Care Quality Commission

Potensial Limited

Potensial Limited - 2 Belgrave Terrace

Inspection report

2 Belgrave Terrace, South Shields,
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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

Overall summary

This inspection took place on 24 March 2015 and was unannounced. This meant the provider did not know we would be visiting. We last inspected the service on 17 December 2013 and found the provider was not meeting legal requirements in relation to safety and suitability of premises. The provider submitted an action plan and we found that appropriate improvements had been made.

Potensial Limited – 2 Belgrave Terrace is based in South Shields in a Victorian terraced house close to the town centre and local amenities. The service can accommodate up to eight people with learning disabilities. At the time of the inspection seven people lived at the home.

There was an established registered manager in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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 understood safeguarding procedures and policies were available for staff to refer to as needed. People received pictorial, easy read information on abuse and bullying and knew to tell someone if they were concerned.

Accidents and incidents were recorded and monitored. Records included potential triggers for any incidents and any behaviour strategies to assist staff to manage the situation.

Risk assessments were in place and included information on referrals to occupational therapy for mobility assessments or specialist equipment.

Emergency plans were in place and each person had a personal emergency evacuation plan which detailed plans should 2 Belgrave Terrace not be habitable. The fire brigade had been involved with the completion of the fire risk assessment.

Everyone we spoke with said they thought there were enough staff to support people and meet their needs. Everyone was aware that the local authority funded a specific number of one to one support hours for people and staff worked with people to ensure they received one to one support at times where it was of most value to people. For example at the weekend to go out on an activity or to attend social events.

Recruitment procedures were robust and people were involved in deciding who they wanted to support them. References and disclosure and barring service checks were completed before anyone was offered employment.

Staff were trained in the administration of medicines and appropriate care plans and risk assessments were in place. Where people had been prescribed 'as and when required' medicines protocols were in place and administration had to be authorised by the deputy or registered manager.

Staff told us they were supported very well and attended regular supervision and team meetings. Annual appraisals were held with people to review performance over the past year.

Training was provided to ensure staff were knowledgeable of the skills needed to support people. This included training in dementia and diabetes as well as infection control, risk assessment and challenging behaviour.

The registered manager and staff had a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Staff had taken time to explain to one person what having an authorised DoLS in place meant to them and the person understood this and accepted the reasoning behind it.

People said the food was good and they were able to choose what they wanted to eat. We saw people were involved in deciding what shopping was needed and had been involved in the decision to move away from a set menu so people could be actively involved in decision making around choice of meals.

Health action plans and hospital passports had been completed with people which gave a record of healthcare professionals who were involved in people's care. A community nurse told us, "They are good at referring people."

People were encouraged and supported to be involved in decision making and we saw information was available for people in a pictorial format using plain English. This included individual charters which explained people's rights and responsibilities.

Care records were individual to the person and everyone had a person centred plan which recorded their hopes and dreams for the future. People were encouraged to celebrate their achievements.

People were involved in planning their care and signed documents to say they had been included in reviews on a quarterly basis. Outcomes were recorded and people's progress was noted as achievements.

A pictorial complaints policy was in place and people knew how to complain if they needed to.

The registered manager was seen working alongside care staff to support people and there was a genuine emphasis on team working. Local authority commissioners said, "Staff are very willing to share best practice and learn from others."

