming to the service.

The staff we spoke with were proud of what the people they supported had achieved. One staff member told us, "All of them have progressed so much." They said two people had learnt to use public transport independently and were now, on occasions, going out on their own. One person had said they would like a job so staff were supporting them to find voluntary work.

The care plans we saw focused on people's strengths and abilities and how the person wanted to be supported. Their likes and dislikes were recorded and other key information staff needed to know in order to provide them with responsive care and support.

Staff were able to tell us how they supported people in line with their preferences. They knew the people they worked with well and were familiar with the information in their care plans. For example, one staff member told us that a person they supported enjoyed sensory activities and listed some of these including arts and crafts, cooking, and classical music. They said staff were hoping to convert a spare bedroom in the person's flat into a sensory room using lighting, music, and objects to provide a relaxing environment.

Records showed that staff liaised with mental health, learning disability, and other relevant professionals both before and after people were admitted to the service. This helped to ensure that ongoing good practice and creative working techniques were incorporated into people's care plans. This meant that staff at the service, and outside professionals involved in people's care, were able to provide them with consistent and continual support.

All the care plans we saw included detailed information on behavioural management, as this was a key issues for people using the service. Staff were advised how best to work with people when they became anxious and the techniques they should use to reduce this. For example, one person's care plan told staff how to support them by encouraging them to use learnt breathing techniques. The staff we met were aware of people's emotional states and any triggers that might cause their anxiety to increase. During our inspection they used this knowledge to provide people with responsive care in a calm and supportive manner.

Although we found that care plans provided good information with regard to people's behavioural issues, they were less detailed when non-behavioural issues were being addressed. For example, one person had a mobility issue. Their care plan stated, '[Person] will benefit from assistance to steady himself up and down stairs and on uneven surfaces.' However there were no instructions for staff on what form this assistance should take. For example whether staff needed to prompt this person to steady themselves, or provide them with some sort of physical support. The person's care plan also stated they wished to increase their attendance at religious services. However, there was no written information in place indicating what support

the person needed.

We discussed this with the managing director and registered manager who said care plans were a 'work in progress' and were continually being reviewed, changed and improved. They said they would address the issues raised and rewrite care plans where necessary to ensure staff had all the information they needed to provide people with responsive care that met all their needs.

People told us they chose their own activities and enjoyed doing these. One person said they had been for an interview that morning for a college course and had been accepted. Another person told us they were always busy doing activities and commented, "I choose what I want." A further person listed the activities they had chosen which included 'swimming, bowling, family, shopping.' A relative also told us people could choose their own activities.

Records showed that activities were central to the support provided and people took part in educational and leisure pursuits on a daily basis. They were also encouraged to become more independent by carrying out domestic tasks at the service and managing their own money. The service's location, close to Derby city centre, meant there was a wide range of community facilities nearby and people made use of these.

People told us they would approach staff if they had any concerns about the service. One person said they had complained about a lounge door being left open and staff had listened to them. A relative told us they had no complaints about the service but if they ever did they would 'talk to staff and resolve issues'.

The service's written complaints procedure was in their statement of purpose. It was also available in an easy-read version which used symbols to explain to people what to do if they were unhappy about any aspect of their care and support.

The complaints procedure stated that any complaints received, however minor, would be taken seriously and addressed. The policy noted, 'We encourage residents to comment when relatively minor matters are a problem to them, such as receiving cold food, or being kept waiting without explanation, or being spoken to in a manner that they do not like.' This meant that managers and staff wanted to hear people's views and would listen to them.

When we inspected the service hadn't received any formal complaints. The managing director and registered manager said minor complaints were recorded in people's notes, discussed and addressed, but not entered into a complaints book. We discussed this with the managing director and registered manager and it was agreed that it would be useful for the service to have a complaints book so any themes that emerged could be more easily be identified and addressed. The managing director and registered manager said they would put one in place.

There was information in the complaints procedure explaining to people how they could take complaints to persons in authority outside the service, including local authority and health commissioners. Information on advocacy groups that could help people make a complaint was also included so people could get support if they needed it.

