Supported Living Solutions (North West) Limited

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Inspection report

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Tel: 01942840181

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 26 and 27 July 2017. We gave the provider 24 hours' notice to ensure someone would be in the office to facilitate the inspection. The service had not previously been inspected since first registering with the Commission on 03 July 2015.

Supported Living Solutions (North West) Limited is a small supported living service whose office is located on the outskirts of Westhoughton near Bolton, which provides the space necessary for the running of the company and management of the regulated activity and its employees, including facilitating staff meetings, training and supervision.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service had a robust recruitment process to help ensure people employed were suitable to work with vulnerable people.

Safeguarding policies and procedures were in place and the staff demonstrated a good understanding of safeguarding concerns and the process to follow if they suspected abuse.

Comprehensive risk assessments were in place and support plans devised to mitigate the risks. Care files contained a daily observation chart that identified the care interventions that staff had provided at each visit such as any nutritional or personal care support.

We saw that people or their representatives had been involved in planning the care provided.

Staff told us they were well supported and were inducted in to the service and received on-going training to support them to undertake their role.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA).

The relative of the person who used the service told us they valued how staff supported their family member. They said staff were kind and caring and paid particular attention to detail which reassured them that their family member was being well cared for.

The registered manager covered care shifts to ensure they maintained oversight regarding the care provided.

The relatives of the person who used the service were fully involved with decisions about [their relative's]

care and it was evident from care records that the person's personal preferences were taken into account.

There was a complaints policy in place and although at the time of the inspection there had not been any complaints received, there were systems in place to track complaints.

We received positive feedback about the registered manager. The relative of the person who used the service and staff, stated the service was managed well.

The registered manager had an infrastructure in place to seek the views of people who used the service and their relatives by undertaking reviews of care delivery.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The relative we spoke with told us they felt their relative was safe using the service.

Care file information included a variety of risk assessments to enable the service to provide safe care.

There were robust recruitment procedures in place and required checks were undertaken before staff began to work for the service.

Is the service effective?

Good

The service was effective.

Staff received training and supervision to support them to undertake their role and were provided with regular support.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA).

There was a staff induction programme in place, which staff were expected to complete when they first began working for the service.

Is the service caring?

Good

The service was caring.

Care plans were in place identifying care and support needs.

Staff were knowledgeable about the person they supported in order to provide a personalised service.

The relative we spoke with felt that staff were approachable and very caring.

Is the service responsive?

Good

The service was responsive.

The service had a complaints policy and although no complaints had been received, there was a system in place to manage complaints.

Care plans were person-centred and information about a person's life history, likes, dislikes and how they wished to be supported was documented.

Is the service well-led?

Good

The service was well-led.

The staff we spoke with told us they enjoyed working at the service and felt valued, were able to put their views across to their manager, and felt they were listened to.

The service had policies and procedures in place to monitor the quality of service delivery and had appropriate auditing systems and processes.

The relative we spoke with was very complimentary about the registered manager, the staff team and the service provided.

Supported Living Solutions (North West) Limited

Detailed findings

Background to this inspection

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

The inspection took place on 26 and 27 July 2017 and was announced. The provider was given 24 hours' notice because the location provides a small supported living service; we needed to be sure that someone would be in.

The inspection team consisted of one adult social care inspector from the Care Quality Commission. The service had not previously had a ratings inspection since first registering with the Commission on 03 July 2015.

At the time of our inspection one person was using the service who was living with autism and in receipt of a regulated activity which was personal care. The service delivered 155 hours of care to this person each week and there were five members of care staff in post.

The service employed a registered manager who was the nominated individual. At the time of the inspection the registered manager also delivered care to the person using the service.

Before the inspection visit we reviewed the information we held about the service, including information we had received since the service registered with the Commission. The service had sent us the Provider Information Return (PIR), prior to the date of the inspection. The PIR 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 reviewed the care records of the person who used the service and records relating to the management of

the service. We looked at three staff personnel files, policies and procedures and quality assurance systems.

During our inspection we went to the provider's head office and spoke with the registered manager and the director and spoke over the phone with three members of care staff. We met and spoke in detail with the relative of the person who used the service as part of the inspection; this was in order to seek feedback about the quality of service being provided as the person who used the service was unable to speak with us in detail. We also spoke with a local authority professional who was involved with the person who used the service.

Good

Is the service safe?