Summary of findings

A variety of audits were completed in order to drive quality and service improvement and the registered manager had a clear vision about the need to support people to be independent, active members of the local community.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe. People told us they felt safe and staff had a good understanding of safeguarding and accident and incident reporting. Staffing levels were assessed by the local authority depending on people's assessed needs. People were involved in decisions made around when they received their allocated one to one support hours. Recruitment procedures were robust and people had been involved in deciding who should be offered posts. Medicines were managed safely.	**Good**	
Is the service effective? The service was effective. Staff had the necessary skills and knowledge to support people and said they were well supported in their roles. Staff had a good understanding of the Mental Capacity Act 2005 and had applied Deprivation of Liberty Safeguards appropriately. People told us the food was good and they were involved in choosing and preparing meals.	**Good**	
Is the service caring? The service was caring. We observed warm and caring relationships between people and staff. Relationships were relaxed but respectful. People were involved and received information in pictorial format which they were able to explain to us. People were aware of their rights and responsibilities and were actively supported to maintain and increase their independence through the promotion of choice and involvement.	**Good**	
Is the service responsive? The service was responsive. The service worked in a very individualised way and understood the needs of people well. People chose how they spent their time and what activities they were involved with. Pictorial information was available for people which supported their understanding.	**Good**	
Is the service well-led? The service was well-led. There was an established registered manager in post who lead by example and was aware of their responsibilities. There were a variety of quality audits completed and the team were working together to ensure people received high quality support. The staff team worked well with external partners and had a positive reputation with local authority commissioners and stakeholders of the service.	**Good**	

Care Quality Commission

Potensial Limited - 2 Belgrave Terrace

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.

The inspection took place on 24 March 2015 and was unannounced. This means the provider did not know we would be visiting.

The inspection team included one adult social care inspector.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We also reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events of incidents the provider is legally required to let us know about.

During the inspection we met and spoke with all seven people who lived at the service and one visitor. We spoke with three members of staff including the registered manager. We also contacted the local authority safeguarding team and commissioners of the service and spoke with a community nurse.

We looked at three peoples care records and two staff files including recruitment information. We reviewed medicine records and supervision and training logs as well as records relating to the management of the service.

We looked around the building and spent time with people in the communal areas.

Good

Is the service safe?

Our findings

A visitor told us, "[My relative] seems settled; they only moved in recently but seem to like it. They know someone else who's moving in so they are excited about that." They added, "It seems safe here."

Staff were clear on what to do should a concern be raised and safeguarding of people was discussed in team meetings and supervisions with staff. Safeguarding information was recorded appropriately and there was a copy of the local authority procedure available as well as the providers own policy and procedure. There were posters on safeguarding displayed in the home and people had received pictorial, easy read information on abuse and bullying.

Risk assessments included control measures that staff were aware of and knew how to report safeguarding concerns. They also recorded that there was a whistleblowing policy for staff if they needed to share concerns. There was a senior manager on call at all times should additional support or guidance be needed.

An accident and incident reporting procedure was in place. Accident and incident reports were completed and included triggers for the incident, whether the risk assessment and behaviour management plan had been followed or needed to be reviewed. A record of support strategies used or any actions that had been taken or needed to be taken were recorded. There was also reference to reporting of injuries, diseases and dangerous occurrences regulations 2013 (RIDDOR).

Pictorial consent forms for support with keeping money safe had been signed by people. This included information on the policy and people's bank statements. It stated 'Staff and me are to sign for any income and expenses.'

Risk assessments documented when professionals had been involved in assessing risk. One person had an occupational therapy assessment and it was advised that grab rails be fitted to support the person in the shower. This had been completed. Another person's recorded that the chiropodist was involved and supported the person with foot care.

Mobility care plans and risk assessments were completed and one person's included standard phrases that staff were to use in order to ensure consistent support but also to ensure the person understood what was being said. These phrases included 'You're safe' and 'walk tall.'

People had individual personal emergency evacuation plans which were to be followed in the case of a fire. These were up to date and relevant. Fire safety risk assessments were in place for people and people took part in monthly fire evacuations.

Fire plans of the building were in place and the fire brigade had been involved in the completion of the fire risk assessment in January 2015. The registered manager said, "This will be redone once [person supported] has moved rooms and the new person has moved in. We just need to ring them [the fire brigade] and they'll come out." The fire file included an evacuation procedure and maintenance checks of equipment.

The fire file had a list of staff signatures to indicate they had read and understood the documentation. A list of staff training dates was in the file and training was up to date.

