Mr Donald Smith

Victoria Street

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 22 December 2017 and 12 January 2018 and was announced.

We previously inspected this service on 5 November 2015. The service was rated 'Good' overall with 'Requires Improvement' in Well-Led. This was because the provider did not have an effective system in place to assess, monitor and improve the quality and safety of the service provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection, the provider submitted an action plan telling us what action they would take to meet the breach in regulation. At this inspection, we checked and found the provider had not completed all the actions and remained in breach of this regulation.

Victoria Street is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.
The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

We were supported by staff working at the service on day one of the inspection and on day two by a registered manager. 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 provider had failed to follow their policy and procedure to ensure staff received regular, appropriate supervision and appraisal of their performance to ensure any training, learning and development needs were identified, planned for and supported.

We found people who used the service were not guaranteed quality care and support as ineffective systems were in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).

Medicines were managed, administered and stored appropriately by staff. We could only evidence one medicine competency check completed within the last four months prior to this inspection. Quality assurance checks on medicines management and administration had not been completed. These were addressed by the registered manager and future dates had been scheduled.

Staff protected people from avoidable harm and abuse. They had received training in safeguarding and

understood how to report concerns for further investigation. The provider carried out thorough investigations to ensure lessons were learnt.

Checks were completed in and around the environment to ensure the safety of everybody who used the service. Risk assessments had been completed and outlined measures taken to mitigate potential risks using the least restrictive options.

Staffing ratios were appropriate to meet the needs of individuals. Recruitment checks were carried out to ensure suitable people were employed to work with vulnerable adults. Confidentiality policies were in place and the service protected people's personal information ensuring files were kept in locked cabinets and only those authorised allowed access to them.

The registered manager understood their responsibilities as part of their CQC registration and had informed CQC of significant events that had an impact on the people living at the service. A clear structure was in place and staff were aware of their responsibilities such as raising issues or concerns, so that improvements were made and people were listened to.

People were supported to access appointments with health professionals to maintain their health and wellbeing. Staff treated people with dignity and respect, offering choices and promoting people's independence. Staff actively encouraged people to participate when cooking healthy meals and made sure that diets were nutritional and balanced.

The service supported people to take part in activities of their choice and links were built within the local community so people could lead fulfilling lives. People were supported to make their own decisions, and when they were unable to make significant decisions alone best interest meetings were arranged to include health professionals and family.

Management and staff understood their responsibilities under the Mental Capacity Act 2005 (MCA). People had consented to their care and support and this was recorded in their care plans.

We found two breaches of legal requirements relating to the on-going governance of the service and staffing under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Medicines were administered, stored and managed well. However, medicines refresher training needed to be completed by some staff and regular competency checks carried out to ensure they were safely administering and managing medicines.

Recruitment processes were in place to ensure appropriate and suitably qualified staff were employed. Some minor improvements were needed in relation to the verification of references.

Risk assessments were in place to minimise potential risks to people. Staff told us about the different types of abuse and were confident about how to report them.

Is the service effective?

Requires Improvement

The service was not always effective.

The training matrix did not confirm that staff had appropriate training to meet the needs of the individuals they were supporting. Supervisions and appraisal had not been completed in line with the providers own policy and procedures.

People were asked for their consent prior to any care and support being carried out. Best interest decisions were arranged when necessary and the appropriate people involved.

Staff encouraged people to eat a healthy and balanced diet, supporting with shopping and preparing meals.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion. Independence was promoted by staff that encouraged participation in daily activities to build life skills.

Equality and diversity policies were in place. Staff respected and understood people's needs and supported them in a respectful and dignified way.

Various methods of communication were used to ensure people understood information about their health care and support needs, including any changes that needed to be made.

Is the service responsive?

Good

The service was responsive.

People received care that was centred around their needs, choices and preferences. Staff had a good awareness of people's likes and dislikes so they could accommodate them.

Activities were planned around what people wanted to do to maximise interactions and participation. Staff observed people and made notes about things they enjoyed to help with future planning.

Complaints policies and procedures were in place and the service responded to any issues raised within an appropriate period of time.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Policies and procedures had been updated but contained out of date or incorrect information. Refresher training, supervisions and observations to check staff competency were not always in place.

