FitzRoy Support

FitzRoy Supported Living – Cambridgeshire

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

Fitzroy Supported Living – Cambridgeshire and is registered to provide personal care to people living in their own home. At the time of our inspection there were eight people on the Autistic spectrum using the service.

This unannounced inspection took place on 17 May 2016.

The service had 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.

Staff's training and knowledge in protecting people from harm meant that appropriate reporting and actions were taken to help ensure people's safety.

The provider's recruitment process and pre-employment checks ensured that staff were safely recruited and deemed suitable to work with people using the service. There was a sufficient number of suitably qualified and experienced staff to support people and meet their needs.

A process was in place that ensured staff were trained and assessed as being competent before they were authorised to safely administer people's prescribed medicines. People's medicines were administered and managed safely.

Risk assessments were in place to help manage each person's assessed health risks. Staff used recognised national standards of de-escalation to support people with behaviours which could challenge others.

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. Appropriate applications had been made and acknowledged to lawfully deprive some people of their liberty.

Staff were supported with regular supervision to develop their skills, increase their knowledge and obtain additional care related and management qualifications.

People's care was provided with consideration of people's needs and this was done compassionately by staff who people well. People were supported to improve their independent living skills and staff respected their choices.

People used their preferred means of communication to inform staff of their preferences and needs. Relatives, care staff, health care professionals and social workers contributed to people's to the assessment of people's care needs. People's care plans were in a format that enabled people to be part of the planning of their care.

People were supported to access a range of health care professionals including dieticians, occupational therapist and GP services. Staff adhered to the advice and guidance provided by health care professionals.

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

Easy read/pictorial format of care plans enabled people's involvement in planning their care. The registered manager was proactive in taking preventative action to prevent the potential for any recurrences. Staff knew when people were happy with their care.

The provider, registered and deputy 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 medicines administration and who safely managed people's risks.

A sufficient number of trained, suitably qualified and competent staff were in place to safely meet people's needs.

Only those staff who had been deemed suitable to work with people using the service were offered employment.

Is the service effective?

Good

The service was effective.

People were supported to make decisions in a way which considered their rights. People were only deprived of their liberty where this was lawful.

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

People's health and nutritional support needs were met.

Is the service caring?

Good

The service was caring.

People were cared for and supported by staff who considered the important aspects of people's lives.

Staff made a positive difference to people's lives on a daily basis.

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

Is the service responsive?

Good

The service was responsive.

People's aspirations were supported and met by staff who knew what people had the potential to achieve. No practicable limitations were placed on people's hobbies, interests and education.

People and those others involved in their care contributed to the assessment and planning as much as possible.

Concerns were acted upon appropriately before they became a complaint.

Is the service well-led?

Good

The service was well-led.

There were effective audits and quality assurance processes in place.

The registered manager was creative in the way they managed the service. Best practice was seen as essential in all aspects of people's lives.

The staff culture was that of putting people's needs first and supporting people with what was important to them.

FitzRoy Supported Living – Cambridgeshire

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 announced inspection took place on 17 May 2016 and was completed by one inspector and an expert by experience. An expert by experience is a person who has personal experience of caring for someone who uses this type of care service.

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 one person who used the service, four relatives, the service's registered, and deputy manager and three members of care staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed people's general care to assist us in understanding the quality of care people received.

We looked at three 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 compliments and quality assurance records.

Good

Our findings

People who used, or who were connected with the service, told us that they felt safe. One person said, "Yes I feel safe and yes staff are kind." One relative told us, "Yes, my [family member] is safe and staff know [them] very well." We saw that staff understood how people communicated either verbally and also 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 arrangements in place supported people to raise concerns if ever they had a need to.

Staff were knowledgeable about recognising harm, reporting and acting upon concerns for people's safety. This included recognising if a person was exhibiting signs or symptoms to show that they were not their usual selves. Staff were confident that people were kept as safe as possible. Where staff had been deemed unsuitable to work with people at the service the provider followed their disciplinary process. This was to ensure that people were safe and that the potential for any future incidents was minimized. One relative said, "Yes, most definitely my [family member] is safe, staff are very good and I have no concerns [about the person's safety]." Another relative said, "Completely safe [family member's] staff are amazing really; they are calm and follow a set parameter [structured routine] for [family member] as [they] need this."