An emergency plan had been completed which included alternate accommodation arrangements for people as well as actions to take if there was a flood, fire or power failure.

The local authority assessed people's need for staffing and this was adhered to by the provider. With the support of a social worker the provider had requested a review of someone's support hours as it was felt an increase was needed due to a change in their needs. People received a combination of one to one support hours and shared hours. This means there were times when people had one to one staff support, or two to one support if there was an assessed need so they could use this time as they chose to do so for outings and activities. At other times when people were at home they 'shared' hours with other people.

The registered manager and care staff explained that someone had recently moved into the home and another person was due to move in the next day so they were in the process of monitoring and reviewing hours of support to make sure everyone's needs were met. The consensus was that staffing would need to be increased, to ensure everyone's needs were met but this was being managed proactively.

Good

Is the service safe?

One staff member said, "Yes there's enough staff, it can be busy and hectic, it just depends on the day." When asked if agency staff were used one care staff member said, "Oh no we don't have agency staff here; we'd sooner do it ourselves." The registered manager said there were two bank staff employed by the provider but they were soon to work permanent hours so more recruitment was needed." Another staff member said, "I'll tell you what's good about working here. The manager is really flexible; we can swap shifts around if we need to for something personal. They are really understanding."

The registered manager explained that one to one hours were used during the week for people to attend appointments or activities. At weekends extra staff were brought in for activities but people worked this out with staff so people could do the things they chose to. We saw the rota reflected people's individual hours and when they had received one to one or two to one support. The registered manager monitored the provision of hours via the rota. The local authority also monitored provision of hours for people.

People had been involved in recruiting new staff. One applicant had been offered employment pending receipt of their Disclosure and Barring Service (DBS) check which had been applied for. Recruitment checklists were used to ensure the appropriate procedures had been followed before someone started in post. This included a check of the application form and interview process as well as ensuring appropriate references and disclosure and barring checks (DBS) had been received.

People had signed pictorial consent forms giving permission for staff to manage medicines on their behalf. Health and well-being care plans included the management of medicines and how people liked them to be administered. Medicine risk assessments described the hazards, who might be harmed, and what steps staff had to take to reduce the risk. This included statements that only medicines prescribed by the doctor were to be administered by staff who were trained in medicine administration. The date of assessing the risk had been recorded and an authorisation and review date was also in evidence. We saw that all staff had signed the risk assessment as agreement that they had read and understood it. Medicine administration records (MARs) were completed, errors were reported and medicines were stored in a locked cupboard.

Protocols were in place for 'as and when required' medicines. As and when required medicines are those given only when needed; such as for pain relief. This included descriptions of when it should be administered and agreement had to be sought from the registered manager or deputy manager to administer. Controlled drugs were managed, stored, administered and recorded appropriately.

One person administered their own medicine and there were care plans in place explaining what support staff needed to offer. There was also pictorial information in place.

There was a robust policy and procedure in place for medicine management which included choice and consent, controlled drugs, the supply, storage and administration of medicines. Self-administration, homely medicines, audits and reporting of errors. There was also information in relation to staff assessment and six monthly competency checks as well as a covert medicines agreement form and a stock check form.

Good

Is the service effective?

Our findings

A staff member said, “We are well supported yes. We have supervision regularly and an annual appraisal.” They added, “Team meetings, we have those. We can raise concerns in staff meetings and air our views and clear the air. They’re good.”

Staff had completed a document signing to say whether or not they gave permission for their files to be viewed by CQC.

Staff received supervision every other month and there was a schedule in place which identified when staff had received supervision and when it was due. Every staff member had received supervision in January or February 2015.

Annual appraisal’s had been completed and positive comments were recorded on a front sheet about the staff members’ performance such as, ‘Valued team member, excellent performance.’

Completed induction packs included infection control, risk assessments, medicines, aims and objectives and values of the home, the fire policy, health and safety responsibilities, people’s files and care records and communication.

