National Autistic Society (The)

Blackdown House

Inspection report

Somerset Court
Harp Road, Brent Knoll
Highbridge
Somerset
TA9 4HQ

Tel: 01278761905
Website: www.nas.org.uk

Date of inspection visit:
30 June 2016
01 July 2016
05 July 2016

Date of publication:
24 August 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Blackdown House is a large detached bungalow situated in the extensive grounds of Somerset Court. The home accommodates up to 12 people who have autism and complex support needs.

The home comprises of the main building and two self-contained flats attached to the home. During our inspection there were four people living in the main part of the home and one person living in each of the flats. People living at Blackdown House can access all other facilities on the Somerset Court site which include various day services.

The service was last inspected in July 2014 and was compliant with the standards we inspected. This inspection was unannounced and took place on 30 June and 1 and 5 July 2016.

There was a registered manager responsible for the service, the registered manager had recently resigned. 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 operations manager was working in the home whilst they were in the process of recruiting a new manager.

Due to their being a predominantly new staff team, some staff were not skilled, experienced or knowledgeable enough to respond to the complex needs of people. Staff did not always feel supported during incidents. At times there was not a suitable staff skill mix available to keep people safe.

Important information relating to people was not easily available for staff and staff were not all aware of the actions they should take to ensure people remains calm, their guidelines and routines.

Where people lacked capacity to make decisions for themselves the principles of the Mental Capacity Act 2005 were not always followed.

There were some gaps in staff training but the acting deputy manager had plans in place to address this. New members of staff received an induction which included shadowing experienced staff, however there were not effective processes in place so support staff to access information about people before working with them.

Staff did not always record information about people in a way that promoted dignity and respect. We observed staff were caring in their interactions with people.

Relatives said the home was a safe place. Systems were in place to protect people from harm and abuse and staff knew how to follow them. Medicines were administered and stored safely.

There were enough staff available to meet peoples needs. A recruitment procedure was in place and staff received pre-employment checks before starting work with the service.

People had access to food and drinks when they wanted them and they were able to make choices about this.

There were systems in place to receive feedback from people who use the service, their relatives and staff. People had access to activities to meet their needs.

Relatives told us they were confident they could raise concerns or complaints with the staff and they would be listened to. The provider had a system in place to audit the service and we saw some progress had been made against the actions identified.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are considering the action we are taking and will produce a further report.

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

Some aspects of the service were not safe.

Staff did not always feel prepared to support people safely and they did not always feel supported during incidents.

People were supported by unfamiliar staff at times and not all staff were aware of what caused people to become anxious and their important routines.

People were supported by staff who knew how to recognise and report abuse.

People's medicines were administered and stored safely.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

People's rights were not fully protected because the correct procedures were not always followed where there were restrictions in placed on them.

People were not always supported by staff with the right skills and competency.

People were able to choose what they wanted to eat and had access to appropriate food and drink.

People had access to healthcare services.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Personal information relating to people was not always kept securely.

People's privacy was not always considered.

Staff interactions with people were positive.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Support to people was not always delivered in line with their care plans.

People's care plans were not always regularly reviewed.

People engaged in meaningful activities.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

Access to important information relating to people and their complex needs was not being managed well.

Systems were in place to monitor and improve the quality of the service for people.

People were supported by staff who felt able to approach the acting deputy manager with concerns.

Blackdown 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 review the rating of the service under the Care Act 2014.

This inspection took place on 30 June and 1 and 5 July 2016 and was unannounced on the first day. It was carried out by two adult social care inspectors on 30 June and 5 July and one inspector on 1 July when we visited the service early in the morning to enable us to meet with night staff.

Before the inspection we reviewed the information we held about the service. We looked at the information we had received from the service including statutory notifications (issues providers are legally required to notify us about) or other enquiries from and about the provider.

During our inspection we spoke with the service operations manager, the area manager, the acting deputy manager and eight support workers. We spent time with five of the people living at the service. They were unable to tell us directly about their experiences due to limitations in their communication so we observed their care throughout our inspection. We looked at the care records of four people living in the home.

We also looked at records relevant to the running of the service. This included staff recruitment files, training records, medication records, and quality monitoring procedures. Following our inspection we spoke with two relatives and received feedback from three visiting professionals.

