Care Quality Commission

Selwyn Care Limited

Matson House

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

Overall summary

This inspection took place on 4 and 5 November 2014 and was unannounced. Matson House is a care home providing accommodation and personal care for up to 11 adults with a learning disability or an autistic spectrum condition. The people living at Matson House had a range of support needs. Some people could not communicate verbally and needed help with personal care and moving about. Other people were physically able but needed support when they became confused on anxious. Staff support was provided at the home at all times and most people required the support of one or more staff away from the home.

There was not 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 and associated Regulations about how the service is run. The person currently managing the service was in the process of applying to us to become the registered manager.

At our last inspection in May 2014 we found the recording of daily notes, medicines administration, support planning documentation and cleaning records to be inconsistent and unreliable. The provider told us they

Summary of findings

would take action to address our concerns. Since we received this feedback from the provider, a new area manager and new manager had been appointed. They were making significant changes within the service at the time we visited.

The staff and relatives told us the service had changed a lot since the new manager had come to post. Staff felt more able to share concerns and were confident they would be listened to. The manager told us about changes he had made following feedback from people and staff. This included using agency staff until a full staff team had been recruited.

The manager was open with us about elements of the service that still needed improving. The need for improvements had been identified through internal audits and quality checks by the provider. The initial focus had been on making the service safe and now the quality of care was being addressed. Both staff and relatives told us the focus of the service was now the people being supported. The activities available to people, the quality of food and the way staff communicated with people were also being addressed.

We observed some unsafe practices. For example, staff not following infection control procedures and not following mealtime guidelines. We found some breaches of our regulations. You can see what action we told the provider to take at the back of the full version of this report.

We observed some staff supporting people in a caring and patient way. However, other staff focused on the task not the person or did not communicate with people as much as they could. Some staff required further training and the quality of record keeping was not consistent. We had not received relevant notifications from the service. Services tell us about important events relating to the service they provide using a notification.

Summary of findings

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 not always safe. On one occasion staff did not follow infection control procedures which put people at risk of infection. On another occasion staff did not follow mealtime guidelines which put people at risk of choking. These were significant but isolated incidents that did not reflect the care provided at other times.

Staff knew what to do if they had concerns about the support being provided. The manager had prioritised building a trusting relationship with staff to encourage them to share any concerns. Risks were managed to achieve a balance between keeping people safe and allowing people to make choices for themselves. Lessons were learnt when things went wrong to allow future improvements.

Recruitment was ongoing to achieve full staffing and in the meantime, agency staff were being used. The way medicines were administered was being changed to make it safer and less institutionalised. Errors in administration were acted upon.

Is the service effective?

Requires Improvement

The service was not always effective. Health records were not fully reliable which risked people not receiving the care they needed. Appropriate applications to deprive people of their liberty had been submitted. However, some assessments required under the Mental Capacity Act 2005 had not been completed.

The food provided was being reviewed as staff had identified the menus were repetitive and people did not always enjoy the options. Work was ongoing to make fresher and healthier food available.

Some staff had not received training required by the provider. Similarly, staff had not all completed training relevant to the needs of the people they were supporting. Staff support through meetings with their line manager was being reintroduced.

Is the service caring?

Requires Improvement

The service was generally caring. People were encouraged to make choices about their daily lives. There was, however, little evidence they or their relatives had been consulted about the running of the service.

We received positive feedback about the support provided from people living at the home, relatives and professionals.

Summary of findings

However, there was variation in the quality of care provided by some staff, particularly agency staff. The manager was aware of this and action was being taken. Some staff were patient and caring. Other staff focused on the task not the person.

Is the service responsive?

Requires Improvement

The service was not always responsive. Support plans recorded people's likes, dislikes and preferences but were not being robustly reviewed to take account of changes.

There was little evidence that people's goals were being worked towards and a new system was being implemented to address this. Similarly, work was going on to ensure everyone had the opportunity to take part in activities away from the home.

Some people were able to share concerns with staff. For other people, monitoring was in place to make sure action was taken if their behaviour showed they were unhappy. Relatives told us concerns had been addressed in the past.

Is the service well-led?

Requires Improvement

The service was generally well-led. Notifications of significant events had, however, not been shared with us in line with the requirements of the law.

