The Edmund Trust

Pauline Burnet House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Pauline Burnet House is registered to provide accommodation for people who require nursing or personal care. It does not provide a nursing service. At the time of our inspection there were eight people using the service.

This unannounced inspection took place on 14 July 2016.

The service had a registered manager. However, as they managed several of the provider's services a service manager was in post and they undertook the day to day running and management of the service. 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.

Staff had been trained in safeguarding people from harm and they knew the procedures and actions to take should they identify any, or potential, harm.

A sufficient number of suitably qualified and competent staff were in place to support people with their care and support needs. Staff were safely recruited through a process that helped ensure that only suitable staff were employed.

People were safely supported with their prescribed medicines. Trained staff who had been deemed competent to administer medicines undertook this in a safe way. Medicines were managed and administered safely.

People were supported to be safe by staff who were skilled in identifying and managing any potential risk. People with behaviours which could challenge others were supported by staff using recognised standards of proactive de-escalation.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The service's registered manager and staff were knowledgeable about when an assessment of people's mental capacity was required. Staff were aware of the circumstances and conditions when an application to lawfully deprive any person of their liberty was required. Mental capacity assessments had been completed to identify those people were needed to be lawfully deprived of their liberty.

Support staff and managers received regular supervision. This was planned to develop their skills, increase their knowledge and encourage and mentor care staff to obtain additional care related and management qualifications.

People's care was provided with consideration of each person's individual care needs and was undertaken with compassion by staff. People were supported to improve their independent living skills and staff respected their choices.

People used their preferred means of communication, or told staff, to inform them of their preferences and needs. Relatives, care staff, health care professionals and social workers contributed to the on-going development of people's care needs. People's care plans were in a format that enabled people to contribute, and be involved in, their care planning.

People were supported to access a range of health care professionals including a speech and language therapist, psychologist and GP services. Staff ensured that they adhered to the advice and guidance provided by health care professionals.

People were encouraged to buy, prepare, cook and eat sufficient quantities of a healthy and , balanced diet which was appropriate for their needs.

People were involved where and whenever this was possible in developing the service. The service manager was proactive in taking actions to prevent the occurrence of any potential incident. Staff knew when people were happy with their care.

The provider's representative and service manager had effective audits and quality assurance in place. These audits were used as a means to drive improvements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from harm by staff who had been trained in what safeguarding meant. Medicines were administered and managed safely.

People were supported and cared by a sufficient number of staff who were deemed suitable and appropriately qualified.

Accidents and incidents were recorded and action was taken to minimise and prevent the potential for recurrence.

Is the service effective?

Good

The service was effective.

People were supported to make decisions in a way which considered their rights.

Staff were trained and supported to perform their role effectively and in a skilled way.

People's health and nutritional support needs were met. Staff adhered to health care professional's advice.

Is the service caring?

Good

The service was caring.

Staff considered and acted upon people's individual care needs and aspects of their lives.

Care staff had a positive impact on people's lives and they did this with compassion.

People were provided with opportunities to gain and improve their independence, and daily living skills.

Is the service responsive?

Good

The service was responsive.

People's goals and achievements were explored and encouraged by staff who knew the potential each person had.

People were made to feel they came first and foremost by staff and managers who knew each person's individual needs well.

Concerns were acted upon appropriately before they became a complaint. Action was taken to prevent any potential for a recurrence.

Is the service well-led?

Good

The service was well-led.

The provider's representative and management completed audits and checks to help drive improvement.

The service manager was creative in the way they identified and implemented good practice.

People came first in the development of the service and staff were encouraged through a culture of openness and honesty.

Pauline Burnet 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 unannounced inspection took place on 14 July 2016 and was completed by one inspector.

Before the inspection, 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 looked at this and information we hold about the service. Before the inspection we also looked at the number and type of notifications. A notification is information about important events which the provider is required to tell us about by law.

Not everyone was able to speak with us. This was due to people's complex health needs. During the inspection we spoke with three people who used the service, the registered manager, the service manager, the operations' manager, a team leader and three members of care staff.

We observed people's general care to assist us in understanding the quality of care people received.

We looked at two people's care records, records of meetings attended by people who used the service and staff. We also looked at medicine administration records and records in relation to the management of the service such as checks on matters affecting people's health and safety. We also looked at staff recruitment, supervision and appraisal process records, training records, and complaints and quality assurance records.