Requires Improvement

Is the service safe?

Our findings

Some aspects of the service were not safe.

Although some staff had received training to enable them to care for people with complex needs and autism, at the time of the inspection there had been a lot of changes in the staffing structure and team. This meant that many of the staff were new to the service and the people living there. Staff working at the home had varying levels of experience of working with people with autism and complex needs. There were staff vacancies including the registered manager, deputy manager and three support workers. The service was using a high level of bank staff, agency staff and staff who usually worked in the provider's other services. This meant at times there was a lack of consistent and experienced staff working in the home.

Each person living at the home had complex needs and required staff to know how to manage their behaviours and routines. This included causes of anxiety and guidelines to minimise behaviour which could be challenging for staff and distressing for people. Most people living at the home displayed higher levels of anxiety when cared for by people who did not know them well or follow the correct routines. Relatives raised concerns about the changes in the staff team and the consistency in staff supporting their family members. Comments included; "I am anxious due to the lack of long term staff, no one there really knows [name of family member] before there was a very robust staff team" and "Staffing has changed a lot, although there are some consistent staff".

We looked at incidents relating to people's behaviour which could be challenging for staff. Most people living at the home had one to one staff support. A higher level of incidents occurred when people were supported by agency, relief or new staff. This indicated people's anxiety levels were increased when they were receiving support from staff who were not experienced in supporting them.

We spoke to staff about how they ensured they knew about people's complex needs, causes of anxieties and routines. Although there were comprehensive records for each person, the files were numerous and unwieldy. When we spoke to staff who had worked at the service for some time, they were knowledgeable about people's needs and able to safely support people. However, newer staff did not always know key information about people, for example, what could cause them to become anxious.

Staff said they had a lot to read and although there was a useful quick reference communication document for people, people's routine care plans and summaries, they did not know some important information. For example, a male staff member said they had been hit numerous times by the person they were supporting when they were, "Sat next to them". This person's file stated they like a 'two meter space around them' and had 'challenging relationships with men'. One person's communication passport, used for quick information, did not mention they did not like staff staying in their room for too long. Some instructions in care records stated for staff to use the 'low arousal approach'. This means staff should aim to reduce stress on people when they are anxious. Some staff were unable to tell us what this actually meant and had not seen any guidance to follow. We saw in two staff supervisions records it was noted that staff had not yet read some of the care files despite working for some months with people. There was no system to know which

staff had read which files, despite the importance of knowing this information to keep people and staff safe.

People were not always supported by staff who felt prepared to support them safely. Staff told us and we saw from records that at times there were agency staff and new staff covering a shift. This meant staff felt unprepared to care for people safely because they did not understand their needs. For example, an incident occurred and the staff on shift required another staff member from another home on the grounds to come and assist. This was because they were the only staff member available that was trained to perform safety techniques that require two staff. Agency staff did not get involved in this procedure because they were not trained to use the techniques. This meant the new staff member had to ring around the other six homes in the grounds to find someone to assist whilst a person living at the home required support to prevent them harming themselves and others. Two newer staff told us of stressful incidents where they also had to wait for support. They said of being on shift with only new and agency staff, "We are using lots of agency staff, people can get anxious with new faces and it can be stressful." Another staff member commented, "Shifts are not always covered with experienced staff which puts a strain on the team."

Staff all said they tended to use verbal communication to pass over information relating to people to the staff on the following shift. There was no allocated time in between shifts for staff to formally hand over information as a 'handover' session can sometimes be stressful for people with autism. A communication book was used but this mainly included details about food to use up in the fridge, who was having a health appointment or visit for example.

There was no overall, easy way for staff to be informed of key information about individuals before they started their shift, such as when a person was anxious or ill. As most people were supported on a one to one basis it was therefore difficult for staff who did not know people to find out how to support them safely, other than verbally. Due to the lack of time and the amount of information they would need to read staff were unable to. We noted the need for a 'thorough' handover was discussed in a staff meeting in April 2016. An action point was raised for one to be added to the daily task sheet. However this had not been actioned at the time of our inspection. This meant there was a risk important information relating to people was not being communicated between the staff team, which put people and staff at risk.