Good

Is the service well-led?

Our findings

People told us they were able to speak openly to managers and staff at the service. They said they knew who the registered manager was. One person said, "[Registered manager's name] is the manager. [He is] in the office upstairs." Another person said, "I know where to find him." A relative said they thought the service was well-managed.

Staff said they could talk with managers whenever they needed to. One staff member told us, "The senior staff are always here and are all approachable." Another staff member said, "If I want to raise something I just come up and see the manager. [He is] always accessible, and I can text him too." They added, "Out of hours contact [with senior staff] is good."

One staff member told us management always listened to staff. They gave us an example of this. They said they were not confident to take a particular person out into the community when their mood was unstable. They said they discussed it with management who listened to them and supported them in their decision.

All the managers and staff we met with were friendly, welcoming and enthusiastic about working at the service. They were keen to discuss 'best practice' and to make any changes to the service that were thought necessary. This approach contributed to a culture of openness at the service and a commitment to continual improvement.

People were involved in how the service was run. The managing director, registered manager and assistant manager told us they spoke with all the people using the service every day (apart from one person who had requested not to meet with them). This was in order to check on their level of satisfaction with the support they were getting. One person had a weekly one-to-one session with the registered manager to discuss their care. Another person preferred to discuss the service over a pizza so the managing director and registered manager took them to a pizza restaurant to do this. This showed that managers used a flexible and personalised approach in order to gather people's views.

Staff told us that residents' meetings had been trialled but hadn't been successful as not everybody using the service liked to discuss their views in a group setting. However they said they would continue to offer people the opportunity to feedback in this way. At the time of our inspection visit service user feedback satisfaction questionnaires had been distributed to people and staff were assisting them to complete these. Relatives' feedback questionnaires had also been sent out. The managing director and registered manager told us that once the questionnaires were returned they would formulate an action plan so people and relatives could see what they were doing in response to any comments made.

Staff told us they had staff meetings and one-to-one supervision sessions with managers, although not as frequently as they would like. The managing director and registered manager told us they were in the process of putting together a more structured programme of staff meetings and supervisions to help ensure staff had the regular support they needed to provide high-quality care.

We looked at how staff managed serious incidents at the service. Records showed they completed 'serious incident reports' whenever these occurred. The reports we saw were detailed and included body maps if any injuries had occurred. Staff then submitted the report to the registered manager.

However it was not clear from the reports what action had been taken following each incident. For example, if the incident was potentially a safeguarding concern the report did not state whether the local authority safeguarding team/CQC/the police (where relevant) had been informed. Nor did the report state what was done to minimise the risk of a similar incident happening again. This meant that the service's incident reporting policy had not always been followed as this stated that follow-up actions 'should be noted on the form, using the reverse if necessary'.

We discussed this with the managing director and registered manager. They told us appropriate action was always taken following incidents but that this was not always recorded on the incident reporting form. They said they would amend this so it included a section where any action taken could be recorded. This would help to ensure that all incidents were safely managed and referred, as necessary, to the relevant authorities.

We looked at how the service had improved through the management listening to the views of the people using it, relatives, visiting professionals and staff. People had been supported to personalise their rooms. Light bulbs in some areas had been changed to give a softer light which was more calming for people. People had said they would like pets so staff had bought two hamsters and two guinea pigs for them. Musical instruments had been purchased for the service. One person had gone to a relatives' home to make tea supported by staff. Another person had started attending a specialised college after both they and their relative suggested this.

The managing director and registered manager told us they were in the process of developing a formal and structured quality assurance system for the service. In the meantime they said they monitored every aspect of the service themselves, including records, staffing, and the premises, to ensure quality care and support was provided and the people using and working at the service were safe. Evidence of these checks was available but not easy to access as the documentation was kept in a number of different places making it difficult to get a prompt overview of how the service was performing. The managing director and registered manager said that once their quality assurance system was in place clear records would be available to show the frequency of checks and audits and how managers and staff responded to findings.