Staff, relatives and professionals were all positive about the manager and the changes that had taken place since he came to post in May 2015. Recent quality audits had identified areas for improvement within the service and these were being addressed. There was a commitment to listening to people's views and making changes to the service in accordance with people's comments and suggestions.

The staff understood the aims of the provider and we saw these being applied by most staff during our inspection.

Matson House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 4 and 5 November 2014 and was unannounced.

Before the visit the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed previous inspection reports, notifications and enquiries we had received. Services tell us about important events relating to the service they provide using a notification.

The inspection visit was undertaken by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience had experience in the field of autism.

On the day we visited we spoke with two of the 12 people living at Matson House, the manager, the area manager for the provider and six members of staff. Other people living at the home were either unable to speak with us or chose not to. We spent time observing the care and interactions between staff and people living at the home. We looked at three support plans, five staff files, staff training records and a selection of quality monitoring documents. Following the visit we received feedback from two relatives and one health care professional.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from avoidable harm. The following two concerns relate to significant but isolated incidents that did not reflect the care provided at other times. During our inspection we observed a member of staff, who had previously been using cleaning equipment, give a biscuit to a person and attempt to clean a mark from around their mouth without changing their gloves. This put the person at risk as the gloves may have been dirty or have had cleaning products on them. Staff had received infection control training, however, what we observed was not in line with the company policy. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.We informed the manager and they immediately spoke with the member of staff about this practice.

One person needed their food cutting up as they ate quickly and were at risk of choking. They were served a meal that had not been cut into small pieces and began to choke. The member of staff supporting them was otherwise engaged and did not notice them struggling with their food. When we highlighted this to a senior member of staff they told us the member of staff should have been encouraging the person to eat slower and they spoke with the member of staff to address this omission. Staff did not follow the guidelines in place for this person and so put them at risk of choking. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Two people living at the home said they felt safe and staff listened to them. Similarly, relatives were confident people were safe and well supported. Some people living at Matson House would be unable to tell anyone if they were being abused. Other people could tell staff or their families if they were unhappy. Staff said they did not ask people if they were worried about anything as this was known to cause them distress. Instead, staff monitored people's behaviour for any unexpected changes that might indicate abuse was occurring.

Staff had access to guidance about safeguarding to help them identify abuse and respond appropriately if it occurred. They told us they had received training. Training records showed 10% of staff had not completed safeguarding training and a further 20% were overdue refresher training according to company policy. The manager was addressing this shortfall. Staff described the correct sequence of actions to follow if they suspected abuse was taking place. They said they would have no hesitation in reporting abuse and were confident the manager would act on their concerns. The manager said he was spending time with staff to build a trusting relationship so they felt able to share concerns. Staff were aware of the whistle blowing policy and the option to take concerns to appropriate agencies outside the home if they felt they were not being dealt with effectively.

Risk assessments were completed with the aim of keeping people safe yet supporting them to be as independent as possible. Most people were not able to assess the risks they faced so family members, advocates or health and social care professionals were consulted. Staff told us they valued being increasingly involved in the risk assessment process. Risk assessments gave staff clear guidance to follow that matched the content of people's support plans. A financial risk assessment was undertaken to identify the support each person needed. It had not been assumed everyone needed the same level of support. The manager told us they were currently reviewing financial processes as some processes posed an unnecessary risk to people or staff. For example, staff had access to people's debit cards and pin numbers.

When something went wrong, a review took place to identify what could be done to prevent the same thing happening in the future. For example, one person did not receive their medicine during a seizure as quickly as they should have done. As a result, protocols were changed and additional staff training was provided. Incidents were recorded and the resulting actions were tracked to ensure they were completed. The types of incidents were reviewed to help identify any trends which needed addressing.

Staff and the manager could request maintenance to be undertaken and they said requests were actioned in a timely fashion. Fire alarms and equipment were regularly tested to ensure they were in working order. There was an emergency evacuation procedure for each person that identified the help they would need to safely leave the building in an emergency.

Each person had a medicines profile that contained information on how to administer their medicines, the reasons they took the medicines and the possible side effects. At our previous inspection in May 2014 we found lists of the medicines people took in their support plans

Requires Improvement

Is the service safe?

and these were not being updated when changes occurred. The provider told us they would be removed and staff directed to the person's medicines profile. Although most support plans no longer contained these lists, some did, and as before they were not current. This inconsistency could cause confusion. The manager told us these would be removed. For medicines taken as required (PRN) there was a protocol that described when and how the medicine should be given. We did not find any gaps in the medicines administration record (MAR).