The provider carried out regular monthly reviews of care plans and risk assessments. However, there were no audits or quality assurance systems in place to identify areas requiring improvement.

Everyone we spoke with gave positive feedback about the

registered manager. They told us how supportive they were and that they were always available to give advice and guidance.

Victoria Street

Detailed findings

Background to this inspection

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

This inspection took place over two days on 22 December 2017 and 12 January 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because the location was a small care home for younger adults who are often out during the day; we needed to be sure that someone would be in.

The inspection team consisted of one adult social care inspector.

Prior to the inspection we gathered information from the local authority in relation to safeguarding concerns and quality assurance visits that had taken place. We contacted five health care professionals who had regular involvement with the service. We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with one person living at the service, two members of staff and the registered manager. We contacted health care professionals, commissioners and the safeguarding team to gather additional information about the service. Following the inspection we spoke with one relative and two health care professionals for their feedback about the service.

We reviewed information such as care planning records, risk assessments, medicines management, two staff recruitment and training records and the provider's internal audits and quality management systems.

Good

Is the service safe?

Our findings

Staff told us they had received training to administer people's medicines. We saw that accredited medication training was included on the training schedule. Five staff were employed to work at this service. We saw three members of staff were recorded as completing training in 2009, 2014 and 2015. No dates of completion had been recorded for two members of staff - the training schedule showed them as 'In progress.' However, the schedule did show us that all five staff had completed the Care Certificate within the last twelve month period and that four out of the five staff had achieved a level three diploma in Health and Social Care. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. The provider information return told us that staff were due to undertake the next medicines training course run by the local authority – the provider was awaiting dates being confirmed.

We saw one annual staff competency check for medicines management and administration had been completed for three staff within the previous four months of this inspection. We saw no evidence that competency checks had been carried out prior to this four month period. However, from our inspections at other services owned by the same provider this had been addressed and the registered manager had now implemented a schedule of regular competency checks for all staff employed by the company.

We saw that medicines were stored safely, obtained in a timely way so that people did not run out of them, administered on time, recorded correctly and disposed of appropriately. Medicines were kept in a locked cupboard in the kitchen. Staff told us that daily checks were in place to count all medicines at the end of each shift to ensure they tallied with the administration records. The staff told us that no controlled drugs were used at the service at the time of our inspection. Some medicines were stored in the fridge and we saw records of daily room and fridge temperatures completed. Dates medicines had been opened were recorded on the boxes for those medicines that needed to be used within a specific timeframe. A specimen signature list was available for each of the five people responsible for administering medications.

We looked at three staff recruitment files and could see that checks had been carried out to ensure suitable staff were employed to work at the service. These included checks with the Disclosure and Barring Service (DBS) which assisted employers to make decisions about whether prospective employees were of a suitable character to work with vulnerable adults. Two employment references had been requested for each applicant. One of the references had not been checked by the provider to verify the details. We noted this was an isolated incident and the registered manager told us they now had procedures in place to ensure all references were verified and the details recorded.

Staff were knowledgeable about the different types of abuse and how they would report them. One member of staff told us, "I'm confident that [registered manager's name] would deal appropriately with any concerns we raised." Safeguarding records showed a recent referral had been made by the service and the registered manager had been open and transparent with the local authority on the outcome of their investigations. Lessons had been learned, shared with the staff team and additional measures put in place to prevent any further incidents of a similar nature.

Staff knew about the whistle blowing policy and actions to take should they need to use it. All the staff we spoke with felt confident that any issues they needed to raise would be immediately addressed by the registered manager.

There was an accidents and incidents policy and we saw that accidents and incidents had been recorded and managed appropriately. Investigations carried out by the provider were thorough and included details of any referrals to other health care professionals and outcomes or advice that had been given for staff to follow.

We observed staffing levels were suitable to meet all aspects of people's care and support. Staff told us, "My manager is always available to support me, I can ring their mobile or phone the sister service which is five minutes' walk away."

Detailed risk assessments were in place for accessing the community, cooking, behaviour and choking. Assessments identified any potential risk of harm and actions taken to mitigate them. These were monitored monthly or earlier should there be any significant changes. This meant that people were supported to live their lives safely and with minimum restrictions in place.