Good

Is the service safe?

Our findings

At our comprehensive inspection of Pauline Burnet House on 8 September 2015 we found that people's medicines were not always stored safely. This put people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our comprehensive inspection of 14 July 2016 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 12 described above.

Improvements had been made in the way people's medicines were stored, managed and recorded. For example, medicines were now stored safely in a secure cabinet. Procedures such as up-to-date risk assessments were now in place to ensure that people were not put at risk of harm by supporting people to safely take their prescribed medicines.

One person told us the reason they felt safe was, "If I ask for help or need them [staff] I never have to wait." We saw that whenever people needed their care and support needs meeting that staff responded promptly. Another person told us, "They [staff] are very kind to me." We saw that staff understood how people communicated either verbally or through their preferred means of communication such as picture cards and objects of reference as well as the use of their body language. This meant that there were arrangements in place to support people if ever any person was concerned about their safety and general wellbeing.

Staff had been trained in and were skilled in recognising any, or potential, sign of harm. This included recognising if people's body language, facial expressions or other vocalisations indicated that the person was not their usual selves. People could be confident that staff kept them as safe as practicable. The provider's PIR included evidence that the audits completed by team leaders helped mitigate against the risks associated with subjects such as the service's environment, hoists, slings and electrical equipment.

We observed that people were able to take risks as part of activities such as going swimming, eating in a safe way and accessing the community. We found that the risk assessments that were in place helped ensure that people were supported and cared for in the safest way practicable. For example, people who preferred a particular form or size of transport were supported with this in a safe way. We saw that some people required the support of two care staff on some occasions. For example, when being hoisted into or from a wheelchair or when going out in the service's transport. Other examples included procedures to support people in the event of an emergency such as a fire evacuation. This showed us that staff considered and acted upon the measures required to help keep people safe.

Accidents and incidents were recorded and responded to. This included where people exhibited behaviours which could challenge others. We saw that actions had been taken to prevent or reduce as far as practicable the potential for any recurrence. This included the use of skilled staff who knew the strategies to support people in a safe way. These strategies included proactive de-escalation and the avoidance of situations to ensure people were kept calm and anxiety free as much as possible. For example, by avoiding crowds, strangers or situations where noise could be an issue. Protocols had also been implemented for people's

medicines when out in the community.

The service manager and team leader confirmed to us the documents that prospective new staff needed to provide. These included previous employment history, recent photographic identity such as a driving licence and a satisfactory Disclosure and Barring Service [DBS] check for any unacceptable criminal convictions. One care staff said, "After I applied for the job I had to provide my passport, explain any gaps in my previous employment, [evidence of] all my qualifications. I had an interview to assess my abilities and attitude before I could start work." We also found from records viewed that the provider's recruitment procedures ensured that only suitable staff were offered employment.

The service manager told us, "More than anything else it is staff who possess the right attitude, the right skills and will to work with people who at times can appear to have behaviours which could challenge others. I will not just recruit a staff member to fill a vacancy as people's safety has to come first."

We observed and found that there were sufficient numbers of staff to meet people's care and support needs. We saw that people's care was provided in a calm and unhurried manner. Staff had the time to sit and talk with people. Support them with going out and ensure that people's personal care was completed in a safe way such as when being hoisted We also saw that staff gave people information in the right quantity, format and the time they needed to understand to help ensure that the person remained as calm as possible. One person told us, "There is always someone [staff] to take me out or help me." A staff member said, "I know each person well but the guidance in care plans and people's communication diaries gives me the knowledge to ensure I support the person safely."

The service manager said, "We have not used any agency staff for over six months. With the two team leaders and on most days, six staff, people are safe both in and outside their home." The service manager and staff told us that arrangements were in place for planned or unplanned staff absence such as sickness. These arrangements included opportunities for over time, swapping shifts or doing extra shifts.

Staff had been trained, and they had been assessed as competent in, the safe administration of people's medicines. This was through a robust assessment of staff's skills and evidence of their knowledge. This was to help ensure that staff administered medicines safely. We observed that staff adhered to safe administration practice. For example, for those people had to have their medicines administered in food [covert medicines] or in a liquid format in the person's best interests. We found that medicines administration records (MAR) included people's allergies and how and when they liked to take their prescribed medicines. Records viewed showed us that people's medicines were recorded, stored, disposed of, managed and administered in a safe way. This included the occasions when people went to see relatives or going out in the community. Where medicines had to be administered straight away such as for people's health conditions, protocols were in place for this. This meant that people were supported to take their prescribed medicines in a safe way.