In the preceding six months, nine medicine administration errors had been documented. Following each error an investigation took place to review and address what went wrong. Actions included stopping some staff administering medicines until they were deemed safe to recommence following a competency assessment. People's medicines were stored in a locked cabinet. When we visited, medicines were being moved from a single cabinet in the staff office to individual cabinets in each person's room. This change aimed to reduce the incidence of medicines errors. The storage and administration of medicines was audited weekly to check good practice was being followed. Where problems were found, such as paperwork that needed updating, they were addressed. We observed staff administering medicines safely and in line with company policy.

The number of staff needed for each shift was calculated using the hours contracted by the local authority. The manager had identified some people needed the opportunity to spend more time with staff on an individual basis. They were reviewing the contracted hours with the local authority. Some staff had recently started working at Matson House and others were being recruited to complete the staff team. In the meantime, agency staff were being used to fill any gaps. Prior to the new manager starting, agency staff had not been used so the number of required staff were not always on duty. Staff reported an improvement in the support they could offer since staffing levels returned to the required level.

Effective recruitment procedures ensured people were supported by staff with the appropriate experience and character. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions that may prevent them working with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

People were not always supported by staff with the required skills and knowledge. The manager told us he had found a significant variation in the skills and experience of the staff team. He planned to give staff with development needs the opportunity to spend time shadowing more experienced staff so they could learn from their good practice. Staff told us the training they had received was "basic" and "didn't feel relevant". They went on to explain there was always a two week shadowing period that allowed new staff to understand each person's needs. They said this was when they really learned what they needed to know.

Training records showed 62% of staff training was current. Most of the gaps related to six members of staff, most of whom worked night shifts. The manager said this level was not acceptable and he was developing a plan to identify the training needed as a priority. The manager had also identified the need for training specific to the needs of people to give staff greater confidence and the skills they needed to support the people effectively. A significant proportion of staff had training in communicating with people with an autistic spectrum condition and positive behaviour management. However, about 40% of staff had not had training on understanding autism or needed to attend a refresher course. This training was necessary to help staff support the people living at Matson House. The manager told us a course was being arranged.

The manager had identified staff were not having the opportunity to meet with their manager regularly to discuss their performance and any concerns they may have. He had arranged for team leaders to start undertaking these meetings but had not yet developed a schedule for the meetings to take place. Minutes of meetings that had taken place recently showed training needs and staff development were discussed along with any concerns the member of staff had about the quality of care provided. There was not yet a system in place to check whether the actions from previous meetings had been followed up. The lack of regular meetings and follow up from meetings that were taking place increased the risk that poor quality care was not addressed in a timely fashion. These issues relating to staff support and training were a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Most staff had received training on the Mental Capacity Act 2005 (MCA) and understood the need to assess people's capacity to make decisions. Training records showed 10% of staff had not completed MCA training and a further 20% were overdue refresher training according to company policy. The MCA is legislation that provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Some of the records about people's mental capacity showed a lack of understanding of the Act. One person's support plan said they understood the need for doors to be locked for their safety and so had capacity to agree to this decision. There was, however, a mental capacity assessment in place that said the person did not have capacity to make this decision. This conflicting information could cause staff to come to incorrect conclusions about the person's mental capacity. This assessment was due be reviewed in November 2013 but there was no evidence this had happened. The person's capacity to make this decision may have changed in the meantime.

Staff were required to support most people with their finances. A capability assessment had been completed for each person so staff knew the level of support they needed. This was not, however, supported by a mental capacity assessment and best interests decision for people who did not have the mental capacity to decide whether staff should support them or not. One person had been assessed as not having the capacity to make decisions about issues including wearing clothes and taking their medicines. A best interests meeting had been arranged by the staff to review these decisions. However, staff could not provide us with any other mental capacity assessments for each person lacking capacity to make decisions about the administration of their medicines. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The DoLS provide a lawful way to deprive someone of their liberty, provided it is in their own best interests or is necessary to keep them from harm. Some people required constant support and would not be safe if they left the home alone. Applications had been made to the local authority to deprive people of their liberty and these had been authorised. Further applications were awaiting review by the local authorities.

Requires Improvement

Is the service effective?

Those people with an authorisation in place received regular visits from an advocate. An advocate is some who helps others express their views, makes sure their wishes are considered and defends their rights.