The accommodation was clean and tidy. Staff received training on infection prevention and control and knew the importance of wearing appropriate personal protective equipment (PPE). Relatives felt that the care and support provided was good and one told us, "We are very happy with the level of service received. [Name] is happiest here than anywhere else they have been."

Checks for maintaining the safety of the premises and equipment had been carried out. These included electrics, central heating and fire alarms. Staff told us that fire drills were completed every six months, which records confirmed. Equipment had been certified as being compliant by a suitably qualified and competent person and met legislative guidelines. Weekly water temperature checks had been completed and recorded.

Requires Improvement

Is the service effective?

Our findings

Relatives and health care professionals told us they felt staff had the appropriate skills and knowledge to meet people's individual needs. Health care professional told us, "The staff follow things up and ask for advice. It's all for the benefit of the service user there."

All new staff completed an induction which included introductions to people living at the service, training courses deemed essential by the provider and a period of shadowing until they were signed off as competent to work alone. Staff received a handbook with information about their employment which included company policies and procedures. New and existing staff completed the Care Certificate; this is a minimum set of standards that all health and social care workers must adhere to. People living at the service were encouraged to be involved during the interview and selection process.

The registered manager showed us a training schedule which provided a breakdown of training completed by staff during 2017; and included scheduled training for 2018. Courses included; fire awareness, food hygiene, safeguarding, first aid and other courses that were specific to people living at the service. However, the training schedule showed that only one out of five staff had received additional training that supported them to understand and meet the needs of the person they cared for. For example, only one member of staff had completed learning disabilities training and four had completed training in autism.

We checked the providers 'performance analysis and supervision policy'. The policy recorded staff should receive as a minimum, an annual performance analysis, formal supervision three times a year and informal supervisions conducted on a day to day basis. We looked at the records for three staff and saw that they had received at least one supervision in 2017. There was no evidence that an annual appraisal had been completed. One member of staff said, "I've had two or three informal chats since starting my job" and another told us, "I speak to the registered manager nearly every day, they always check everything is ok and ask if we need anything." The new schedule for 2018 showed each member of staff would receive one observation, one appraisal and two supervisions each year. This schedule was not reflective of the provider's current policy.

In addition to the above, one supervision from October 2017 had identified autism and medication training needed to be completed. At the time of our inspection this had not been completed and no training had been arranged.

This meant that the provider had failed to follow their policy and procedure to ensure any training, learning and development needs were identified, planned for and supported. Staff did not receive regular supervision and appraisal of their performance in their role from an appropriately skilled and experienced person.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection, there was one person that had restrictions in place. The provider was compliant with meeting the conditions and working within the MCA. The registered manager submitted renewal applications to the designated local authority within the specified timescales.

The training schedule did not show that MCA training had been completed by all staff. Training was in place for 2018 and all staff that we spoke with had a good understanding of the principles of the MCA and when a DoLS application would be required.

Care plans included details of people's consent to have their photograph taken and we observed staff asking for a person's consent prior to supporting them. Best interest decisions were held when needed and appropriate health professionals and family members were involved.

The staff spoke to us about supporting people to maintain a healthy and balanced diet. They supported one person to complete their shopping, sometimes they accompanied them and other times the staff had to complete shopping tasks alone – this was dependant on whether the person wanted to assist with shopping as during longer periods it was sometimes difficult for them to remain focused. The menu confirmed plenty of fresh fruit and vegetables were incorporated into meals. Staff encouraged people to make their own drinks and snacks according to their capabilities.

Staff often supported a person to prepare their own meals. We heard staff supporting them and giving minimal choices as outlined in their care plan so that the person did not get overwhelmed or confused.

Care plans included an initial assessment of people's health and any associated needs. Records included people's mobility and exercises, height and weight, diet, eyesight and hearing. People were supported to maintain their health and wellbeing. People confirmed they had access to their GP when required and we saw records where staff had worked in partnership with health care professionals to meet people's needs.

The home was easy to navigate with a long hallway leading to a bedroom and further along a living room. All areas of the home were clean and tidy and additional safety features had been put in place, such as television screen protectors, and a dining table specifically designed for people that may display more complex behaviours. Rooms were light and airy, with blinds for privacy and laminate flooring to maintain a hygienic environment.

