Avocet Trust

Avocet Trust - 21 Potterill Lane

Inspection report

21 Potterill Lane
Sutton On Hull
Hull
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

21 Potterill Lane is located in the east of the city of Hull and is registered to provide care and accommodation for up to a maximum of four people with a learning disability. Accommodation is provided in a large detached house with parking at the front of the building and a garden to the rear. The service is situated in the village of Sutton, close to local amenities.

We undertook this unannounced inspection on 28 November 2016. There were three people using the service at the time of our inspection. At the last inspection on 23 April 2015, the registered provider was compliant in all areas we assessed.

At this inspection we found there was a registered manager in post. The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

We found improvements were required to ensure monies belonging to people who used the service were held securely. During our inspection we saw a number of safety deposit tins were stored in an unlocked safe.

We found improvements also needed to be made to ensure records were accurately maintained in the service. This included fridge and freezer temperatures and food temperatures not being fully completed. The quality monitoring system had not been effective in identifying these shortfalls.

The majority of people who used the service had complex needs and were unable to tell us about their experiences. We relied on our observations of care and our discussions with staff and relatives involved.

The environment was found to be clean and tidy throughout, but improvements were required to ensure the safe storage of disposable gloves.

We found staff were recruited safely and there was sufficient staff to support people. Staff received training in how to safeguard people from the risk of harm and abuse and they knew what to do if they had concerns.

Staff had access to induction, training, supervision and appraisal which supported them to feel skilled and confident when providing care to people. This included training considered essential by the registered provider and also specific training to meet the needs of the people they supported.

Staff had received training in legislation such as the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and the Mental Health Act 1983. They were aware of the need to gain consent when delivering care and support and what to do if people lacked the capacity to agree to it. When people were assessed as

not having capacity to make their own decisions, meetings were held with relevant professionals and other people with an interest in the care such as family members to discuss options and make decisions in the person's best interests.

Medicines were ordered, stored, administered and disposed of safely. Training records showed staff had received training in the safe handling and administration of medicines.

We found staff had a caring approach and found ways to promote people's independence, privacy and dignity. Staff provided information to people and included them in decisions about their care and support.

People who used the service had assessments of their needs undertaken which identified any potential risks to their safety. Staff had read the risk assessments and were aware of their responsibilities and the steps to minimise risk.

We found people's health and nutritional needs were met and they accessed professional advice and treatment from community services when required. People who used the service received care in a person centred way with care plans describing their preferences for care and staff followed this guidance.

Menus were varied and staff confirmed choices and alternatives were available for each meal: we observed drinks and snacks were served between meals. People's weight was monitored and referrals made to dieticians when required.

People who used the service were seen to engage in a number of activities both within the service and the local community. They were encouraged to pursue hobbies, social interests and to go on holiday. Staff supported people to stay in touch with their families and friends.

There was a complaints process and information provided to people who used the service and staff in how to raise concerns directly with senior managers. Relatives knew how to make complaints and told us they had no concerns about raising any issues with the staff team or the registered manager.

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 consistently safe.

Improvements needed to be made to ensure people's monies were being held securely. Not all staff recognised how their actions in not following organisational procedures, had the potential to provide an opportunity for financial abuse.

There were sufficient numbers of staff, available at all times to meet the needs of the people who used the service. Safe recruitment processes were followed.

Staff displayed a good understanding of the different types of abuse and were able to describe the action they would take if they observed any incident of abuse, or became aware of an abusive situation.

Is the service effective?

Good

The service was effective.

People were supported by staff that undertook a range of training, relevant to people's care needs. Staff received supervision, support and appraisal.

Staff understood the principles of the Mental Capacity Act 2005 (MCA), which meant they promoted people's rights and followed least restrictive practice.

We saw people were supported to have a healthy and nutritious diet and to receive appropriate healthcare when required.

Is the service caring?

Good

The service was caring.

We saw staff had developed both positive and caring relationships with the people who used the service and were seen to respect their privacy and dignity.

People were supported by staff that had a good understanding of their individual needs and preferences for how their care and

support was delivered.

Is the service responsive?

Good

The service was responsive.

Arrangements were in place to ensure people had the opportunity to engage in a variety of different activities both within the service and the wider community. People were enabled to maintain relationships with their friends and relatives.

People received person centred care. People had assessments of their needs and care support plans to guide staff in how to support them in line with their preferences and wishes.

There was a complaints procedure in place which was available in alternative formats.