Some people needed staff to guide them away from potentially harmful situations. Staff did this by redirecting people's attention and, if necessary, using gentle touch to encourage them to move away. Staff did not move people using physical force.

Each person had a health action plan that identified their primary health needs and the support they required to remain well. This helped staff ensure people had the contact they needed with health and social care professionals. The system to identify when people needed a review with health and social care professionals was not working well. The recording of appointments and the frequency of appointments needed was inconsistent. For example, it was not recorded how often one person needed to visit the optician and there were no visits on record for them. Therefore problems with their eyesight may not be picked up and managed in a timely manner. Their eyesight may deteriorate without proper monitoring.

A relative told us staff had responded well when their relative became unwell. Staff monitored people's physical and psychological wellbeing and addressed their changing needs. They contacted health and social care professionals for guidance and support when a need arose. For example, referrals had been made to a speech and language therapist and an occupational therapist for specialist guidance.

Two people told us they liked the food. A four week rolling menu was used to plan the meals for most people but two people preferred to make their choices daily. The menus were being reviewed as staff felt they lacked variation and people did not always enjoy the options. Staff told us "the food's really not good" and "it's always the same. You'd get bored". For example, sandwiches were very often served for lunch. Staff had been asked to make suggestions about what should go on the new menus based on their knowledge of people's likes and dislikes as many people could not say what they wanted. Staff told us the food purchased in the past had been low quality and this was being addressed. For example, less food was being bought in bulk and more was being bought fresh each week. Staff told us food on the menu was currently not always available so alternatives were provided. The manager explained they had been using agency staff whilst staff were recruited which had made it harder to set up a routine to buy food regularly.

The provider had recently agreed to maintenance work taking place within the home to make it feel less institutional. For example, the staff office had been moved from the entrance hall to give people more room to sit. Other areas of the home were being redecorated and modernised. People had private space when they wanted to be alone and this was especially important to those people with an autistic spectrum condition.

Requires Improvement

Is the service caring?

Our findings

There was little evidence of how people were involved in planning their care and support or how they were able to provide feedback on the running of the service. The manager was aware of this omission and it had also been highlighted in a recent quality audit by the provider. The manager planned to address this as he developed a better understanding of how each person could be best supported to do this. For example, he was intending to introduce "talk time" which would be an informal opportunity to speak with people and gather feedback from them. This would be adapted to suit each person's communication needs.

Staff provided care that was generally safe but this was often done in a way that focused on the task rather than the person and so lacked a caring focus. We observed some staff speaking to people but then not waiting for a response. Some people were sitting in the same room as staff but staff did not speak with them as they were talking with other staff or watching television. The manager was spending time informally observing staff to identify areas for improvement. He planned to complete regular observations in the future that would form part of the performance monitoring systems. He had already identified that staff needed to increase the interaction they had with people and ensure they were proactive in supporting people to take part in activities away from the home.

In contrast, we observed some staff patiently reassuring people over and over again. Other staff communicated in a warm and friendly way with people and often got some level of positive response. We also saw some staff sharing jokes with people and chatting about topics of interest to the person. The manager told us he was aware of the variation in the quality of care provided and was seeking to share good practice and address poor practice. Staff told us they now felt more confident to challenge poor practice as they felt they would be listened to by the manager and action would be taken.

One relative told us they were very happy with the support their relative was receiving. They said he was very settled and staff "had built a good team around him". They told us staff were allocated flexibly to meet his needs. Another relative said the staff "are very caring" and they said their relative seemed happy. When someone did not have family or friends to represent their best interests, an advocate was arranged for them. The advocates attended care planning meetings and were involved in significant decisions about the person.

People were mostly supported by staff who knew them well. Some agency staff were being used and they generally understood people's needs but some knew little about the person's history or preferences. A recent quality audit had identified significant variation in the quality of care provided by agency staff. The manager was recruiting new staff to reduce the use of agency staff and improve staff consistency. Most permanent staff demonstrated detailed knowledge about the people living at the home. They told us what could upset people, what helped them stay calm and what the person was interested in. This closely matched what was recorded in people's support plans.