We observed that people were able to take risks such as going out to a gym, going swimming as well as accessing the community for shopping. Records we viewed confirmed that the risk assessments that were in place helped ensure that people were supported and cared for in the safest way practicable. Care staff told us, and we saw, that some people required the support of two care staff for the person's safety. For example, when going out in the service's transport. Other examples included plans and measures that were in place to support people in the event of an emergency. This included fire alarm and drills to ensure these emergency measures worked well.

Accidents and incidents were recorded and responded to. This included where people experienced an injury or where people had behaviours which could challenge others. We saw that actions had been taken to prevent or reduce as far as practicable the potential for any recurrences. This included the introduction of strategies to support people in a safe way such as by avoiding situations where there was undue noise. For example, on the day of our inspection the registered manager had briefed a visiting tree surgeon to this requirement. We saw that as a result of this, the tree surgeons had used hand saws and taken the cuttings away to be shredded rather than on the premises. We saw that people watched this worked being undertaken but they did not become anxious as a result of the registered manager's prior intervention.

Staff confirmed to us the documents and records they had been required to produce prior to them taking up their employment. These required checks included those for evidence of staff's good character, previous employment history, photographic identity such as a passport and evidence that any risks that staff presented had been considered. This included a clear Disclosure and Barring Service [DBS] check. One care staff said, "When I started I had an interview as well as having to produce [evidence of] my qualifications. This was as well as my DBS which I had to get before I started work here." The provider's recruitment procedures ensured that staff were recruited in a safe way.

The registered manager told us, "Staff had to have the right attitude, skills and will to work with people who at times could have behaviours which challenge. It is hard to get the right staff but more than anything people come first."

During our inspection we saw that there were sufficient numbers of staff to meet people's care needs. We saw that due to the number of staff present, people had the time they needed to do the tasks and activities they wanted to at their pace. For example, staff making sure that when people were going out they did this at a comfortable pace and in stages to ensure that the person remained as calm as possible. One member of care staff said, "The care plans give clear detail on the level of support each person needs such as two staff and getting them [the person] ready nice and slowly." The registered manager added, "We are aiming to not use any agency staff. We do use bank staff but these are only the ones who know people well. We have an 'about me' guide for each person which helps any staff get to know the person's basic care needs quickly."

Other arrangements for planned or unplanned staff absence such as sickness included opportunities for over time or extra shifts. One member of care staff said, "I am doing a bit extra this week as some staff are off and for some people with anxieties it is essential that staff know them well." The registered manager told us that more staff were being recruited. This was confirmed by an applicant handing in their recruitment documents on the day of our inspection.

Staff had been trained in the safe administration of people's medicines and they were assessed as being competent over three sessions. This was to ensure that staff administered medicines safely. We observed medicines administration and we saw that staff adhered to safe administration practice. For example, for those people had to have their medicines hidden in their food [covert medicines]. We found that medicines administration records (MAR) included people's allergies and how and when they liked to take their prescribed medicines. Medicines were recorded accurately on each person's MAR and were stored securely in people's homes as well as medicines that had to accompany the person out in the community. Where medicines had to be administered straight away, protocols were in place for this. Unwanted or unused medicines were disposed of safely and accurately accounted for. This meant that people were supported to take their prescribed medicines in a safe way.

Good

Our findings

We saw that the depth of staff's knowledge about the people they cared for had impacted positively on the way people were cared for. Staff were aware of managing people's behaviours that challenge. An example of this was to ensure that visiting arrangements were managed to minimise the risk of people becoming unsettled This was to minimise any situation which could, or had the potential to, impact on the person's life and to keep people as anxiety free as possible.

Staff were matched to those people who shared similar skills and interests such as going out for a drive, autism care skills and going to the gym. Staff knew people well and this included responding to people based upon the person's communication skills and staff's understanding of each person's request. For example, with the use of objects of reference and how people indicated a "yes" or "no" response in their own way. A relative said, "Staff are very good and communication is good, it is a very good service. They attend to all [family member's] health appointments, overall we are very happy with everything [for health and nutrition]."