Our findings

The relative of the person using the service told us they felt their relative was safe using this service and said, "[Person name] gets support on a two-to-one or one-to-one basis at different times of the week, depending on what they are doing. Too many staff would cause confusion to [person name] and I feel the current support is right and this is helping [person name] to do new tasks and activities in a totally safe and supportive environment."

A local authority professional told us, "If I could bottle this service and give it to everyone who is living with autism I would do, and I have nothing negative to say about this service."

We asked staff if they felt there were sufficient staff on duty, one staff member said "I feel we have enough staff and have just taken a new person on who is very experienced. You get a minimum of two days off plus and extra day if you do a sleep over. We never work extra hours and the manager always steps in to cover for staff absence as he doesn't expect staff to do this on top of their normal shift." A second staff member commented, "At the minute we have enough overall."

We asked staff if they had enough time available to safely support the person who used the service. One staff member said, "We have plenty of time with [person name]; we can do activities during the day and then maybe out for dinner later on." A second staff member told us, "I feel there is plenty of time to do things with [person name]. We have a plan for what we do each day and this is 100% important to [person name] and they are fixed on this routine, for example they put the shower on and this tells us that they want one at that time." A third staff member said, "We have plenty of time to do things, there's no rush."

The home used a dependency tool based on the assessed care needs of the person who used the service and we reviewed this during the inspection. We also viewed a sample of staffing rotas to ensure the agreed numbers of staff were consistently provided. We saw there were more staffing hours available each week than required.

The service had appropriate systems and procedures in place which sought to protect people who used the service from abuse. The service maintained a safeguarding policy and associated procedures which were up to date. Staff we spoke with demonstrated a good understanding of local safeguarding procedures and how to raise a concern.

Staff confirmed they had undertaken safeguarding training as part of the induction process and/or continued personal development. One staff member said, "Yes I've done this as part of the induction process and have done this before in other employment. Signs of abuse could be withdrawn behaviour or changes in behaviour, bruising could be physical abuse, or not listening to the person. We work closely with the family and see them regularly. I've never had to raise any concerns in the past but would tell the manager or the director, if they weren't available I know I can contact the local authority or Care Quality Commission." A second staff member told us, "Yes I have done this when I first started. Indicators could be neglect or lack of personal care, or not seeing to the person's needs and not including the person and taking

on board their ideas."

The service had a whistleblowing policy in place and this told staff what action to take if they had any concerns. Staff we spoke with confirmed they were aware of the policy, but had never had to raise any concerns about the service with any other organisation such as the police or local safeguarding team. We asked staff about whistleblowing and comments received included, "Yes I've done this training, I would report to the manager and if there was an issue about the manager I would go to the CQC," and "Yes I've had this and know who to contact if I need to. If it was about the manager I would report to more senior management and I have confidence that they would all listen to me."

Robust recruitment procedures were in place and required checks were undertaken before staff began to work for the service. Personal details had been verified and at least three references had been obtained from previous employers in the staff personal files we saw. Application forms were detailed including previous work history, and interview questions and answers had been fully recorded. Proof of identity and address had also been determined prior to any offer of employment. Disclosure and Barring (DBS) applications had also been obtained for each staff member. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people.

We looked at how the service managed medicines and found that suitable arrangements were in place to ensure that people who used the service were safe. There was an appropriate and up to date medicines administration policy in use covering areas such as ordering, administration, storage, transportation, self-medication, pre-administration check, administration, non-prescribed medicines, controlled drugs and their storage and disposal, general medicines disposal and storage, error reporting and consent.

We found that the person who used the service did not require or take any prescribed medicines but used a certain toothpaste, ear spray and cream to be applied to the knee area. We saw that detailed records were in place regarding the application of these items and medication administration (MAR) charts were used to record this. The staff we spoke with confirmed they had received training in the safe handling of medicines which we verified by looking at staff training records. All staff spoken with confirmed the person being supported did not have any prescribed regular medicines and the service did not administer any controlled medicines.

Staff were subject to a 'practical assessment of medication competency' which was undertaken by the manager. Competencies considered included correct administration, monitoring for any adverse effects, correct record keeping, maintaining the security of the medication, maintaining the correct storage conditions, storage and confidentiality of information. We looked at documentation to verify this had taken place.