Staff spoke about respecting people's rights and supporting them to increase their independence and make choices. For example, one person was being encouraged to try new activities and new foods to widen their horizons. People were offered choices about food, social activities and how they spent their time. Staff told us choice boards were available to help people communicate what they wanted but they went on to say these were not often used as staff generally knew what people were trying to say. They could not locate the boards when asked. Staff told us people had not got any specific spiritual or cultural needs. This had been discussed with people's families where the person was unable to communicate this for themselves.

Staff were considerate of people's dignity. Some people liked to spend time alone and this was respected. Staff made sure people were dressed appropriately before leaving their rooms. One person did not like the sensation of wearing clothes and staff had been working with professionals to find ways of ensuring his dignity was maintained. They had tried different types of material and different types of clothing and progress was being made.

Requires Improvement

Is the service responsive?

Our findings

The majority of people using the service had limited communication skills. As a result, support plans were important tools to ensure people received the support they needed. Each person had a support plan which was personal to them and identified how involved they had been in putting it together. For most people there had been little involvement. The plan started with a section called "What is important to me" which contained information all staff must know about the person and their preferences to help staff treat them as an individual. One plan we looked at was three months past the allocated review date. There was information in this plan about college courses planned for Spring 2013. When the plan had been reviewed in February 2014, this outdated information had not be removed or replaced. Staff did not have access to reliable and current information about the person. The manager told us each plan was being reviewed to make them more focused on the person and to reduce unnecessary duplication.

Support plans included information on maintaining people's health, their daily routines and how to support them emotionally. It was clear what the person could do themselves and the support they needed. Where people could become very anxious there was clear information about how to support them to manage their anxiety and how to communicate effectively with them. There was also information on how to support the person to make decisions. Each person had a financial capability assessment in place so staff knew the level of support they needed to look after their money. For one person an action plan had been developed in March 2013 to help them learn to use a cash point so they could be more independent. However, there was no evidence of progress against this goal and staff still withdrew money on their behalf.

We asked staff how they took account of people's changing views and preferences. They told us there was a verbal handover at the beginning of each shift where the incoming staff team was updated on any relevant information. A recent quality audit had suggested handovers should now be recorded. The manager was now encouraging staff to update support plans when they became aware of changes. Staff said they were being more involved in support planning and hoped the reintroduction of key workers would help ensure support plans remained current.

At our last inspection there had been gaps in the daily notes and cleaning records for each person. We found this had improved but there were still gaps which resulted in staff not having all the necessary information about the person. For example, one person needed daily documentation of their medical condition, including any warning signs of potential deterioration. In the October 2014 notes, 12 out of 30 days were blank but it was not clear if there had been no signs or if the recording had not been done. This lack of information could make it more difficult for staff to respond appropriately to that person's needs.

These recording omissions were a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Each person had a list of suggested activities they were known to enjoy. Staff ticked to show when the person took part in an activity and recorded if it went well. The manager planned to change this recording system as it did not provide the kind of information he needed to support effective activity planning. Staff were starting to review the activities each person was able to take part in. They had identified there was scope for people to go out more and had identified the people they needed to focus on as a priority. Some people went swimming, others went to local pubs and local shops. Staff told us there was now more transport and staff available to take people out and there was an increase in the number of activities people took part in.

Each person had a number of goals staff were expected to help them work towards. Staff did not know what they were and the goals had not been reviewed for some time. There was no recent evidence recorded of progress against these goals. For example, one person had two goals; to go food shopping and help prepare lunch. Both had a single update in August 2013 but no record of progress since. To address this, each person had recently been supported to identify a wish. The manager now planned to convert these into a small number of achievable goals for people to work towards.

Requires Improvement

Is the service responsive?

The manager was working with staff to change the way support was provided. One member of staff had been responsible for all cleaning and cooking and the support of two people who did not have one to one hours commissioned by the local authority. This had resulted in both people spending much of their time in the house. All staff were now responsible for cooking and cleaning with the person they were supporting. This gave the member of staff previously responsible for cooking and cleaning more time to spend with the people they were supporting. Other barriers to supporting people away from the home, such as staff not having the right training, were also being addressed. For example, one person needed to be supported by staff with epilepsy training but only a small number of staff had this training which limited who could take the person out. Training for more staff was being arranged.

One person told us they could tell staff if they were not happy. A relative told us staff responded well to any concern they raised and they felt comfortable mentioning any problems. Another relative told us they were confident staff would act on any concerns they raised. Most people would be unable to make a complaint verbally so staff monitored their behaviour for changes. If someone's behaviour changed, staff tried to find out if they were unhappy about anything and address this. A complaints procedure and log were available but no complaints had been received recently.