Good

Is the service effective?

Our findings

People benefitted from, and because of, the support and care that staff provided. We observed that staff knew and understood the people they cared for in detail. This had resulted in a positive impact in the way people were cared for. Staff were aware of how to manage and prevent people's behaviours that could challenge others. An example of this included the arrangements that were in place to minimise the risk of people becoming anxious.

People were cared for and supported by trained and skilled staff who were matched to those people who shared similar interests such as a liking for books. This included those staff who people had developed an affinity and ability to get on really well with. One person told us, "I think they [staff] know me very well as I am happy." Staff said, "Each one of us is a key worker (a staff member with specific responsibilities for the person such as keeping relatives informed about their family member's care). As well as knowing the finer points of people's lives and the impact we can have on this is crucial." They added that the service manager used key workers to the greatest benefit of the person. For example, by using the most appropriate staff who could keep people's anxieties to a minimum or prevent these entirely. Staff used various means of communication such as objects of reference, social stories and people's body language to help them identify and understand what people were telling them. This showed us that staff considered and acted on the information that people gave them.

Staff received and were supported with regular training and planned supervision. This gave those staff with a supervisory role such as the service manager and team leaders the opportunity to guide staff in developing their skills. Several methods were used to encourage staff's development such as observed practice, regular supervision to help identify any potential improvements as well as recording what staff did well. One staff member told us, "I have had regular mentoring from my team leader and they are there for me at any time. It doesn't matter how small the issue, they help me in a positive way." Another staff member said, "I can ask for further training for my role. I have just completed my level three quality credits framework (QCF). (The QCF recognises qualifications and units by awarding credits to staff). This gives care staff the ability to get qualifications at their own pace. Staff were supported in a constructive manner such as with areas for potential development as well as those things they did well.

As well as formal training, staff were mentored and coached by more experienced team leaders, a service manager and access to an operation's manager. This was to ensure that in conjunction with training the provider had deemed mandatory, staff also completed other specific training related to the people they supported. For example, training on diabetes, autism and epilepsy. Training staff had completed and were updated on included medicines administration, fire safety, food hygiene, health and safety and proactive responses to behaviours which could challenge others. This was planned to help ensure that those people living with these conditions had their care needs met in a safe way. Training records we viewed showed us that staff had undertaken their planned training in a timely manner.

The Mental Capacity 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 home services are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Staff confirmed to us that they always assumed that people could make their own choices. The service manager said, "Knowing the decisions people can or can't make and those they need some support with, as well as those decisions that are in the person's best interests is essential. For example, when taking their medicines in a covert way. We are not here to decide for people where they have [mental] capacity. It's their choice." The service manager confirmed that for those people who met the criteria of being supported all the time by staff when out in the community and under staff's control they had completed mental capacity assessments. They had engaged with the local authority and were in the process of applying for the DoLS. This was to ensure that people were only deprived of their liberty when this was lawful.

The service manager and care staff at the service understood the MCA and DoLS codes of practice and how to put these into practice. For example, by always assuming people had mental capacity and that any restrictions on people's liberty were in the least restrictive way. One staff member told us that sometimes people could make a decision that they did not understand the consequence of, "If for example someone refused to take their medication even if they knew the consequences. I would explain to them why it wasn't safe and what might happen."

It was clear from our observations and the conversations that people had with us, staff and other people at the service that meal times were relaxed and informal. One person said, "I like all the food I eat. I like it when we have pizzas." Another person told us their favourite was "fish and chips" at the seaside. People could, and did, choose when and where they preferred to eat such as in the service's lounge, at a local pub, restaurant or in the gardens. We saw that people could choose what to eat and drink from their preferred choice of freshly prepared food. We also saw that people could choose from photographs of menu options. Another person said, "I get plenty to drink, orange or blackcurrant and tea. I don't like coffee." People were involved in decisions about what they ate and drank as well as being supported to eat healthily as much as possible. Where people had allergies or food intolerances staff ensured that the person was supported to eat only those foods and drinks which were safe for them to have.