This had resulted in some staff telling us they felt that newer staff were unprepared to support people in a safe way. Staff told us, "It's fair to say that relief and newer staff may not know all routines and triggers" and "It's hard to look up anything quickly." All risk assessments started with, "All staff to read PBS (positive behaviour support plan), PCP (person centred plan), ELP (essential life plan), Studio 3 techniques (safe methods of intervention) and SPELL (structure, positive, empathy, low arousal and links) training, which was not happening. One support worker said, "It's hard to remember what you've read and what you've heard." All the staff we spoke with said they did not have time to read care files once on shift.

We saw that staff often had to ring another home to ask a staff member to come over and witness medication administration as two staff trained in medication administration were needed. Sometimes there was no-one on the shift who was trained to do this, meaning there could be a delay in giving medication, including medication prescribed to support people when they are anxious. Staff said, "We just have to start at the top and ring around and hope we get someone." There was no easy way to know what staff from which other home would be available.

People were at risk because staff did not always have the right skills to support them in a way that would support them to remain calm. For example, some staff were not authorised to drive for people who lived at the home. This was because there was a minimum age limit on staff driving the vehicle and some staff were under this age . This meant that some people living there who liked to go out regularly, as stated in their care

plans were unable to, which could further increase their anxiety. This had been noted by the provider and more staff were being trained. One support worker was completing their driver training during our inspection.

We saw incident forms were completed where people became anxious and displayed behaviours that could be challenging for staff. These records were analysed monthly as part of the service review by the registered manager. However this information was not always shared with the staff. Staff who did not work regularly did not know about some incidents, telling us certain behaviours had not happened in a while despite us seeing records of recent occurrences. This meant people were being supported by staff that did not always have up to date knowledge of individuals patterns of concern.

We found people had been exposed to an unnecessary increase of their anxiety at times by staff. For example, we saw one incident record where staff did not follow the person's correct way of supporting them when they became distressed. We were told the incident was discussed verbally and a meeting was arranged for the person to review their routine. However, there was no record of a discussion with staff to review their response or guidance so they would respond better in the future and use the correct techniques for the individual. There were also no records of why they had responded in a disproportionate way to the level of the incident, which appeared to have escalated due to staff input.

The lack of consistent staff knowledge about how to manage complex autism and challenging behaviours, lack of timely analysis and learning around incidents and lack of easy access to appropriately trained staff put people living at the home and staff at risk.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

We looked at medication management and medication records. Medicine administration records had been completed after each medicine had been administered and there were no unexplained gaps. Where people needed assistance with their medicines, assessments had been carried out and consent had been obtained for staff to administer medicines. Staff understood when to offer medicines that were prescribed on an 'as required' basis (PRN) and there was information in the medication administration records (MAR) about when to give these medications. For example, one person displayed signs to show they may have a headache and staff were aware and followed the instructions in the person's communication passport. Medicines were stored securely in a medicine cupboard that was locked when not in use and each person had their medication given individually. There were secure storage facilities for medicines that required additional storage and we checked the records which were complete. There were no medicines that required storage in a refrigerator at the time of this inspection.

We observed a member of staff administering medicines at lunchtime. They demonstrated good knowledge of each person's medicines and followed safe practice by checking the medication records before removing medicines from the packaging and giving to the person. There were efficient systems in place to make sure stocks of medicines were replenished regularly by the local pharmacy. Out of date or unwanted medicines were returned to the pharmacy each month. Staff knew how to use people's prescribed creams and lotions. These were detailed on the MAR charts and the acting deputy manager said they would also include body maps to make this clearer. People's care files included information about how people liked to take their medication, for example in their hand and with water. Allergies were well recorded and there was a notice reminding staff to take emergency medication out with people accessing the community. All the staff we spoke with knew about this medication.

Staff were aware of indicators of abuse and knew how to report any worries or concerns. They told us this would be reported to the acting deputy manager and they were confident it would be dealt with appropriately. They were also aware they could report this outside of the organisation to the local safeguarding authority. Staff told us they received training in safeguarding and records confirmed this. We observed information around the home instructing staff on what action to take if they thought a person was being abused. Staff were aware of the whistleblowing policy and felt confident to use it if they had concerns. One staff member told us they had used this and we saw the appropriate action had been taken by the registered manager.