Requires Improvement

Is the service well-led?

Our findings

Important information is shared with the Care Quality Commission (CQC) using notifications. The manager was openly informing CQC when a significant event occurred which allowed us to monitor the safety of the home. He had, however, not informed us when Deprivation of Liberty authorisations were approved by the local authority. This was a breach of Regulation 18 The Care Quality Commission (Registration) Regulations 2009.

The manager had joined the service in May 2014. One relative told us the "new manager is caring and communicates well with staff". He planned to introduce a feedback survey for family members, particularly for those people who could not easily communicate their views. He had not yet asked families how and when they would like to be communicated with by the staff.

Staff described a better management structure with managers that listened and took action. One member of staff told us disciplinary action had not been taken when needed in the past but this had now changed so poor practice was no longer tolerated. We saw examples of concerns staff had raised with the manager, including concerns about the performance of other staff. The manager told us about actions that had been taken to address these concerns. Staff understood the pathway for raising concerns with the manager or senior staff at the provider. Staff said they had an opportunity to discuss what happened if something went wrong. One member of staff said "the manager seems really nice at heart and I really feel he wants feedback. It's really open now."

The manager and staff told us about changes ongoing within the home. This included changes to the way staff worked and the culture of the home. Staff told us the culture of the home had changed for the better since the current manager came to post. They said he "wants to change what is not working". For example, new staff were being recruited and agency staff were being used in the meantime to keep people safe. Staff described a "more modern person-centred approach" from the manager and area manager. For example, staff were being supported to review activities and ensure they were the best options for the person concerned. The manager had recently arranged the first meeting for all staff. Staff meetings aimed to ensure all staff understood the ongoing changes within the service and to ensure staff had a chance to discuss any concerns. In the last meeting, some performance issues were highlighted such as cleaning, reporting maintenance requirements and record keeping. We could see changes had since been put in place by staff.

We asked the manager and staff about the key challenges facing the home at this time. The manager said he needed to build up confidence in his leadership and work towards empowering staff to be more proactive about updating care plans and suggesting improvements to the service. The manager wanted staff to feel able to suggest activities people could take part in or skills they could be encouraged to develop. The manager also told us quality monitoring procedures had not been followed in the recent past and these were being reintroduced to improve quality. Staff told us they were working to address the problems identified by recent audits. They were looking forward to having a full permanent staff team and to the new ways of working being fully embedded.

The provider's primary aim was "to deliver the very best care for adults with autistic spectrum disorder". The manager's vision for the service was to provide a "fun environment where people could do things and gain independence by taking positive risks". Staff understood the aim of the company and we saw it being put into practice by most staff during our inspection. For example, staff meeting minutes showed staff had spent time discussing how to support people to meet their unique needs.

The provider visited the service to monitor compliance and share relevant developments in compliance and best practice. An audit had recently been completed by the compliance manager which had resulted in a range of actions for the service. The actions had been prioritised in a service improvement plan and were being addressed by the staff when we visited. The actions included improving financial safeguarding arrangements, paying staff to come in for team meetings to improve attendance and improving medicines recording. The actions focused on the impact on people rather than systems and processes. Many of the problems we identified during our inspection had been picked up in the provider's own audit. The audits and reviews benefited people as they resulted in improved practice.

Matson House was accredited by the National Autistic Society and the staff were working towards ongoing accreditation. To achieve accreditation staff had

Requires Improvement

Is the service well-led?

demonstrated they provided a service that met the needs of people with an autistic spectrum condition. The provider shared information with the manager when legislation or best practice changed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The registered person had not notified the Commission without delay of authorisations received from the supervisory body to deprive people of their liberty.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The registered person had not ensured that service users were protected against the identifiable risks of acquiring an infection by the effective operation of systems designed to prevent the spread of infection.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **The registered person had not ensured service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user including appropriate information and documents in relation to the care and treatment provided to each service user.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person did not have suitable arrangements in place in order to ensure that persons**

This section is primarily information for the provider

Action we have told the provider to take

employed for the purposes of carrying on the regulated activity were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by receiving appropriate training, professional development, supervision and appraisal.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe, by means of the planning and delivery of care in such a way as to ensure the welfare and safety of the service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangement in place for establishing, and acting in accordance with, the best interests of the service user.