We looked at the care and support records of the person who used the service and found these were very comprehensive, well organised and easy to follow and included a range of risk assessments and checks relating to the property in which the person lived to help keep the person safe from harm, including the environment, fire safety and prevention, the floor plan of the house including utilities shut-off points, smoke alarm checks, weekly cleaning checks, weekly electrical appliance testing (PAT), fire blanket and extinguisher checks, first aid box, gas electric and water supplies

The person's care file we saw contained a variety of risk assessments including an environmental risk assessment which covered the physical environment in the person's own home that helped to identify any hazards to the person themselves and the staff members providing support. The care file also contained risk assessments including those for moving and handling, bathing/showering, nutrition/hydration and

medication. We found these risk assessments were reviewed and updated as required in response to the person's changing needs The person had a personal emergency evacuation plan (PEEP) in their file. This meant that in the event of the need to evacuate the building in an emergency, staff had all the relevant information required to ensure this was done safely.

We saw that appropriate fire evacuation processes were in place and fire fighting equipment was available in the head office premises. A health and safety risk assessment had been completed. In the event of the need to vacate the office premises, people's care records were available via secure lap-top access. There was a contingency plan in place which covered actions required for an unforeseen event such as loss of staff and an associated 'business impact analysis' document was also completed which referenced 'what minimum level of resources were required to deliver the minimum level of support,' 'what contingency/control measures were in place to reduce the impact or likelihood of losing the minimum level of service,' 'the maximum amount of time that the function could remain undelivered' and 'if the function was critical at specific times.'

In addition risk assessments were in place for biological hazards, waste disposal and food poisoning and a PPE policy and procedure was in place. Detailed weekly cleaning logs were kept identifying the task and the date completed for each different task on each day of the week.

Personal protective equipment (PPE) was available in the property of the person being supported for staff to use at any time necessary, including gloves and aprons which would assist with minimising the potential spread of infections.

We looked at how the service managed accidents and incidents. There was an appropriate up to date accident/incident policy and procedure in place. We found since registering with the Commission, no accidents or incidents had occurred at the service.

Good

Is the service effective?

Our findings

The relative of the person who used the service told us they felt staff had the right skills and training to do their job. They told us, "Staff know [person name] very well indeed; it's the little things like subtle changes in body language that make all the difference. The manager spends a lot of time with staff before they do their first sleep-over at the property and is always on hand to provide them with back-up. I feel that staff are very experienced and many have worked in the area of autism in the past." They confirmed they felt carers knew what they were doing, and that they always knew the carer who would be providing support for [person name] as this was detailed in their care plan information.

We looked at the process of staff induction for new staff members. New staff were given an employee handbook at the start of their employment which identified the principles and values underpinning the service. Staff confirmed that they had received these documents and undertaken a process of induction which included 'shadowing' more experienced colleagues until they were assessed as being competent to work individually.

There was a staff 'induction booklet' in place which was used to audit the progress of new staff relative to the induction process. This included the aims and objectives of the organisation, the organisational structure, contact details, a job description and person-specification, a twelve week scheduled structured induction programme, an induction training record and induction evaluation. We found the staff induction programme for new staff was robust.

The manager told us that as part of the staff induction training there was discussion about the company's policies around safeguarding, the routes for reporting abuse including individual responsibilities from alerting and investigating cases of abuse, and the whistle blowing policies. This was verified by the staff we spoke with.

In addition an 'employee handbook' was cited in the property of the person being supported which included policies and procedures in a number of areas including personal appearance, equal opportunities, training and development, bullying and harassment, whistleblowing, anti-bribery, performance and capability, which staff could refer to at any time.

We asked staff about the process of induction, one staff member told us, "I had an induction at the beginning and I read care plans and policies and procedures and had a general introduction to the service. I shadowed other staff on shifts for about three to four weeks and felt confident at the end of this. Most times there are two staff on duty at the property." A second staff member said, "I had a 12 week induction period and we had a booklet to fill in each week; this was two years ago. I got shown what to do and what the expectations of the service were and shadowed other staff until I was deemed as competent and I had a supervision meeting with my manager to discuss this. At the end of this period I felt confident to work independently."

We saw that staff were given a copy of the organisation's policies and procedures which were available

electronically or in paper format and staff knowledge of these policies and procedures was tested at supervision meetings and as part of the process of induction. This meant that staff were clear about the standards expected by the service and how the service expected them to carry out their role in providing safe care to people in their own homes.