We looked at recruitment procedures. Recruitment processes were thorough and staff files contained evidence of each stage of the recruitment process. This included references from previous employers and people who knew them well and interview notes. The provider had also carried out disclosure and barring service (DBS) checks before new staff started work. The DBS checks people's criminal record history and their suitability to work with vulnerable people. For permanent staff there was a clear induction process including shadow shifts where new staff worked in addition to usual shift staffing levels, with more experienced staff who knew people well. One new staff member was arranging shadow shifts with the acting deputy manager during our inspection.

Requires Improvement

Is the service effective?

Our findings

The service was not always effective.

People's rights were not fully protected because the correct procedures were not always being followed where people lacked capacity to make decisions for themselves. No one living at Blackdown House was able to make complex decisions independently.

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. Any restrictions placed on people should be regularly reviewed.

We found where restrictions were placed on people, the principles of the MCA were not always followed. We found restrictions in place for people such as access to toilet roll, access to taps in rooms, restrictions to minimise biting, having a bath and the use of particular tea bags. Whilst staff were able to describe why restrictions were in place and demonstrated they were looking at other less restrictive options, we found there a lack of documentation in place to support this in line with the MCA. One person had a movement sensor in their bed and sound sensor in their bedroom because they had epilepsy. We asked staff when the person last had a seizure and they told us this was in 2013, they told us the person had four seizures in their lifetime. This meant the home was not ensuring the least restrictive option was being considered for the person.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

We found some examples were capacity assessments and best interest decisions had been made in line with the MCA such as supporting people with their medicines and sharing information. Staff had received training on the Mental Capacity Act (MCA). Staff we spoke with had understood the importance of gaining consent and what to do if people could not consent on a day to day basis in relation to offering choice such as when to get up, choice of clothes or food.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether any conditions on authorisations to deprive a person of their liberty were being met.

The service had submitted Deprivation of Liberty Safeguards (DoLS) applications for all the people living at the home because people would not be safe if they did not have certain restrictions in place. All of the DoLS applications had been authorised. Care plans showed how they had reached the decision to apply for DoLS authorisations and there were mental capacity assessment forms completed by health professionals, and

care plans contained evidence of application documents and review dates.

We looked at three staff files and saw that staff had regular supervision sessions. These were completed using a clear format enabling staff to discuss issues, training needs and competency. However, there had been an investigation into the conduct of a staff member in line with the service disciplinary process. This had been comprehensive and the staff member no longer worked permanently at Blackdown House but as a staff member in the provider's other homes on site when required. There had not had any recent supervision or monitoring of their progress for some months. We discussed this with the service operations manager who told us they would ensure the staff member would receive on-going supervision and monitoring.

The provider had a training programme in place for staff that included basic training such as first aid, food safety and health and safety. We looked at the training records for Blackdown House and found there were some staff that required updated training in some subjects. Following our inspection, the service operations manager confirmed dates had been arranged for staff to receive the training. Staff also received training in supporting people with autism and specific health conditions such as epilepsy. Staff told us the training they received was, "Really useful" and "Alright".

Staff told us they completed an induction when they commenced employment; the acting deputy manager told us they had linked their induction to the Care Certificate. The Care Certificate standards are standards set by Skills for Care to ensure staff have the same skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. Staff told us the induction included completing training and three shifts shadowing staff in the home and they thought the induction prepared them for the role. However we found their induction into the home was not sufficient to prepare them to support people effectively. Staff did not have time to read important documentation about people and how to support them effectively. Staff also raised concerns about working with agency staff who had not received the providers training in supporting people if they became anxious. This meant they were not able to physically intervene and support staff during incidents. Some staff told us they lacked confidence to support some people with complex needs.

There were different ways in place to communicate with people's family and friends. Monthly newsletters were sent out giving details about how people had been that month and what they had been doing. People were also supported to arrange regular person centred planning (PCP) meetings. This is an approach to assist people to plan their life, it enables individuals to increase their personal self-determination and improve their own independence. These were well done with clear involvement from people with a range of abilities. For example, people sent out invitations to who they wanted to attend, what food they wanted and where people should sit. This not only involved people in their care but put them at the centre of decision making reducing their anxiety.

There were two in-house 'partnership' days a year. This was when families were invited to the service to enjoy a meal, BBQ and music with people living at the service. Senior management attended and were available for families and friends to speak to. These events were seen as a good way to build and maintain partnerships.