Staff were supported with regular training and informed supervision. This gave the registered and deputy manager the opportunity to guide staff on opportunities to develop their skills. In addition to this, areas for improvement were identified and staff were reminded of their roles and responsibilities in completing accurately records of when medicines had been administered. One member of care staff told us, "I can share my ideas and suggestion with the [registered] manager. We get on really well and are never afraid to challenge each other." Feedback to staff was provided in a constructive manner. Staff were well-supported to provide people with positive encouragement such as the things they did well.

The provider had introduced the 'Care Certificate' [this is a nationally recognised qualification in the standards of care to be provided] as part of new staff's induction. One member of care staff said, "I had a good induction followed by six months' probation. At each stage of this I had to complete a record of my learning achievements." We found that the registered manager had signed the staff as being competent. As well as formal training, staff were mentored and coached by more experienced staff in providing care based upon what worked well for each person. The provider determined the mandatory training staff had to complete included medicines administration, fire safety and moving and handling. Other more specific training included subjects such as proactive responses to people with behaviours which could challenge others, autism and epilepsy. 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 were empowered to plan and complete all their training at a time that suited them and impacted upon people in the smallest

way.

One relative told us, "Staff are very effective, they read [family member's] behaviour very well and know what is going to happen before it happens. Staff know what it takes to look after my [family member]; we have familiar staff that are consistent which is really good, staff are continuously assessing [family member].

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 must be made through the Court of Protection [CoP] for people living in the community. 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. One relative said, "They [staff] always have my [family member's] best interest at heart." Another relative explained to us how people, who were not able to communicate in a verbal way, that "the staff always involve my [family member] in conversations". The registered manager showed us how they had, as a result of people lacking capacity, contacted the local authority and had had their DoLS requests acknowledged. This was to ensure that people were only deprived of their liberty when this was lawful. Risk assessments had been implemented as part of people's DoLS applications. This was to ensure that any restrictions that were currently in place were the least restrictive option such as monitoring equipment for people when they moved around the service.
The registered manager had attended the local authority's MCA) and the Deprivation of Liberty Safeguards (DoLS) training. The registered manager had as a result of this training supported staff on how to implement this knowledge. Staff were very knowledgeable about applying people's care whilst respecting the requirements of the MCA and DoLS codes' of practice. The registered manager and staff were able to describe the specific decisions people could make and also where people required support with their decision making. For example, when taking their medicines in a covert way [this is where people are not aware of the need to take their medicines which is then disguised in food or drink.]
It was clear from the conversations that people had with staff and the general happy atmosphere at lunch time that mealtimes were relaxed and informal. People could, and did, choose when and where they preferred to eat such as outside under a gazeebo. We could see for ourselves, that people could choose what to eat from their preferred choice of freshly prepared food. We also saw that people could choose from photograph pictures of menu options including eating out and having a pub lunch. This reduced the potential for anxieties and meant that people could enjoy the meal time. People were involved in decisions about what they wanted to eat and drink. Ways the service did this was by placing people's drinking and eating utensils where people could access them. People were also supported to make healthy living choices. For example having grapes, strawberries and salads with meals. One relative told us, "I have [only positive comments] and staff monitor [family member] all the time; we have had a SALT [speech and language therapist] come and assess [family member] for [their] swallowing and staff make sure [family member's] food is the right consistency."

We saw that staff supported to people to access a range of health care professionals. This included attending hospital appointments. A relative told us, "Yes, my family member sees the GP and dentist regularly and they [staff] definitely meet their health needs. [Family member] has a choice of food and they have managed to control [family member's] weight and staff definitely have the skills to support [family member]." We saw that staff had been provided with, and followed the guidance health care professionals

had offered such as from dieticians, occupational therapist or GPs. We saw that appropriate referrals were made to health care professionals and that these were followed up in outpatient appointments or other health care appointments. We saw and found from records viewed the difference various health care professionals had made to improve people's lives and confidence levels.