Good

Is the service caring?

Our findings

Staff showed kindness and respect to both the person living at the service and their relatives. We observed staff interacting regularly and giving the person time to communicate and express their needs to them. On one occasion the staff had asked a question and the person responded using their own adapted language to describe what they needed. The staff immediately understood and proceeded to support the person as they had asked.

Equality and diversity policies were in place and staff accommodated the choices made by the person living at this service. Staff told us about this person's interests and preferences, it was clear they knew them well and supported all aspects of their health and wellbeing. One member of staff told us, "We are here to enable [person living at the service] to live as they would like to in their own home. [Name] likes no fuss and to have a quiet life." Staff were guided by health care professionals to find the best ways to support individuals, and the team worked together to communicate methods that worked effectively to achieve good outcomes – these were well documented in the care file.

People were supported to maintain relationships with their families. We could see from the communications book and visit record sheets that family made regular visits to see their relative. Staff kept communications open and often received calls from family asking for updates following appointments. Staff shared any changes in behaviour with family so they felt involved and had awareness. On one occasion it was decided that medications should be reviewed and both staff and family worked together to support the person throughout this transitional period.

Appointments or reviews were scheduled with health care professionals. Staff ensured that any friends or family that were important to the person were invited to take part at reviews and when planning any aspect of care and support. For example, staff used a communications book to record any changes and utilised this to provide updates for health care professionals and to monitor daily events. Daily notes were also used to capture important information, such as; bathing, activities, tasks such as washing up that had been completed independently and any new words or phrases used so that other staff knew what they meant.

Staff understood the importance of maintaining people's privacy and dignity. One told us, "We have to remind [Name] to shut the door when using the bathroom so that no one can see through the window. As I open the door I peer in to check [Name] is fully decent – if not, we remind them to go back into the bathroom and tidy up." We observed that staff knocked on the door before entering and ensured the person was presentable before exiting the bathroom. Another member of staff told us, "[Name] loves baths on a morning, we prepare and monitor the water temperatures and assist them to wash. We try to make it sensory by using bath bombs and allow time for [Name] to have a soak. [Name] shouts when they have finished and we ensure they safely get out of the bath."

Staff were aware that at times people wanted to be alone and they kept the bedroom door open at all times so that there was another room available should they wish to sit down or lay down for any length of time.

People's independence was promoted as much as possible. Staff told us that they always tried to encourage building life skills and promote people doing things for themselves. One member of staff told us, "Occasionally I can get [Name] to assist with the washing up, but sometimes they will be disinterested." This showed that staff promoted people's independence and respected people's choices should they not always wish to participate.

Staff used various methods of communication which were led by the individuals' preferences on each occasion. For example, if verbal communications did not work we observed staff using touch to divert their attention. They knew the person enjoyed having their arm tickled lightly and when they wanted this to be done - when they had enough the person communicated for them to move away by gently pushing the staff who immediately recognised they wanted some space.

The registered manager told us that advocacy support would be sought if needed. This was not required at the time of our visit as family, health care professionals and staff held meetings and discussions to ensure decisions were made in the person's best interests. Advocacy services help people, particularly the most vulnerable in society to: access information and services, be involved in decisions about their lives, explore choices and option, defend and promote their rights and responsibilities.

People's records were kept securely in the upstairs part of the building which only authorised personnel had access to. Staff told us they had received training on data protection and we saw that policies and procedures were in place to guide and promote staff awareness.

Good

Is the service responsive?

Our findings

People received person centred care that was responsive to their needs. Records showed that initial assessments of people's care and support needs were carried out by the service prior to placements being accepted. Staff reviewed care plans every six months or earlier should they identify any significant changes. We saw evidence that staff worked closely with health care professionals to meet the complex and diverse needs of people.

A health care professional told us, "Everything's been wonderful. I can't fault it. Staff follow any advice I give to them."