Is the service well-led?

Good

The service was well led.

There were systems in place to enable staff and other stakeholders to express their views. As the people who used the service were unable to be fully involved in completing questionnaires, the way their views and experiences of the service were captured could be further developed.

The registered manager reviewed all accidents and incidents had occurred in the service so learning could take place.

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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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care act 2014.

This unannounced inspection took place on 28 November 2016. The inspection was completed by two adult social care inspectors. The service was last inspected on 23 April 2015 and 30 August 2013 and found to be compliant in all outcomes assessed at the time of the inspection.

Prior to the inspection, we asked the registered provider to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at notifications sent to us by the registered provider, which gave us information about how incidents and accidents were managed. Information we held about the service was reviewed and we contacted the local authority's contracts monitoring and safeguarding teams. Where any issues had been identified by these parties, we included them within our inspection.

A tour of the service was completed and we spent time observing care. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who were unable to talk with us.

During our inspection, we spoke with the registered manager, one senior carer, two care staff, one person who used the service and two relatives following our inspection visit. We looked at the care files for two people who used the service, which included support plans, assessments undertaken before a service commenced, risk assessments, medication records and records made by staff.

We looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty code of practice

to ensure that when people were deprived of their liberty or assessed as lacking capacity to make their own decisions, actions were taken in line with the legislation.

We also looked at a selection of other documents relating to the management and running of the service. These included four staff recruitment files, supervision and training records, the staff rota, menus, minutes of meetings with staff and those with people who used the service, complaints, quality assurance audits and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People who used the service had communication and language difficulties and because of this we were unable to fully obtain their views about their experiences. We relied mainly on observations of care and our discussions with people's relatives and staff to form our judgements.

Relatives told us, "I feel they are very safe, I don't question it at all." They also told us they felt there was sufficient staff available and considered their relative to be well cared for.

During our inspection we found safety deposit boxes containing monies of people who used the service, stored in an unlocked safe and required improvement to ensure people's personal monies were stored safely. At this point of the inspection the registered manager had not arrived at the service, but was on their way in after having been contacted by staff on their day off.

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When we spoke with the registered manager and staff about this, all but one confirmed this was not in line with the organisations policy for the safe keeping of people's monies. Daily records seen showed that checks of balances of monies were made at each shift handover and regularly further audited by the registered manager. There had been no discrepancies found. The registered manager offered us assurances the situation would be dealt with.

We checked this policy and saw it clearly stated that all monies should be kept in a locked box within a locked cupboard at all times, but the policy had not been signed by all of the staff team. This situation needs to be monitored and discussed with staff to ensure people's monies are stored safely at all times.

We recommend the registered provider puts in place systems to assess and manage risk issues that have been highlighted from the safe keeping of people's monies.

The registered provider had contingency plans in place to respond to foreseeable emergencies including extreme weather conditions and staff shortages. This provided assurance that people who used the service would continue to have their needs met during and following an emergency situation.

We saw that improvements were required to one person's personal evacuation plan, it referred to two staff being available within the service and did not guide staff what to do for example during the night when only one staff member was on duty. When we spoke with the registered manager about this they agreed the information could be potentially misleading and needed further clarification which they would address. Staff we spoke with were clear about how the person could be supported safely in the event of a fire despite this.

Staff we spoke with told us they were provided with personal protective equipment (PPE) including gloves and aprons. We observed staff using the correct PPE during our observations. This showed us that the registered provider was taking steps to ensure good hygiene practice, reducing the risk of infection or cross contamination.

However, during a tour of the building we found a box of disposable gloves had been left in a bathroom and had the potential to present risks.

When we spoke with staff about this they told us only one person used the bathroom independently and had never shown any interest in the gloves. They immediately removed the gloves from the bathroom to a secure area. When we discussed this with the registered manager they offered assurances that a lockable cupboard would be immediately requested for staff to store disposable gloves securely.

Regular audits were completed, which ensured the safety of the people living at the service. For example, regular fire safety checks and checks of the environment were completed to ensure people lived in a safe environment. We saw certificates and documentation to confirm the building was safely maintained. The registered manager recorded and analysed information about accidents and incidents within the service. We saw records which showed emergency lighting, fire safety equipment and fire alarms were tested periodically.

The registered provider had policies and procedures in place to guide staff in how to safeguard people from the risk of harm and abuse. Staff confirmed they had completed safeguarding training with the local authority and they were aware of what to do if they had any concerns. They were also aware of the whistleblowing policy and procedure.