One staff member said, “I’ve done that much training I can’t remember the name of it all. Mental capacity, first aid, safeguarding, moving and handling, nutrition and food hygiene, medicines. I’m doing some training with the college at the minute and I’ve done a diabetes workbook.” They added, “I’m doing a dementia workbook at the minute because [person] has early onset dementia so we need to know about it.”

Training records were in place and the training provided ensured people were supported by staff who had the necessary skills and knowledge to care for them well. This included training in medicines, moving and handling, food hygiene, safeguarding, challenging behaviour, mental capacity act, epilepsy, diabetes, equality and diversity and diet and nutrition.

The Care Quality Commission (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. We saw that were required DoLS authorisations were in place and were being managed appropriately. People and staff were able to explain the meaning of the restrictions and understood why they were in place. Care plans were in place in relation to restrictions as were missing person procedures.

Where appropriate people had been appointed an independent mental capacity advocate (IMCA). An IMCA has a legal responsibility to represent a person’s view if they lack capacity and do not have an appropriate family member or friend to represent them. Other people had a relative who had been appointed as their relevant person’s representative.

People had signed pictorial consent forms in relation to receiving lifesaving medical treatment and cardio vascular resuscitation.

Staff were knowledgeable about people’s behaviour and how to respond should someone present with a behaviour that the service found challenging. We saw a care plan for behaviour which stated, ‘My behaviour can be a problem for others.’ It went on to explain that the person likes routines and needed to follow their routines in a consistent and organised way. It also stated that staff needed to offer positive reinforcement and be consistent in their approach as the person showed traits of an autistic spectrum condition. This meant that if staff were consistent and supported the person’s routines the incidents of challenging behaviour would reduce.

Staff were very clear that restraint wasn’t used and wasn’t needed if they supported people in consistent ways.

One person said, “The food’s good here. It’s my birthday and I’m having a party. I do sandwiches because I can’t go near the cooker.” Staff explained that the risk assessment stated that the person needed to be supervised if using the cooker. To this the person said, “Oh, yes, supervised, [staff member] will watch me then.”

Care plans for food and drink were in place and included peoples like and dislikes as well as specific instructions such as, ‘I like my sandwiches to be cut into small pieces.’ There were also highlighted instructions on food that people could not eat due to the medicine they were taking. Any specific equipment people used to support their independence at meals times were also seen to be documented as were the reasons why people used this equipment.

Good

Is the service effective?

Staff were aware of the need to consult with dietitians or speech and language therapy teams if additional support and advice was needed.

People gave written consent via pictorial information for staff to offer support to attend any medical appointments.

Each person had a health and well-being care plan which was specific to their needs. One person's included arranging of appointments. It recorded the date that the person had attended an annual health check with their GP. It also advised that the person wanted to be supported to choose and cook healthy and well balanced meals. They wanted support to be weighed on a monthly basis and this was to be recorded and monitored. One person's care plan stated that staff should liaise with professionals and record all incidents of ill health and seek medical advice. It was recorded that 'staff are to offer information on my history on a need to know basis.'

Record's stated 'Familiar staff who know my health needs are to support me to my appointments.' We saw this was the case and when one person asked the registered manager if they would attend an appointment with them they were more than happy to accept. The registered manager said, "It's really important that if someone asks me to go to an appointment with them that I go."

Each person had a health file which included a health action plan and hospital passport. This meant there was an up to date record of any health appointments attended and any professionals involved in the persons care. A record was being kept of any future appointments, any allergies, any tests people had had and a record of immunisation. A full medical history was recorded and a list of current medicines including the dose, the reason for the medicine, the start date and any side effects. Medicine reviews were recorded as was a record of support people needed. In this way the file could be used as a 'grab pack' of information should a person need emergency medical support or a hospital admission as it contained all the relevant medical and health information known about that person.