Staff we spoke with told us they felt they had received sufficient training to undertake their role competently and confirmed the process they had followed since they first stared working for the service. A staff member told us, "We did autism training last year which was very helpful to me and all staff have done this. I've done safeguarding training and training in the mental capacity act (MCA) and deprivation of liberty safeguards (DoLS). A second staff member said, "I've done NVQ level two in the past and now I'm doing NVQ level three and I've done other training such as safeguarding and whistleblowing."

We verified the training staff had undertaken by looking at training certificates and the training matrix. Training included QCF/NVQ levels two and three, health and safety, the administration of medicines, medicines competency, MCA/DoLS, safeguarding, whistleblowing, data protection.

Staff received supervision and appraisal from their manager and a record was kept of all staff supervisions that had previously taken place. These processes gave staff an opportunity to discuss their performance and identify any further training they required. Staff told us they were actively encouraged by managers to share their views and opinions through the mechanism of supervision. Staff told us they received supervisions every two to three months in addition to an annual appraisal. One staff member said, "We get these about every other month and get a list in advance and we go to the office for these. At least every two weeks we go to the office for informal support; we get notes of the meetings and agree the contents." A second staff member told us, "I've had supervision in the past but recently we have had quite a bit of staff bereavement leave which affects it but I hope to get a schedule for this year at the next staff meeting next week."

We looked at records of previous staff supervisions and saw discussions included annual leave and sickness, actions from the last supervision, appraisal targets, training, health and welfare, updates on the person being supported, any safeguarding issues, performance and progression, equality and diversity. Supervision records also contained objectives that were specific, measurable, achievable, realistic, time scaled, (SMART).

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.

Where capacity is felt to be impaired around a particular decision a best interest meeting of people who know the person can determine the best course of action. We saw that a best interest meeting had been held regarding a recent hospital admission and the need for a general anaesthetic, which included the relatives of the person who used the service and other appropriate health professionals. This was undertaken as the person did not have the capacity to make an informed decision regarding the proposed medical treatment. This demonstrated that the service had acted in line with the mental capacity act (MCA) by ensuring the person was appropriately represented at the best interest meeting to enable a best interest decision to be made to address the person's health needs.

Discussions with staff identified that they had received training in respect of MCA/DoLS and had knowledge and understanding of the processes involved. However one staff member told us they had not yet had this

training. At the time of our inspection we found that the provider was working within the principles of the MCA.

The relative of the person who used the service told us there was a care record file in [their relative's] home into which staff entered information about what had occurred at each visit which ensured that information was passed between staff to promote continuity of care.

We looked at the way the service managed consent for any care and support provided. Before any support was provided, the service obtained consent from the person who used the service and their relative. We were able to verify this by speaking to the relative of the person who used the service, checking their care file and speaking to staff. The relative of the person who used the service said, "I can honestly say that staff listen to me and [person name] and they care about what they do."

We asked a member of staff how they would ensure the person they supported had provided consent to care and they told us, "[Person name] cannot communicate verbally but they understand everything we say, so we give information bit by bit so as not to overload them. We are precise in what we say and need to be so not to cause them worry." A second staff member commented, "You can tell by body language or facial expression if [person name] doesn't want to do anything and we respect that."

The relative of the person who used the service said, "Procedures are in place for emergencies and things are now okay compared to what was there before with another service provider."

We looked at how the service supported the person to maintain good health and to access healthcare services. We found a comprehensive health assessment was completed which was easily accessible within their individual care and support plan. This gave clear information and appropriate guidance about health needs and how best to manage their on-going health issues. Where there was a need to refer to other professionals such as a doctor this had been done.

Comprehensive records were in place regarding eating and drinking. There was a four week planned menu which recorded food preferences for each day of the week, in addition to a nutrition log which recorded what had actually been eaten during the day and night. The person who used the service was supported to do their shopping on a regular basis each week as part of their planned schedule and this was recorded in daily activity log sheets.

Good

Is the service caring?

Our findings

The relative of the person who used the service told us that staff were kind and treated them and [person name] with dignity and respect, they said, "Staff listen to me and care about what they do. They interact with [person name] very well and get the timing right, it's all very dignified and respectful. It's the little things like making sure the flap on [person name] training shoe is right; the manager has spoken to the staff about this and they make sure it's on properly. "

During our inspection we looked to see how the service promoted equality, recognised diversity, and protected people's human rights. We found the service aimed to embed equality and human rights through well-developed person-centred care planning. Support planning documentation used by the service enabled staff to capture information to ensure the person received the appropriate help and support they needed to lead a fulfilling life and meet their individual and cultural needs.