In discussions, staff demonstrated knowledge of the different types of abuse and signs and symptoms that may alert them to concerns. Staff told us, "We contact the registered manager straight away and complete a safeguarding referral and abc (antecedent, behaviour and consequence) or incident record following any incidents between people, for example verbal abuse."

Discussions with the registered manager confirmed that where safeguarding concerns had been identified, they had been appropriately referred to the local authority's safeguarding adult's team and fully investigated. We reviewed the safeguarding incidents records that had occurred at the service, this confirmed appropriate referrals had been made when required.

Records showed risks were well managed through individual risk assessments that identified the potential risk and provided staff with information to help them avoid or reduce risks. We looked at the care plans for two people who used the service and found these identified potential risks and how this would be managed. These included examples of road safety, travelling in a car, going out into the community and activities such as cycling and supporting with cleaning their rooms.

We saw risk assessments also included plans for supporting people when they became distressed or anxious and detailed circumstances that may trigger these behaviours and ways to avoid or reduce these.

Discussions with the registered manager and staff confirmed that restraint was not used within the service. Records confirmed that low level interventions and distraction techniques were effective in diffusing incidents of behaviours that were challenging to the service and others. These had been developed with the input from the person, professionals and staff. Staff had completed training with regard to changing behaviours and managing potential aggression.

We checked the recruitment files for four staff members. The registered manager described the staff recruitment process, which consisted of shortlisting from application forms, checking gaps in employment, selection by interview process, obtaining references and completing checks with the disclosure and barring service (DBS). They told us staff were unable to start work until all employment checks had been completed.

This helped to ensure only suitable staff were employed to work with people who could potentially be vulnerable to exploitation. Staff we spoke with confirmed this process had been followed when they had been recruited.

Where a positive (DBS) disclosure was made, an interview was held with senior management and an assessment made of any potential risks to people who used the service before a decision was made as to whether the applicant would be appointed. Records of decisions made in such situations and safety measures introduced to monitor their performance were maintained.

We found there was sufficient staff on duty to meet the current needs of people who used the service. Rotas indicated the three people who used the service were supported by a minimum of two staff members during the day and one staff member during the night. Additional staffing was provided at intervals during the week to enable people to go out. During our inspection we saw each person using the service being given the opportunity to go out. One person went out with a staff member to do some shopping, while a second person went out with two members of staff, when a third staff member arrived to support with facilitating activities. The third person was seen to decline all suggestions offered to them and we saw their wishes were respected.

The registered manager showed us the staff rota described how staff were allocated for each shift, dependent on people's individual needs. Staff we spoke with confirmed additional staff was provided when required. The registered manager explained that although funding had been recently reviewed, risk assessments had been completed following this and staffing levels were being funded by the registered provider, to ensure people's safety was maintained.

Medicines were administered as prescribed. We saw the recording was accurate and medicines were checked in and out of the building as required. Regular audits were undertaken to ensure the correct procedures were followed. Medicines were kept securely and stored appropriately. Individual protocols were in place for the use of 'as and when required' medicines such as paracetamol.

Records showed staff received regular training with regard to the safe handling and administration of medicines. We looked at the records maintained for people's medicines and saw that the registered provider completed risk assessments and developed care plans, which included how people preferred to take their medicine. During our observations of the administration of medicines, we saw people's preferences for the way they wished to take their medication was respected and implemented.

Good

Is the service effective?

Our findings

Relatives we spoke with told us, "The staff are absolutely fantastic, they know them well, I couldn't ask for anything better."

Staff understood people's preferred routines and the way they liked their care and support to be delivered. Staff described in detail how they supported people in line with their assessed needs and their preferences. We saw staff communicated with people effectively and used different ways of enhancing communication. For example using symbols and signing in people's preferred way or offering people objects to choose from and confirming their choice with them. This approach enabled staff to create meaningful interactions with the people they were supporting.

Care records contained clear guidance for staff on how to support people with their communication and how to engage with this. This supported people to make day to day choices relating to how they wanted to spend their time, activities, meals and about their care and support.

We saw people's nutritional needs were assessed and kept under review and there was a good range of food and drink supplies within the service. Staff confirmed that menus were planned in consultation with people who used the service where possible. Where people were unable to inform staff verbally of their preferences we saw the staff would show people different options to choose from or sign with them in order to establish their wishes.