A community nurse said, "Things are positive, they are very good with new people, putting in visits. They are good at referring people and will ring for support. If I ask for any paperwork to be completed it will be done, I have no concerns."

Work was being finished to adapt one of the bedrooms to meet a person's needs and they were due to move into the new room the day after the inspection. The maintenance contractor was at the home on the day of the inspection and was actively involved with the registered manager in ensuring all required work was completed. Some redecoration work had been completed in the communal areas and the basement stairwell and some was ongoing. New carpets had been laid in the lounge which people were happy with.

There was a formal reporting procedure in place for repairs and maintenance. Emails requesting reactive maintenance were stored in the maintenance file. Work sheets were signed off on completion of work and this acted as an audit trail.

Good

Is the service caring?

Our findings

People and staff had warm and respectful relationships. They engaged well together and were able to share mutual jokes and have a laugh together. One person told us, “It’s my new home, I’m happy here, it’s good.” Another person said, “It’s good living here, I like it.”

Staff had a good understanding of people’s communication needs and were able to read people’s body language and facial gestures to assess their mood or interest in activities or going out. Staff were encouraging of people and involved them in day to day activities but recognised and respected that some people did not want to be involved.

There was a variety of information available for people in pictorial format. This meant information was presented as a series of pictures or symbols and was easier for people to understand. Staff spent time with people in an unhurried way supporting their understanding and decision making.

Each person had a person centred plan which they had been involved in developing. Person centred plans provide ways of helping people to plan all aspects of their life whilst ensuring they remain central to the plan. It is about making changes in a person’s life and planning for the future. One person recorded that they wanted to go ‘up in a plane on holiday’ and the action was to ‘save up for a passport.’

People had shared their hopes and dreams in developing the plans and when dreams had been achieved this had been celebrated. Where people were unable to achieve their goals and dreams they were able to tell us why this was. One person added, “It doesn’t stop us dreaming though.”

Residents meetings were held once a month and were led by people using the service. Everyone had a turn to speak and minutes were taken. Discussions included what people were enjoying doing and what they would like to do in the future. Meetings were opened by a different person each month.

We saw an action plan which had been developed from a quality assurance survey. People had identified that they needed a new sofa in the communal lounge and this had been provided. People thought a non-slip floor was needed in one of the bathrooms. This request had been put on to the property audit to be replaced and as an interim measure non-slip mats had been purchased. People were very proud of their home and the decisions they had made with regard to furniture and fittings.

An inventory of people’s property and clothing was in place and was updated in response to new purchases or items being disposed of due to breakage or wear and tear. In this way staff could ensure people’s belongings were noted.

People had been given pictorial service user guides which included information on how to complain, support to manage their money and staffing. The contact details for CQC were also in this guide.

People also had a copy of the statement of purpose which included the promotion of people’s independence, rights, inclusion and choice. People had signed pictorial confidentiality statements and had pictorial information on dignity and equality including saying no to abuse.

People had individual charters in place which documented their rights and responsibilities in pictorial format so people were able to understand the information. One person went through this information and had a good understanding of their rights and responsibilities.

Good

Is the service responsive?

Our findings

One person discussed their care records with us and said, “This is my person centred plan, it’s all about me.”

People had a photograph in their care records and had signed, alongside a community nurse or representative to say they agreed to the care plans. People were able to tell us about the care and support they received.

An index of care plans were in place and included records on communication, health and well-being, personal hygiene, food and drink, the environment, relationships, community participation and finances, mobility and social and spiritual needs.

The registered manager explained that it was important for people to be actively involved in their community and all care plans were outcome focused. This meant there were clear goals that people were working towards and progress could be recorded and achievements celebrated.

People had a document called ‘This is Me’ in their care records. This included people’s preferred name as well as the contact details of their GP. There was also information on people’s family history, their personal history and detail of what support was needed and how they needed to be supported.