Involvement of the person who used the service and their relatives was embedded into everyday practice. Their views and opinions were actively sought and information was presented in a way that enabled them to fully participate and make informed choices. For example a staff member told us, "One of the ways we are now communicating with [person name] is by doing picture cards and we use these so [person name] can point to what they want to do like shopping, or identifying what they want to eat. Body language is also important and they will close their eyes if they don't want to interact with people so we respect this and try again later." A second staff member said, "It's about putting [person name] at the centre of everything you do; everything works around them." A third staff member commented, "It's about caring for the whole good of [person name] and they are at the centre of it all; they like going for walks and the care plan reflects this. Mum and Dad are also involved and regularly visit the house so they know everything about [person name] as well.

The relative of the person who used the service told us they were involved in care planning, they said, "I'm involved in care planning and can be involved or not as is required. I visit a lot and talk to staff about new ideas. I get regular updates from the manager when things change and I can see all [person name] information in their file so I know what's happened and what the plans are for where they are going."

Support plans included details of long and short term goals which had been discussed and agreed with all relevant people at care plan review meetings, including family members. Anticipated outcomes were monitored and information was used to determine if any new approaches were necessary in order to enhance the quality of life of the person being supported.

It was clear from the conversations we had with the manager and staff that they had a detailed knowledge of the person they supported and understood their individual needs, without needing to refer to care file information. Their relative told us, "Staff will listen to [person name] and they understand their communication needs well. [Person name] can be unpredictable and staff know this so they re-phrase things or use objects of reference to help out if they are confused."

Staff communicated effectively with the person who used the service and their relative. Any specific communication needs and individual methods of communication were addressed in the care plan information. A staff member told us, "[Person name] likes to go swimming and shopping and this is planned; you can tell by body language or facial expression if [person name] doesn't want to do this."

A second staff member told us, "When we go swimming [person name] carries their own bag and gets the cards to give to the reception at the centre; they put their own clothes on but you have to arrange them in the right position and they won't put them on if we don't do this."

We found that the person who used the service received support from the same small group of staff members who were very familiar to them. This enabled the development of positive long-standing and trusting relationships between the person who used the service and the staff who supported them.

The service had a service user guide which was given to the person who used the service in addition to the statement of purpose, which is a document that includes a standard required set of information about a service. These documents provided a wide range of information such as the care philosophy; principles and values that the service followed; the standards of care that people should expect; details of the registered managers; a description of the services and facilities provided and how to make a complaint.

The service had a range of policies and procedures in place to cover all aspects of care provision. Staff confirmed they had read policies and procedures and that they were aware of the provider's requirements in respect of data protection and confidentiality.

The service did not provide end of life care. At the time of the inspection the service was not supporting any other organisation or anyone who was in receipt of end of life care.

Good

Is the service responsive?

Our findings

The relative of the person who used the service told us, "[Person name] likes to go swimming as part of their regular routine so staff take them to an ordinary swimming pool and not [specialist pool name] just like anyone else would do. I see staff rotas and pictures of where [person name] has been and sometimes staff text me when they've been somewhere, which is nice. It's all about giving [person name] life chances in the ordinary world."

A social care professional who was involved with the person who used the service told us, "[Person name] is a young man who is now reaching his full potential and able to get out into the community as a result so he's been to a family barbeque which is something he couldn't do before; the service uses the commissioned support hours appropriately."

We looked at how new referrals to the service were assessed. The needs of the person who used the service had been assessed by experienced members of staff before being accepted into the service and thorough pre-admission assessments were completed to ensure the service could meet their individual needs. This included gathering background information from a variety of sources including other health and social care professionals involved in their life and from those individuals who were important in the person's life. A series of initial assessments which covered areas such as health, medicines, social history, preferred activities, moving and handling, environment had been completed.

The person who used the service had a care plan that was personal to them with copies held at both their own home and in the office premises. This provided staff with guidance around how to meet their needs, and what kinds of tasks they needed to perform when providing care. Their relative told us, "It's so good now and [person name] is doing many new things with staff help. Life is not stale for [person name] they need their routines but also need new things offering to expand their views, so now they're learning many new things in life."