We saw that staff supported to people to access a range of health care professionals. This included but was not limited to attending hospital appointments, opticians, GPs, dentists and psychologists. One person told us, "I have been to see my [health care professional] today and they have [made me better]." We saw that staff followed the advice provided by the health care professional. We saw that appropriate referrals were made to health care professionals and that these were followed up in outpatient, or other health care, appointments. We saw and found from records viewed the difference various health care professionals had made to improve people's health and quality of their lives. People could be assured that their healthcare needs were identified and met.

Good

Is the service caring?

Our findings

During our observations and by our conversations with people it was clear how passionate that staff were. The staff's approach had a positive impact on each person and their care needs. We saw examples of staff asking a person, "How are you; you were at the [health care professionals] this morning." We than saw the staff attend to the person's needs with sensitivity. One person told us, "They [staff] are very caring. All of them. They are all very nice to me." Another person said, "Yes, it's a nice friendly pace to live." The service manager told us, "Some people don't or can't speak but we make sure that staff consider each person's needs and preferences based upon staff's knowledge of the person and what they were communicating." We observed that staff's approach to people's care was gentle, considerate, compassionate and based upon listening and achieving the best possible outcome.

Staff told us about those situations and circumstances they needed to consider, and be aware of, when providing any personal care. One staff member said, "I always make sure I knock on the person's door, that they answer and consent to me entering their room." Another member of staff told us, "If I am helping a person to have a bath I cover their dignity with a towel and make sure I explain each stage of what I am going to do." They added, "Some people can't hear a knock on the door or they would not be able to answer verbally so I enter the room very carefully and introduce myself by [in the way the person prefers]." We saw that each person was offered and provided with their care in privacy and dignity. One person told us, "I don't mind if a girl [female staff] does my care. They are all very careful with me. We have such a laugh."

We found that people benefitted from a visiting Pets As Therapy dog (PAT). (PAT is a national charity providing therapeutic animal visits to care services). The service manager explained to us the benefits that this had had on people such as for those people with non-verbal communication skills who smiled or laughed at the therapeutic and sensory stimulation that these visits had provided.

We saw how staff communicated sensitively and in a caring way with people as well as using social stories and showing or pointing to objects of reference such as foods and communication cards. This was to help ensure that people were supported to have all their care and support needs met and that this was to the person's benefit. People's care plans and communication diaries were provided in an easy read format where this was appropriate. This was to involve people as much as possible in determining all their care needs, and the way the person wanted to live their life in a fulfilling way.

We observed that saw that staff regularly checked and sought assurance as to people's wellbeing as well as checking if the person wanted any other assistance; this included sports or other clothing associated with the person going swimming. Throughout our inspection we found that people and staff shared a common ability to be as happy as possible. We saw how staff were aware of those people who had attended health care appointments and of their on-going care needs and pain management. One person told us, "I am cared for well as I have been to a [health care] appointment." We saw that staff showed a genuine interest in the person's welfare and that they were as comfortable as possible. For example, by making sure that the care provided was in consideration of the person's wellbeing such providing the right sorts and type of foods.

One care staff said, "This [the service] is people's home and I treat each person as such. If this was my home I would expect the same." The staff gave us examples of how they respected people's home such as letting people choose their room's paint scheme, doing day to day activities such as shopping, going out for a coffee or having a barbecue. This had provided people with positive aspects to their lives.

The service manager told us, and we saw in the service's office and people's care records, about the advocacy arrangements available and in place. Advocacy is for people who can't always speak up for themselves and provides a voice for them. The service manager explained how some people could speak up for themselves but in some other situations their relatives did this for them. This meant that people who were not able to speak for themselves were supported to have their rights respected.

Staff responded to people's requests sensitively and gave people time to consider their response. People's care plans were in a format such as easy read and pictorial format: this was to enable people to be involved as much as possible with the planning of their care. This included the subjects that were important to the person such as people's circle of friends, favourite films, foods and how the person wanted to communicate their wishes. People's care plans also included staff's knowledge of the person and what worked best for them.

Other methods were used to support people to be as independent as they wanted to be. This included the use of the service's transport, public transport and taxis. These methods considered the person's care needs such as a certain size or type of car.