Care plans detailed what people wanted help with, who they wanted to help them, when they wanted the help, how they would like to be assisted and what their expected outcomes were. For example, one person’s care plan said, ‘Include me in decisions and conversations that concern me.’ It stated, ‘Be patient and listen to me. Consult with professionals on my behalf. My keyworker is to support me whenever possible. Encourage and assist me to express my wishes. Support me to attend reviews and meetings. Answer correspondence and phone calls with me.’

Documents stated to, ‘Include me in a person centred way, support and encourage me with communication, consult and involve me with professionals, develop my vocabulary and be consistent and focused.’ Expected outcomes included things such as, ‘I will express my choice and decisions. You will respect my wishes. Support to express my individuality and develop my likes and dislikes. To develop meaningful networks and to become self-directed and improve in confidence.’

One person’s health and well-being care plan stated that they had some ritualistic behaviours associated with autism and liked to carry out tasks in a certain way. Staff understood the importance of this and supported people with their routines in a respectful way.

Care plans recorded people’s preferences for male or female staff. One person’s stated that they were to choose items when out shopping and it was important that staff supported the person with this.

A community nurse told us, “I’ve been to team meetings to look at expectations and changes in relation to dementia.” They added, “When [person] came for a visit before moving in there was some concern about the stairs. The registered manager arranged for an occupational health assessment and a referral to physiotherapy to assess their needs before they moved in.” This showed the registered manager to be assessing risk in a proactive manner and planning ahead to ensure they would be able to meet the persons needs before they were offered a place. The community nurse added, “They are very observant of people’s needs.”

People chose a range of activities that they enjoyed doing and arranged timings of this with staff especially at weekends. People spent their time doing things like going to the gym, to church, to the day centre and one person had a voluntary job.

Care plans were signed by the person and were reviewed on a quarterly basis. The date of the next review was always recorded and clear progress against outcomes was noted, for example, ‘My communication has improved.’

A complaints policy and procedure was in place which included time frames for responding to any complaints. The complaints log included the date, who the complainant was, the nature of the complaint and the action taken. The outcome/resolution was also recorded. People who used the service also received a pictorial guide to making a complaint.

One person had made a complaint. This had been appropriately recorded and investigated. A resolution and outcome had been noted to everyone’s satisfaction.

Compliments were recorded and included comments such as, ‘I couldn’t praise the staff enough for the way they have helped [the person] settle into their new home.’ And, ‘A big well done, one of the nicest homes.’

Good

Is the service well-led?

Our findings

There was an established registered manager in post who understood their responsibilities and had positive relationships with the staff team and the people they supported. They had introduced various systems and processes to support the management of the home.

Written handovers were in place and included a summary of the jobs completed such as cleaning, banking and shopping, information on maintenance, paperwork completed, activities and personal care.

Staff meetings had been held monthly and opened with a thank you for attending and a reminder to feel free to speak openly. Items discussed included safeguarding and whistle-blowing, communication, the service development plan, training, confidentiality, networking and the social care commitment.

There was also time spent discussing the people staff were supporting, new referrals to the home and making best interest decisions on people's behalf. The meeting in January 2015 had included a discussion around the service development plan. This had been picked up by the area manager in their audit in March as needing to be reviewed. Safeguarding and CQC's revised approach to inspection had been discussed as had training needs.

There was a variety of information around the home including commitment to 'I will succeed,' the code of practice for social care workers and investors in people award.

We saw the results of a staff survey from May 2014 which had found that staff were satisfied that the service was well-led, that they felt included in decision making about the service and could share any issues concerns or thoughts. Staff had identified actions that were needed which included replacing flooring and needing additional funds for activities. In response the flooring had been replaced and the provider had allocated a sum of money each year to spend on activities for people.

Stakeholders such as, visiting social workers had also completed a satisfaction survey and they had also identified that new flooring was needed and the sofa needed to be replaced in the lounge.