People were not able to tell us about their thoughts about the food provided in the home. We saw there was a weekly menu displayed on a notice board in the lounge. Staff told us each person chose a meal for each night of the week by using pictures and an i-pad. Staff told us they supported people to prepare meals. People could choose what they wanted to eat from the options available. Staff gave an example of how one

person refused a meal by throwing it away. They told us they supported the person to choose another meal option which they happily ate. We observed people choosing meals by getting food from the cupboards and fridge and showing them to staff. Staff responded by supporting and encouraging people to prepare their meals.

People had access to food when they wanted it and they could go and buy food items from the providers on site canteen if they wished. Staff knew where people liked to have their meals. For example, alone or in the communal areas. One person, for example, liked to know what was about to happen so staff went to their room with a plate before a meal. They knew they liked time to unwind and prepare for a meal to reduce anxiety.

Requires Improvement

Is the service caring?

Our findings

Some aspects of the service were not caring.

The service was generally caring but some areas did not show that staff were consistently using appropriate language or using agreed procedures for people to manage behaviour which could be challenging for staff. We saw there were comments in the communication book, which was easily accessible in the staff office, that commented on personal details about people or used inappropriate language. Records of some incidents about challenging behaviour were written using words such as, "I told him to" and "Told [person's name] to go to their room as opposed to "asked" or "encouraged."

The service was not always considering people's privacy. For example, some people had monitors in their rooms and one person had a monitor in their flat, these were linked to speakers in the communal lounge. Staff were not consistent about the reasons why these were in place, stating general safety or epilepsy. Staff did not know how these were managed, when to turn them on or off, for example to enable people to have private time or when any risk was reduced. During the night some people living at the home were awake in the communal areas and would be able to hear activity in some people's rooms. We spoke to the night staff who said at night the monitors were turned down. Two staff members told us how they, "Turned the monitors down" if people needed privacy.

Staff told us how they knocked on people's doors before entering their rooms and we observed this during our inspection. Staff also told us how the ensured doors were closed whilst they were supporting people with person care and they explained how they offered the amount of support required to encourage independence.

The service did not always support people with their cultural needs. For example, one person's birth language was not English. They were well supported by their family who lived abroad but visited regularly. However, although there had been input for them in their mother tongue in the past and there was information of phrases for staff to use when supporting them in their care file we did not see staff using these. One staff member said, "[Person's name] used to respond much more in [birth language]". Therefore this person had no regular input of their culture and in their birth language which could negatively affect their relationship with their family and sense of identity. We discussed this with the acting deputy manager and service operations manager and they said they would ensure this was looked into and actioned.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

During our inspection we saw staff behaving kindly towards people and showing real affection for the people they cared for. Staff talked positively about the people they supported. We observed staff prompting and encouraging people to do things for themselves rather than doing things for people.

People were able to make choices about day to day aspects of their care such as when they got up and went

to bed, meals and what personal care they wanted. Staff told us that although they were allocated to provide people's one to one hours, if a person wanted another staff member to support an aspect of their care they could choose them. We observed this happening during our inspection. Staff also told us how they supported people to choose where they wanted to go in the community by using an i-pad.

There had been two compliments formally received by the service. One of these was from a family member complimenting the staff. The other was from an agency stating the staff team were good at sharing their knowledge and making agency staff members feel included in the team.

Relatives told us they could visit when they wanted and there were no restrictions. We received mixed feedback from relatives on how welcoming the staff were. One relative told us how their family had visited at the weekend and staff had been, "Casual" and "Offhand". Another relative told us staff were "Fine" and "Welcoming." A visiting health professional told us when they visited staff were, "Always welcoming."

Requires Improvement

Is the service responsive?

Our findings

Some aspects of the service were not responsive.

People had individual care plans and guidelines detailing how staff should support them. Some people's care plans, guidelines and risk assessments had not been updated since 2015. Which meant staff did not always have access to up to date information and guidance on how to support people. We discussed this with the service operations manager who told us they were aware the care plans were in need of updating and stated this process had started. The acting deputy manager confirmed they were in the process of updating two of the care plans.