Care plans included medical histories and any interventions, behaviours that may challenge or cause risk and a list of current medicines including what they were used for, maximum doses and the dose that was required. Various charts were in place to record information such as, bathing charts and behavioural charts. Behavioural strategies were in place to guide staff when dealing with any complex behaviour and these were reviewed monthly. Each health condition had a plan in place to guide staff on the type of health need, what needs to happen and who would carry out any actions. For example, one plan was in place for breathing and heart, this showed that the person had a specific health condition at a particular time of the year, how staff could minimise the risks of this condition occurring and if it did occur the measures that staff and the GP could take. This showed us that staff had detailed guidance to support every aspect of a person's life.

A member of staff told us, "We have a consistent team of staff working with [Name] and we all get on well together. We work with health care professionals and follow any best practice advice they provide. It's a case of trying different things until we find something that works best for [Name]." Another member of staff said, "It's a case of getting to know [Name] and learning their way of communicating with us."

Staff had an awareness of people's likes, dislikes and preferences and these were documented clearly in the care plans. For example, one person liked spicy foods such as curries and this was considered when shopping each week. This was something staff had recognised from observations as the person was unable to verbalise that they enjoyed spicy foods. The person also enjoyed a hand massage. We observed the person raising their arm and gesturing for the member of staff to support them. Staff walked over to the person and massaged their arm with cream for a short period of time until they expressed a wish to stop. Staff were very in tune with the person and when we asked a member of staff about how they communicated they told us, "I have worked with [Name] for over five years now, so it's just second nature. It feels like we are part of a family. We all (staff) get on well with [Names] family and work together to resolve issues."

The staff told us activities were very much person centred on the individual and what they would like to do. These included; listening to music and watching videos on the computer, visits to a local aquarium centre, walks around the local area, biking and watching television. The staff told us of a person's favourite film and how they placed their hands on the screen whilst watching it. One member of staff said, "We have done a lot of work previously with health care professionals, used sensory toys and other methods of interaction. In the

end it was agreed that [Name] just likes a quiet and simple life without too much fuss. We work together to ensure [Name] has everything they need that keeps them happy and balanced." We observed the member of staff asking what music the person would like to play and they chose Abba. The staff member said, "[Name] likes musicals and loves to sing, they have a really nice voice." Staff also told us that the person enjoyed a takeaway on a Saturday night.

People received support from staff during the day and night and there was a bedroom and bathroom upstairs for staff to use during sleepovers. Staff documented information in the communications book and in daily notes. In addition, they came in twenty minutes before shift changeovers to receive a verbal handover from the existing staff on duty. This meant that staff were aware of the person's presentation that day. This helped them to keep a consistent approach and ensure things such as meals were varied and activities changed to suit the person.

Staff told us they researched topics relating to their role outside of work to further their knowledge and skills. They liaised with health care professionals during review meetings, health appointments and assessments where they discussed approaches, knowledge and new practice.

The service worked to incorporate the Accessible Information Standards (AIS). This is a set of standards introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. We saw that care files had pictorial content and used short phrases to describe and explain things. Easy read formats were obtained from health care professionals so these could be read and communicated to the person. Staff told us that a person had sensory impairment and they had worked with the speech and language therapists (SALT) to obtain picture cards. However, the person had adapted their own use of words which were well documented in their care plan. Observations confirmed that staff understood the verbal and body language used by this person and responded appropriately.

A complaints policy and procedure was in place and records showed that this was followed when responding to any concerns that had been raised. Easy read formats were available for people to read. The registered manager ensured people's complaints were acknowledge, responded to and an apology given when necessary within an appropriate timeframe. Staff told us they were confident that if they raised any issues they would be resolved by the registered manager.

The service advised us on the PIR that advanced decisions about end of life choices were a work in progress. They intended to discuss this at the next multidisciplinary review and advised mental capacity assessments and best interests decisions would need to be arranged. The registered manager advised "It is unlikely that the service user will be able to comprehend what is being decided however our best efforts will be made to include them."

Requires Improvement

Is the service well-led?

Our findings

During our previous inspection on 5 November 2015, we found people who used the service were not assured a quality service. This was because there was not an effective system in place to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action to make improvements. The provider submitted an action plan which told us actions would be implemented and completed by March 2016.

At this inspection, we checked and found despite the implementation of some quality assurance checks in November 2016, the provider had not completed all the actions.