Staff we spoke with had a good understanding of people's preferences for food and their individual dietary requirements. They gave examples of people's routines around their preferences for food and told us, "We always offer people choices, but we find some people are quite structured in their routines around food. For example, [Name of person using the service] likes to buy quiche from the local deli. They will sign they want to go and buy some if we are going on a picnic, but when we are shopping and they are offered this they always sign 'no'. However, they also like to have soup when we go to visit the farm, but it has to be soup from the café there, they don't like to take a flask of soup with them."

Another staff member gave an example of a person whose independent living skills had deteriorated and as a result of this, experienced difficulties with eating and drinking. They explained the person had been referred to the dietician and speech and language team for advice and support. The introduction of adapted crockery and a textured diet had been successful in enabling the person with their nutritional intake.

During the inspection, we observed a mealtime and saw that people had a choice of where they wanted to take their meal and choices of what they would like to eat. One person told staff they were too busy and had things to do, before they could make time to have their lunch. We saw staff waited until the person was ready and later approached them. The person then requested the meal that had been prepared for them be replaced. We saw staff responded to their request. Staff recorded people's food and fluid intakes in order to monitor people's nutritional needs were being met as well as using this to offer a varied balanced diet to people.

People who used the service were supported to maintain good health and had access to health check services for routine checks, advice and treatment. Staff we spoke with told us they supported people who used the service to see their GP when they were unwell and attend appointments with other professionals when this was required such as; dentists, opticians, chiropodists and members of the community learning disability team. Care records seen showed people's health needs were planned, monitored and their changing health needs responded to quickly.

We saw people who used the service had health action plans in place that gave an overview of people's health needs, how they communicated their needs and identified areas of support the individual required with this. This document described what actions professionals and others needed to take to help and support the individual in their approach and what was not helpful to them.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager had acted appropriately and assessed each of the three people who used the service as meeting the criteria for DoLS. They had made applications to the local authority for DoLS, but none been assessed and authorised at the time of our inspection. The registered manager showed us emails they had submitted to the local authority to enquire if there had been any further progress with the applications. They told us they would continue to follow these up.

Staff we spoke with they told us they had completed training in the MCA and were aware of the legislation. They were able to provide examples and demonstrate their understanding clearly and how they would apply this in practice. An example was given about a situation where a person required medical investigations and was unable to consent to this, so a best interests meeting had been held with all involved professionals in order to discuss this further.

We looked at staff training records and saw staff had access to a range of training the registered provider considered to be essential and service specific. This included equality and diversity, MCA and DoLS, autism awareness, MAPPA (management of actual or potential aggression), medication, epilepsy, food hygiene and infection control. Staff were also either working towards or had completed an NVQ (National Vocational Qualification in Health and Social Care).

The staff we spoke with confirmed they attended both face to face and e-learning to maintain their skills. Staff we spoke with told us they felt they had adequate training and could request additional training through both the supervision and appraisal systems in place. One staff gave us an example of how Makaton training (Makaton is a language programme using signs and symbols to help people to communicate.) had been provided to the staff team at the service which was personalised to each individual's needs so it could be used at a level suitable for them and support them to express their wishes.

They told us they were supported through regular supervision, which were used to discuss a number of topics including changes in practice, changes in people's needs, care plans, rotas and training. They told us they felt fully supported by the registered manager and senior staff.

The registered manager told us, that after their appointment, all new staff completed a week of induction which covered essential training including; medication, safeguarding and care planning. They then had a period of shadowing experienced staff in the service. Following this they completed a work based induction booklet during the next three months. Specialist training was also made available to them during this time including epilepsy and autism. Staff spoken with confirmed this process.

Bedrooms were personalised and reflected people's personalities and interests. The registered manager and staff told us how work was being done within the service to provide a more dementia friendly environment to accommodate people's changing needs. For example a heavily patterned carpet had recently been replaced with a plain carpet, following advice from the dementia mapping team.

Good

Is the service caring?

Our findings

Relatives told us they considered their family member was well cared for by staff. Comments included, "I have nothing but praise for them", "I couldn't ask for anything better" and "It is marvellous, staff know them so well."

We saw people who used the service were well cared for, were clean shaven and wore clothing that as in keeping with their own preferences and age group. Staff told us people were supported to make their own purchases of clothing and toiletries.

During the inspection, we used the SOFI tool which allows us to spend time observing what is happening in the service and helps us to record how people spend their time, the type of support received and if they had positive experiences. We observed staff interacted positively and sensitively towards the people who used the service. We observed people going out of the service to engage in different activities including going out for a farm visit and to do some shopping.