Due to the large amount of records and information recorded about people and the fact this was kept in several documents, we found important information relating to people was not easily assessable and staff confirmed this.

People's health needs were well managed. However we found records of health visits where the outcome were not always noted. For example, we saw in the communication book one person had been identified as needing to see their GP. We looked in the person's records and could not find any details of a GP visit. Staff told us the person had visited the GP and been prescribed medicines as a result of this. We looked at the person's medicine records which confirmed they had been prescribed new medicines and staff had been administering these for nine days. Staff were not clear about how long the medicines should be taken for as there was no record of this. Staff confirmed a record of the GPs instruction on how to use the medicines should be recorded in the persons health action plan (HAP). We found a record of the medicines prescribed in the medication list in the HAP, however there were no recorded instruction of how long it should be taken for. This meant people the person could be at risk of receiving medicines when they are not required because appropriate records were not kept.

People all had health action plans (HAP) which detailed their needs. For example, how they communicated and information about health professional input such as dentists, chiropodists and hospital appointments. Records showed people had attended appointments. There was evidence of annual health checks for people. People were up to date with dental checks and optician checks. People were referred to appropriate health professionals in a timely way. For example, some people had been assessed by speech and language professionals and their recommendations were being followed. Health professionals told us staff made appropriate referrals and acted on guidance given.

People also had personal goal records. These had been created clearly on a large document showing people's goals and then regular progress reports. For example, to be able to cook a meal, go horse riding and go on holiday. These goals had been achieved and amended accordingly. For example, staff had used photographs and objects to prepare one person to go horse riding and to celebrate a new baby in their family.

Each person had a named key worker. We saw there were weekly check lists that should have been

completed by key workers to ensure people were monitored overall by staff who knew them. For example, to ensure their goals were being completed, checking shopping requirements and family contact. These records were not always completed but staff said the checks were being carried out.

Relatives told us they were invited to annual reviews of people's care. One relative told us of how they were happy with their family members care plan and they were kept up to date with changes in their care. Another relative told us how they had attended a review but they had not received a record of what was discussed and the agreed actions. They went on to say they were aware the changes of staff within the home could have contributed to this.

People had the opportunity to engage in activities. There were clear timetables and notice boards telling staff and people living at the home what they were doing that day. Staff gave people time to get ready and used appropriate objects of reference to inform people what was happening. Staff also knew not to give some people too long to think about the day as they got anxious if they knew too soon.

Some people attended community based activities specifically designed to meet their sensory needs. During our inspection we observed sensory activities being offered to people in the home, which they appeared to enjoy. Staff told us how they thought about trying to give people new experiences and activities. One staff member described how they had supported one person to visit various places of interest to find out what they enjoyed. Another staff member told us how one person liked trees and they were supported to plant one in the grounds. Night staff told us how they engaged with one person 'star gazing' at night, as this was one of the persons interests. All people living at the home had the opportunity to attend at least one supported holiday each year, including travelling abroad. People had birthday celebrations and trips to see their family if appropriate. One person had a car which staff drove and we observed them requesting to go out with staff by getting the keys out of the office.

People were not able to verbally raise concerns or complaints and needed to rely on staff to raise these on their behalf. There were pictorial complaints procedures displayed within the home stating who people should talk to if they had a concern. We discussed with staff how they supported people to raise concerns. A staff member told us how they observed one person appeared reluctant to attend day services. They told us in response to this they were reviewing the persons activities at the day centre to see if there were specific activities they chose to or not to engage in. Staff also told us how they recognised a change in another person's routine, they were aware that the persons daily routine had been getting later in the mornings. In response to this they were monitoring how to resolve this for the person, looking at possible causes. There had been no formal complaints received by the service since 2010. Relatives told us they were aware of the complaints process and they would speak to staff or the manager if they had any concerns.

The service had systems in place to receive feedback from people and their relatives. This was completed on an annual basis. We saw the results of the survey conducted in 2015. Areas covered included people's feedback on being able to make choices, trying new things, staff and activities. Four of the people living at Blackdown house contributed to the survey. Feedback received identified people were satisfied in these areas. The relative's survey covered areas such as; being involved in relevant decision making, being listened to, the environment and their opinions on how people were supported. Two relatives had contributed to the survey and the feedback received was positive.

Requires Improvement

Is the service well-led?