The provider told us on the PIR, 'Quality audits have been carried out however they have fallen short of expectations and a new system will begin to be used this year.' The registered manager told us they had an action plan to address the shortfalls and had identified two staff members from other areas of the company who would become internal auditors.

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Relatives had completed a satisfaction survey on behalf of a person living at the service. It was in an easy read format to encourage input from the person. They rated the service 10 out of 10 (ten meaning the service is perfect for the person). It included that they saw the registered manager once a week. We noted there was no date on this questionnaire and therefore we could not tell when it had been completed.

The provider had a variety of policies and procedures in place which included guidance for care workers on areas of service. Examples included policies for medicines and safeguarding. We saw these had been reviewed but not adequately updated to reflect current information. For example, the safeguarding policy had an out of date contact number for the emergency duty team which covered services out of hours. The medicines policy had not been updated to include the current dispensing pharmacy for the service. Audits of these documents by the provider were found to be ineffective in ensuring they were fit for purpose and contained the most current guidance for staff to follow.

Other records were maintained to document staff training and development needs. We found these were incomplete. For example, where observations and competency checks were required, these had either not been completed or were inconsistently recorded.

Quality assurance checks on medicines management and administration had not been completed. The registered manager had addressed this and plans were in place to implement a medicine audits to ensure they had oversight that medicines were being managed and administered appropriately. This was in line with practice in other services owned by the provider.

We saw that the registered manager completed monthly reviews of people's care and support and staff completed daily safety checks of the premises. Despite this, the provider did not have effective governance in place including assurance and auditing systems or processes to continually evaluate the service provided. We saw no evidence to record visits from the provider to check standards and the quality of care being

provided, or where actions were required to improve the service people received. In addition, the quality assurance systems had failed to pick up the issues with medicines and identify gaps in supervision, appraisal and training.

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

The last staff meeting held covered a three month period from September to November 2017. Prior to this meeting we only saw evidence of one other meeting taking place which covered the months from February to March 2016. A member of staff told us, "We have regular informal one to one chats with the manager each week." We saw evidence that the provider sought and acted on the views and feedback from health care professionals including dieticians, occupational therapists, psychiatrist and the speech and language therapists (SALT).

The registered manager understood their responsibility to notify CQC of significant events that happened at the service which affected the people living there. They told us they had applied to remove their registration from the service. They said, "I am not leaving, just working within another service owned by the same provider. We are promoting a team leader to the role of manager and they will then apply to be registered with the CQC."

Everybody we spoke with was positive about the registered manager. Comments from staff included, "The registered manager is fantastic. They care about the service users and are very supportive." Another staff member said, "They are brilliant. No matter what it is they always answer my questions and if I'm unsure I know I can go to them for help or advice."

Staff told us that the registered manager was only ever a phone call away and worked at another service that was a five minute walk away. Staff confirmed they could contact the registered manager at any time and they were always available. The person living at the service had indicated on the satisfaction survey that they knew who the registered manager was and their relatives felt that the service was managed extremely well.

Staff encouraged relatives to visit whenever they wanted to and communications was regular whether it be face to face, telephone or by email.

The registered manager told us they shared new information, leaflets, and best practice to further develop the skills and knowledge in their workforce. An open door policy was adopted so that staff could discuss any concerns or ask for guidance.

The service built strong community links and supported health care professionals input at the service. Staff encouraged people to engage with the outside community. For example, visiting local pubs for lunch and visiting local shops.

The provider had a generic 'statement of purpose'. The aims of the service included to provide a safe environment, develop people's potential, encourage self-determination, offer protection and implement the best possible outcomes for people. The objectives were to provide community based support for people with an autistic spectrum disorder and to strive to provide people with every opportunity to lead as fulfilling a life as possible. This was on the whole achieved by the service, with some areas requiring improvement as detailed in our findings at the back of this report.

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish and implement systems or processes to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). The provider had failed to ensure that their audit and governance systems were effective. Breach of Regulation 17(1) (2)(a)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to follow their policy and procedure to ensure staff received regular, appropriate supervision and appraisal of their performance in their role from an appropriately skilled and experienced person and to ensure any training, learning and development needs were identified, planned for and supported.