People were seen to approach staff with confidence; they indicated when they wanted their company, for example when they wanted a drink or snack, and when they wanted to be on their own and staff were seen to respect these choices. We observed staff responded quickly to requests from people who used the service. The atmosphere was calm and relaxed and people responded confidently to the communication with staff.

Staff told us they viewed the service as the home of the people who used the service and respected their privacy, always knocking on doors and waiting to be asked to enter. During our observations, we saw people were always asked for their consent before any care tasks were undertaken. The two care plans we reviewed also contained the person's or their representative's written consent to each section of their care plan.

Interactions between staff and people who used the service were seen to be kind and caring. We observed staff engage people constantly in conversations using their preferred method of communication. They also encouraged and motivated people to be involved in tasks they were completing within the service and suggested things they may be interested in for example, baking a chocolate cake for tea. We saw people were given time to respond to the information they had been given or any request made of them, in a caring and patient manner.

The registered manager informed us how one person had been supported at the service for their end of life care. Professionals had supported staff to enable the person to remain at their home with their friends who they had shared accommodation with for many years.

A conscious decision had been made that the person's room would not be used until their peers had been given time to grieve and come to terms with their loss. Staff had recognised that each person had done this in different ways. They described how one person would spend time in the persons room, sitting quietly looking out of the window, whilst wearing the person's hat. The registered manager and staff had ensured

photographs were in place throughout the service, so people could initiate conversations about the person, should they wish to.

Staff described to us the importance of maintaining family relationships and how they supported and enabled this, for example, supporting people with home visits and to purchase gifts and cards for special occasions. Relatives spoken with confirmed this process to be in place.

Good

Is the service responsive?

Our findings

Relatives told us they considered the service to be responsive to their family member's individual needs. Comments included, "We are involved in all aspects of their life and the decision making process. They always keep in touch and let us know what they are involved in or if there are any changes." and "They are always out and about and have a full life."

Relatives told us they felt able to raise concerns. Comments included, "I have no complaints whatsoever, I am aware of whom to liaise with should I need to, but have never had the need."

Evidence confirmed people who used the service and those acting on their behalf were involved in their initial assessment and on-going reviews. Relatives we spoke with confirmed their involvement. Individual assessments had been carried out to identify people's support needs and care plan s developed following this, outlining how these needs were to be met.

Individual assessments were seen to have been carried out to identify people's support needs and care plans had been developed following this, outlining how these needs were to be met. We saw assessments had been carried out to identify the person's level of risk. These included identified health needs, nutrition, accessing the kitchen, choking, changing behaviours and going out in the community. Where risks had been identified, risk assessments had been completed and contained detailed information for staff on how the risk could be reduced or minimised. We saw risk assessments were reviewed monthly and updated to reflect changes in people's needs when required.

We observed staff interacting with people; they understood people's needs and were responsive in their approach. Staff told us how one person may present if they became anxious and how they would support them in order to diffuse the situation.

During the inspection an incident occurred that we observed staff managed calmly and confidently. Following the incident staff described to us what further actions the person involved would take to assure staff they were calm and the incident was over. Shortly afterwards the person presented themselves to the staff and completed the actions as staff had described.

People's care plans focused on them as an individual and the support they required to maintain and develop their independence. They described the holistic needs of people and how they were supported within the service and wider community.

We looked at the care plans for two people who used the service and found these to be well organised, easy to follow and person centred. Sections of the care plans had been produced in an easy to read format, so people who used the service had a tool to support their understanding of the content of their care plan. Easy read information is designed for people with a learning disability and is a way of presenting plain English information along with pictures or symbols to make it more accessible.

Details of what was important to people, such as their likes, dislikes and preferences were also recorded and included, for example, their preferred daily routines and what they enjoyed doing and how staff could support these in a positive way were available. We saw that when there had been changes to the person's needs, these had been identified quickly.

When we spoke with staff, they confirmed they read care plans and information was shared with them in a number of ways including a daily handover, communication records and staff meetings. Staff spoke about the needs of each individual and demonstrated a good understanding of their current needs, previous history, what they needed support with, what they may need encouragement to do and how they communicated and expressed their wishes. Staff told us that care plans provided them with sufficient information about people.