People told us, staff confirmed and we saw that relatives and friends could call in to see people at any time with the person's agreement. We saw that a barbecue was due to be held in July 2016 and that a host of support was being provided. This included people, families, staff and local businesses.

Good

Is the service responsive?

Our findings

We found that improvements had been made since our inspection in September 2015. This was in the provision of a new minibus as well as the drivers to enable the effective use of this resource.

People using the service had lived there over several years. An on-going programme of reviews were in place to regularly reassess people's needs. People, staff, relatives and health care professionals had contributed to gaining each person's life history information. This information supported staff with their knowledge and understanding of the person and was also included in people's detailed care and health action plans. This was for subjects such as what worked well and what did not work quite so well. Examples of this included the type of bath or shower gel and also if the person had any anxieties such as those for crowds or noisy environments which were avoided. This helped to ensure that the staff responded to people in an individualised manner. One person told us, "I went to the seaside and had fish and chips and ice cream. My favourites." Staff told us that the aromatherapy sessions for people had been very well responded to. One person said, "If I get anxious they [staff] make me happy again."

We found that the complexity of people's care needs was reflected in the level of detail in the care plan. Our observations showed us that as a result of people's detailed care plans staff knew the finer points of each person's care and what made a difference to the person's life. Staff spoke with passion about each person they cared for, how they supported them and what people did for themselves. For example, how some people had undertaken a hobby, pastime or something social for the first time. This showed us that the service considered what really was important to people.

People were supported with a wide range of their preferred hobbies and interests, social and independent living skills. Records we viewed and our observations of staff supporting people confirmed the meaningful pastimes people took part in. These included going to an age related day centre, swimming, shopping, art classes, listening to music and seeing the visiting owls from a local raptor centre. One person told us, "I love my outings [day centre]. I like the people there and doing lots of [interesting hobbies]." Other options were available if the person changed their minds such as helping in the kitchen, having a chat with staff or just relaxing in the person's room. All staff saw the positive aspect of each person's care and what the person could, or had the potential to, achieve. This was aided by people's visual support which included those prompts that worked best. For example, facial expressions, picture cards, vocalisations or items that staff could use to the benefit of the person. This meant that each person was treated as an individual and that their independence was respected.

A complaints process was provided and in a format that was accessible to people. We saw and found that any concerns or complaints raised by people were acted upon. People's complaints had been resolved to their satisfaction. This included a personal apology and resolving the person's complaint to their complete satisfaction. One person said they would, "tell [name of staff]" if they weren't happy about something. And, "They sort it out for me." A representative of the provider considered each complaint and put measures in place to prevent the potential for any recurrence. One staff member told us, "We did accidentally wash a person's cardigan incorrectly. We asked the person what they wanted and they said "an apology and a new

cardigan" which is what happened. I now mark any clothing with special washing requirement and wash them myself." No further instances of this nature had reoccurred.

One member of care staff told us, "If ever anyone is unsure or unhappy about anything I can usually identify what the issue is. Some people will tell me whilst others use their body language and facial expressions or they can refuse to eat or go out when they normally would. I give people the option. Sometimes it is best to leave the person to be quiet, as this works for them, until they are calm and ready to tell me what their preference is."

Good

Is the service well-led?

Our findings

A registered manager was in post. They also managed some of the provider's other services. The registered manager told us that they undertook various checks at the service such as if food was in date and how staff interacted with people. The day to day running of the service was undertaken by a service manager.

We saw that the provider was not clearly displaying their CQC inspection rating prominently in the service. We saw that a copy of our inspection report was on display. The service manager told us that they were not aware of this. We did however note that the provider had their rating correctly displayed on their web site. The service manager immediately displayed the provider's CQC rating's poster prominently and conspicuously where people and visitors could see it. Although our previous inspection had been completed in September 2015, the registered manager, at their various visits to the service had not identified this omission.

The service manager explained to us, with passion, how they determined the required care needs for each person and that staffing levels to meet these needs were frequently reviewed. We found that as a result of this they had adjusted the staff hours so that people had more time out of the service and more independence. The service manager said, "With two team leaders on board it is now so much better as people can now go out every day if they wished." The provider's PIR included details of, and we saw, how the service manager was following the National Autistic Society framework to support people in identifying underlying issues, reducing the disabling effects of the condition and providing a cornerstone for communication. This showed us that people were supported by staff who had the personal attributes of calmness and empathy.