We saw care planning information contained detailed records of any activities undertaken including activities for daily living. External activities included swimming, walking, meals out and pub visits, visits to the library, outings with family members, weekly shopping. There was a set of planned structured activities for each week that were important to the person who used the service and staff followed this guidance.

We saw that care file information contained a document that identified the type of support required and specific tasks undertaken on each day of the week. This meant that the person who received the service and their relative were clear about what was support was being provided, where, when and how.

The structure of the care planning information was clear and it was easy to access information. The care plans were comprehensive and person centred, and contained details regarding the person's background and life history, interests and social life, any existing support network and recorded details of people who were involved in care planning such as family members and other relevant professionals.

The manager also visited the person who used the service in their own home to deliver care on occasion and to identify their views and experiences which was confirmed by the relative of the person receiving a service at the time of the inspection. They said, "I have lots of engaging discussions with the manager; he listens to me and we work through any issues so we can identify realistic goals for [person name]. The manager understands about having strong foundations in place; we work out what the problem is together and get it sorted."

There was a system in place to regular review the care needs of the person who used the service. Care planning documents identified regular reviews had taken place and the date when the next review was due.

The service had a complaints policy and procedure in place and information on how to make a complaint was provided to the person who used the service and their relatives. We noted that since the date of registering with the Commission the service had not received any form of complaints or concerns regarding any aspect of service provision.

The relative of the person who used the service told us that should there be a need to complain they felt confident in talking to the manager directly and had regular on-going discussions with the manager as part of the normal process of care delivery. They told us that information on how to make a complaint had been given to them before any care was provided. The said, "I have never had cause to make a complaint but know what to do if need be. I talk to staff openly and I can honestly say I have never had any concerns."

Good

Is the service well-led?

Our findings

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

An up to date registered manager's certificate was on display in the office premises in addition to an appropriate certificate of employers' liability insurance.

Staff told us they felt they were able to put their views across to the registered manager and the director, and felt they were listened to. They told us they enjoyed working at the service and said they felt valued and there was a positive culture. They said they thought the staff team worked well together and it was clear from our observations that the manager worked efficiently and effectively and in a mutually supportive way with staff team members.

One staff member told us, "I can definitely put forward ideas and suggestions and feel we do this all the time in meetings. I think the manager is very fair and is always there to support us and he does the 'on-call' as well; I definitely enjoy working for this service." A second staff member said, " I feel the manager is very approachable and will do anything to help you out. I can suggest things and the manager wants and encourages us to do this and is willing to take this on board any suggestions we may have. I definitely enjoy it here; team working and working with [person name] is good and the manager is very supportive. We get feedback all the time on the good things we do and also if things are not going so well, and this is a fair position in my eyes as things need to be done properly."

The service had an infrastructure in place to seek the views of the person using the service and their relatives, and opinions were documented in care file records. The relative of the person who used the service commented, "I have never felt they (the service) have not taken on board what I say. The manager is the nearest thing to being [person's name] parent that I can think of and he supports me with emotional issues."

A social care professional told us, "I have known and worked with the registered manager for a number of years; he has a very thorough knowledge of autism and is very person-centred."

Staff told us meetings with the manager were held regularly. We looked at the minutes from recent staff meetings, which were usually held each month and discussions included care file updates, communications book review, community based and in-house activities updates, any safeguarding concerns, health updates, health and safety, annual leave, service updates, any other business.

One staff member told us, We review [person name] situation every month at the team meeting and we all get round the table and go through everything about them. Dad comes and takes [person name] out so we can all go to the meeting at the same time, so nothing is missed and we all know what's going on." We saw notes of these meetings were very detailed and centred around the needs of the person being supported at

the time of the inspection.

The service had an infrastructure of auditing in place to monitor the quality of service delivery. We saw a number of audits/reviews of care file information were in place and spot checks on care staff to verify their competence in providing safe and good quality care were also carried out, which staff verified.

We noted that since registering with the Commission the service had not received any form of complaints, and there had been no accidents or incidents or any other occurrences that would necessitate the need for a statutory notification to be sent to CQC. Discussions with the registered manager showed that they understood their responsibility in respect of submitting statutory notifications to the Commission.

The service worked in partnership with other professionals such as GP, consultant, social worker as necessary and their involvement was documented in the care records we saw.