Our findings

The service was not always well led.

One of the National Autistic Society values is to provide care 'until everybody understands' autism. We did not find this was not the case in Blackdown House. There had been a lot of staffing changes within the service over the last few months. Most recently the registered manager had resigned. The service operations manager told us they were basing themselves in the home until a new manager was recruited. They told us they were actively recruiting to the manager's position and they were hoping to recruit a temporary manager until a suitable permanent one could be employed. The senior support worker was currently acting as deputy manager. There were also vacancies for three further permanent support staff. The service operations manager told us there were on going recruitment plans to fill these vacancies. Following our inspection the service operations manager told us a temporary manager had been recruited into the manager's position. They told us this manager would be in post until the home recruited a permanent manager which could take some time.

Despite the issues reflected in this report relating to the lack of experienced core staff, staff told us they felt positive about the future. They felt they worked well as a team, although they were a relatively new team. Staff comments included, "I love working here, it's a brilliant place and I love working with the people who live here", "It's all good change but a lot of it" and "We are encouraged to read the care files and add to them."

However, there were areas of concern that had not been addressed by the provider which could put people living at the home at risk. For example, the lack of consistent staff knowledge about how to manage complex autism and behaviours that could challenge, lack of timely analysis and learning around incidents and lack of easy access to appropriately trained staff put people living at the home at risk. Risk assessments had been completed mainly for any trips out but these were numerous and it was unclear for staff which were current. Some were not detailed enough to keep staff safe such as lack of detail about exact routines for people when they were driven home or back to the service or about risky behaviour and what staff should do. The acting deputy manager said risk assessments were being changed to make this easier for staff.

The provider had not ensured the current care files and recording documents were 'staff friendly' and easy to access. They did not ensure staff had time to read essential information before working with people to ensure staff and the people they were caring for were safe.

Staff felt unsupported during times of incidents and for support to administer medication. They told us that they had not felt well supported by the previous management team. There was an on call system where a manager was available on the telephone. Staff said this was not always helpful especially when trying to cover vacant staff shifts which took up time. Staff said they had not previously felt able to voice any ideas and feel heard. They said they felt well supported by the acting deputy manager who listened to them in a professional way. For example, one staff member had had some positive ideas to support a person and

these had been put into place and valued.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

During our inspection the service operations manager was taking actions in response to our concerns for example, they were arranging for more staff to be able to drive the vehicle and ensuring that no more than two agency staff worked on each shift.

The provider had not always notified us of significant events which had occurred in line with their legal responsibilities. We had been notified of some events. However, during our inspection we found two incidents where alleged abuse had occurred between staff and people who used the service. Whilst both of these incidents had been investigated internally by the provider with appropriate action taken and reported to the local safeguarding authority, neither of them had been reported to us. This meant we had not been able to review the incident and ensure the correct action was taken to ensure people were safe. The service operations manager told us they were aware the registered manager had not reported one of the incidents to us, they told us they had instructed the registered manager to complete this as part of an on-going management procedure.

The service operations manager audited the service on an annual basis and as a result of this created a 'service audit action plan'. The service audit action plan was then reviewed by the service operations manager and registered manager on a four monthly basis. Areas covered included; care planning, records, health and safety checks and the environment. We saw the service audit record from October 2015. This audit identified 89 actions that needed to be completed. A review of the actions required carried out by the service operations manager in March 2016 demonstrated 22 of the actions identified had been resolved. We discussed this with the service operations manager who told us they had been working with the registered manager to ensure the actions were completed.

We looked at staff meeting records which showed meetings were held on a regular basis to address any issues and communicate messages to staff. Items discussed included; record keeping, changes to people's needs and routines, medicine guidance and reminding staff of the safeguarding policy. Staff told us they felt able to voice their opinions during staff meetings. One staff member told us, "Staff meetings are good, you can raise any issues and they are written down and sorted".

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy was not always considered. People were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The correct procedures were not always followed where people lacked capacity to make decisions for themselves.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems and processes were not in place to monitor and mitigate risks relating to the health, safety and welfare of service users and others who may be at risk.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always supported by staff with the right competence, skills and experience to provide care and treatment safely.

The enforcement action we took:

We have issued a warning notice to the provider. They must become compliant by 27 September 2016.