Staff told us how they kept relatives informed about issues that affected their family member and ensured they were involved in all aspects of decision making. Relatives were also invited to reviews and if they were unable to attend their views were sought and shared in reviews and other meetings. Records seen confirmed this.

We saw people's care plans were reviewed monthly to ensure people's choices, views and healthcare needs remained relevant. When there had been changes to the person's needs, we saw these had been identified quickly and changes made to reflect this in both the care records and risk assessments where this was needed.

Records of all activities people had engaged in were recorded. We saw people had the opportunity to participate in a variety of different activities they liked. These included, annual holidays, day trips, going shopping, visiting a local farm, swimming and bowling.

The registered provider had a complaints policy in place that was displayed within the service. The policy and procedure was available in an easy to read format to help the people who used the service to understand the contents. In discussions with the registered manager, they told us the service received very few complaints. No complaints had been received by the service since our last inspection, but where suggestions had been made to improve the service these had been acknowledged and action taken.

Good

Is the service well-led?

Our findings

Relatives told us, "I think the service is marvellous, the staff do a fantastic job and are very caring, they know them so well." and "I know I can ring at any time and they will always make time for me."

Staff told us the registered manager was supportive of them and always made time for them.

We observed people who used the service were comfortable in the registered manager's presence and although they did not always approach them directly, they engaged with them confidently when they were approached by them. During our inspection we observed the registered manager took time to speak with people who used the service and staff and assisted with care duties. The registered manager told us they were supported by senior managers within the organisation and a board of trustees.

We saw improvements needed to be made to ensure records were fully completed in relation to food temperatures and fridge and freezer temperatures as we found some gaps in recording. This did not ensure food was always prepared to the correct temperature. When we brought this to the attention of the registered manager they offered us assurances that this would be dealt with.

We saw an organisational wide system was in place to monitor the quality of the service people received. This included a range of audits, meetings and surveys to gather feedback from people who used the service and their relatives, and observations of staff practices. Relatives we spoke with confirmed they were involved in this process. As well as being invited to attend relative's meetings and receiving newsletters, they were also invited to various social events, arranged by the registered provider.

The quality monitoring programme also included a structured programme of compliance reviews by the quality assurance manager. These were completed every two months and covered all aspects of service provision. The records showed that, where shortfalls had been identified, action plans had been developed and compliance dates achieved.

Records showed the registered manager completed a range of internal checks of areas including the care plans, personal financial accounts and medication management. Results of these checks were positive. The medicines were also checked each year by the contracting pharmacy.

Accident and incident records were maintained and demonstrated immediate appropriate actions were taken following these. The registered manager confirmed how all accident, incident and safeguarding reports were sent to the senior management team for analysis and review in order to identify any emerging patterns and outcomes to inform learning at service and organisational level.

A redecoration/refurbishment plan was in place that identified a plan for any improvements required within the service.

The registered provider encouraged good practice. For example, there was a system in place to nominate

staff for specific awards for recognition of good practice. Staff were provided with handbooks which explained the expectations of their practice and described the registered provider's vision. This was described as promoting a 'lifetime support to vulnerable people to enable them to live fulfilled and valued lives through making personal choice, an inclusive society where people have equal chances to live the life they choose.' Staff also received long service awards.

The registered manager told us the organisation was working through the process to become accredited with the national autistic society, Autism accreditation is an internationally recognised quality standard provided by The National Autistic Society.

When we spoke with the registered manager about their management style they told us, "I like to listen to what is going on and will act as a mediator, and always investigate if there is any wrong doing and follow the disciplinary route without question in such situations. I support staff through regular supervision, staff meetings and the appraisal process, finding out what they want to do and how I can support them to achieve this. I enable and encourage staff to progress through the NVQ (National Vocational Qualifications) if this is what they want. For those who don't want this I will offer them alternatives to utilise their skills. Everything centres around the care and support of the people who use our services they are the driving force."

Meetings took place for all registered managers in the organisation to share information and best practice guidance. Registered managers also had the opportunity to network with external care providers to share best practice initiatives and share experience. A group of registered managers had recently attended an autism conference. The registered manager told us that these meetings and networking opportunities were both useful and informative.

Staff told us they attended meetings where the registered manager would inform them of any changes to policies and procedures and to share new guidance on best practice. Staff meetings were held on a minimum of a monthly basis and records of these were maintained.

We found the registered manager was aware of their role and responsibilities and notified the Care Quality Commission and other agencies, of incidents which affected the welfare of people who used the service. We have found the registered manager responded to requests for information when required.