One particular example of successfully integrating people, relatives, staff and the local community was at the planned 'Big Barbecue' which was to include the provider's other services where appropriate. This was an opportunity to raise funds for the services gardens to include accessible flower beds and wheel chair access to these. One person told us, "I love gardening and barbecues." The person's key worker told us, "Having the addition of a crazy golf course for people who use a wheelchair will be a bonus. The gardens are kept tidy but this will be a real plus. It will mean that some people will get more of their hobbies to do at home." Various pictures and advertisements of the event had been created by people and staff. Local communities including schools and businesses had been involved with contributing towards the event. Another example was with the involvement with the local school whose children had performed a singing contest for the people who lived at Pauline Burnet House who had then picked the winners.

The operations' and service's manager were both extremely passionate about making a real difference to the quality of people's lives. As a qualified trainer with skills in caring for people with a learning disability the service's manager passed these on to the team leaders and staff. They said, "We used to have service user meetings but people didn't like this title so we asked them what they wanted the meetings to be known by. The answer was "People's action group." This had enabled people to contribute in a better way to improving the quality of service provided. For example, by including people who wanted, to attend new staff's interview and assessing their abilities. This had become a regular feature and included people having a

coffee and chat with prospective staff.

To support an open, fair and transparent culture the service manager was visited frequently by the operations manager. This was by spending sufficient time assessing each of the services and the service managers and staff supporting these. This was to ensure that all staff were maintaining the provider's values of supporting people in the most person centred way practicable, such as during a family bereavement and supporting people who communicated in a non-verbal manner. The service manager and team leader confirmed that this had been a learning experience to be aware of the potential emotions that could emerge sometime after the event.

Staff told us that their performance could be assessed at any time for subjects including medicines administration, care provision and how they engaged with each person they cared for. One member of care staff said, "The [service] manager is always there for me at any time, day or night. If something is bothering me I can speak to, or call, them and their door is always open. People can call in anytime. The management puts people first." They added that during meetings if any person wanted support the staff would leave the meeting and attend to the person first.

Care staff explained to us how the daily contact with people and regular contact with their relatives as a key worker helped to keep them up to date. For example, staff frequently contacted people's relatives to let them know about healthcare appointments and where changes had been made regarding additional hobbies and interests.

Quality assurance, audit and spot checks were completed by representatives of the provider as well as the service manager and team leaders. This was to identify what the service was doing well and where any potential improvements could be made. For example, audits of people's prescribed medicines and the changes that had been implemented by each person having their medicines held securely in their room. This had resulted in each person's medicines being administered in and environment free from distractions.

Staff told us that they were aware of whistle-blowing procedures and would have no hesitation in reporting their concerns, if ever they identified or suspected poor care standards. One member of care staff told us, "I would report any poor care straight away, no matter what the issue was. People living here are people and they deserved to be treated correctly." A team leader told us, "We would know straight away if there was any unacceptable staff behaviours as the team has gelled really well. People come first and foremost."

From records viewed we found the registered manager had notified the Care Quality Commission (CQC) of incidents and events they were required to tell us about. We found however that the registered manager as the 'managing authority' had not undertaken mental capacity assessments. This was for people who lacked mental capacity for some or most of their decisions that were in the person's best interests such as with covert medicines. This meant that some people had previously been deprived of their liberty unlawfully. Applications had not previously been submitted to the local authority for depriving people of their liberty under the Mental Capacity Act 2005. We found that a process was now in progress to address this shortfall to ensure that people were only deprived of their liberty lawfully. This showed us that the registered manager was not fully aware of their responsibilities. The operations' manager told us that, with the agreement of the provider's representative, they were planning to change the way the service was managed. This was by each service having a registered manager.

The registered and operations' manager visited the service at Pauline Burnet House at least monthly. This was to assist the service manager and other staff to mentor them in their roles as well as receiving up-to-date information about each person. Anything that required improvement was acted upon. For example, the

availability of an additional and adapted mini bus. Staff meetings were held frequently where matters such as repairs to people's mobility equipment, health care appointments were planned and staff being reminded of their roles and responsibilities. In addition, team leaders held a Monday morning meeting with the service manager as well as regular meetings with the provider's representative. At these managers' meetings information was shared regarding good and best practice such as people living with Autism and person centred care based upon people with these needs.