Overall statistics had been produced which gave collated satisfaction levels as 96% for participation, 93% for staff support and external support; 92% for safety and security; 90% for diet and nutrition. One of the lowest scoring areas was activities but additional monies had been made available to support the development of more activities for people.

A community nurse said, "Joint working is good, communication is good."

Staff received an employee handbook from the organisation which included information on key policies and their responsibilities as staff members. The accident reporting procedure was included as was information on infection control, lone working and manual handling.

The registered manager was well established in the area and attended the local authority provider forum. Commissioners of the service told us, "Potensial staff attend the provider forum in South Tyneside and are very willing to share best practice and learn from others."

A managers meeting had been attended on a quarterly basis. This was a forum for sharing good news stories; workforce developments; quality assurance; training and monthly reporting.

The local authority told us, "The manager is very responsive and makes contact with Commissioning and Safeguarding where appropriate. We have recently had to source placements for people and the staff have worked very closely to ensure positive transitions for people which have been imperative."

A variety of quality assurance audits were in place, some of which were daily and weekly checks by the registered manager. These checks included fire safety, fridge and freezer temperatures and medicines. Actions needed were recorded and these included the completion of personal emergency evacuation plans and a fire risk assessment. These had been completed.

The registered manager completed monthly audits of care plans and risk assessments, activities people had engaged in and a check of medicines to ensure it had been ordered, booked in as received, stored correctly and that any returns had been managed appropriately.

Six monthly and annual audits were completed as were three monthly checks by the area manager. This ensured rotas, training, supervision and appraisals were all up to

Is the service well-led?

date as well as ensuring all necessary health and safety checks were complete such as the gas safety certificate, firefighting equipment, portable appliance testing and public liability insurance cover.

Health and safety monthly audits were completed in a timely manner and it had been recorded that a new carpet was needed in the lounge. This had been fitted the day before the inspection.

Monthly keyworker summaries were completed and checked. These included ensuring paperwork was up to date, accurate and timely such as health visits, incidents and actions needed, any as and when required medicines were recorded and managed, the review of support plans and risk assessments. It also recorded whether someone's person centred plan had been reviewed, if there were any action needed in relation to activities.

A file audit had been completed in February 2015 and included person centred plans, daily reports, keyworker monthly summary, support plans and risk assessments, health action plans, consent and capacity, complaints, family information and medicines. Any actions needed had been recorded.

People were involved in completing and recording room checks to ensure there were no maintenance or health and safety issues.

An area manager audit had been completed on 19 March 2015. Actions from the last report were reviewed for completion. Feedback from staff and people was included in the audit and there was a review of peoples care records, safeguarding information, the environment, CQC, supervisions and appraisals, finances and health and safety. Actions were recorded as being to archive old information, to update the service development plan, recruit bank staff, to review emergency evacuation procedures once the new person moves in.

The registered manager explained that a new 'set' of policy and procedures had been received and needed to be shared with staff. The registered manager said, "They are being shared with staff in priority order for them to read and sign." This was so they weren't overloaded with information. The whole set of policies were available in the office for staff to read and refer to as needed.

The new policies included health and safety, medicines including covert administration, safeguarding, compliments and complaints and mental capacity and deprivation of liberty safeguards including best interest decisions, department of health guidance and standard forms for record keeping. There were also policies for dignity and equality and a pictorial policy for people about abuse. Deprivation of Liberty Safeguards information was available for relatives and carers.

There were specific autistic spectrum disorder policies which included specific information in relation to supporting people with bereavement, communication, flexibility of thought, sensory issues and social understanding. There was information in relation to the provider's internal behaviour support and therapy tool. Information included a reference tool for staff to use which explained positive behaviour support (PBS) and person centred approaches. PBS is a recognised approach which aims to enhance community presence, increase people's skills and competence and places emphasis on respect and liking for the person. Information on person centred approaches included privacy and dignity, independence, choice, rights and fulfilment.