Good

Our findings

During our observations it was clear how positive the impact was for staff's passion for the people they cared for. Examples we saw were staff asking a person they recognised as being tired, "would you like a snooze on my shoulder"? We observed that the person appeared happy and contented before falling asleep on the staff's shoulder. Another example was staff applying sun cream to people who liked to spend time outside in the sun. One person told us, "Yes, staff are caring and it's very nice here." One relative said, "Staff have passion, kindness, humour, and respect. Staff here have a very difficult job and they do it amazingly. Staff are adaptable and they are always finding strategies to support [family member]." The registered manager told us, "Just because people don't normally speak to us we don't assume that they never will. I always judge that people had the potential to, one day, speak." This told us that people were being treated the same with hope for developing verbal communication skills.

Staff were able to describe the circumstances they needed to be mindful of when providing any personal care such as avoiding words or situations which caused people anxiety. We saw that each person was offered and provided with their care in privacy and with dignity. Where people preferred to have their privacy respected in their home with curtains closed, this was always respected by staff. We saw that people benefitted from a pet cat. People showed by their smiles or happiness at the difference this made to them such as having the sensory stimulation of stroking a pet.

We saw how the registered manager and staff showed people objects they were familiar with to determine what the person was "telling them". This helped ensure that each person's care was as individual as possible and based upon making the greatest difference to the person's life. One care staff said, "I treat each person as I would expect to be treated. They each have their own preferences and it is up to me and the others [staff] to make sure we do know what people really want. It is sometimes trying things but until we have done this at least three times we can't say it will never work." They gave us examples of this such as introducing people to going in the service's transport in stages until the person was happy to try a short journey. This and other similar methods provided positive results.

The registered manager told us, and we saw in 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 registered manager also told us that other options such as the input from people's families was always considered. This meant that people who were not able to speak for themselves were supported to have their rights respected.

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 to be included in their care plan. People's input also included the person's preferred means of communication such as items of reference and staff's knowledge of the person and what worked best for them.

As well as people's input, family members' views and advice from health and social care professionals were included to inform the person's care plan. This was to help ensure that staff supported people with their independent living skills as well as doing this sensitively. 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 or the person's relative's car and how this was done in consideration of the person's care needs.

We saw that each time staff gained permission from the person or acknowledgement and agreement before providing them with personal care. At lunchtime we saw that staff offered people a choice of the sauces they could have but in a way which respected people's rights. Staff knew what worked well including not always asking people's sauce options in the same order. This meant that people's care was person centred.

Relatives told us and we saw that people were always treated with respect. One relative told us, "Staff are very caring, my [family member] is always well dressed and they [staff] have the balance just right. We have an open door policy [for the registered manager or staff to contact them] and they all seem to work together. We are very happy with them all." Where people were not able to express their feelings verbally we saw that staff responded and understood what the person was communicating to them such as when people pointed to an object they wanted. Staff responded to people's requests sensitively and gave people time to consider their response.

We saw that staff regularly checked if people were well and if there was anything else they wanted: this included any item or belongings the person needed with them whilst out in the community such as swimming clothing. Throughout our inspection we found that the atmosphere was that of happiness, joviality and that staff were passionate about the role they performed. We saw how staff had informed the registered manager when they had administered medicines for people's anxieties or pain. One relative told us, "Staff are very kind and caring, my [family member] presents extreme challenging behaviour and staff cope brilliantly with [caring for] them."

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. As part of a person centred and holistic approach, people who mattered to them were included in the care of people. We saw that a family barbecue had been held where relatives had assisted in doing improvement works to the service. This included a new gazeebo roof, doing the gardening and improvements to people's sensory stimulation options. In addition, relatives could take people out for lunch, to go home or at a time of the person's choosing. This was also where staff had identified the benefits to the person of doing hobbies, interests and pastimes on a certain day as the person preferred this clear structure and routine.

Good

Our findings

People's needs were assessed prior to them using the service. Other information from people's life histories, relatives and staff's knowledge of the person was also included in people's detailed care and health action plans. This was undertaken in a way that assisted in care staff understanding people's care needs. This also included and the way, how and when staff provided people's care. This helped to ensure that the staff were able to respond to, and safely meet what people actually wanted. Situations where this had occurred had been the provision of a specialist chair to ensure the person was as comfortable as possible as well as the provision of ingredients for the person to make a Christmas cake. People described examples of their perfect week as going for a long walk, giving staff a hug and relaxing in their home having their personal hygiene needs met.

One member of care staff told us, "I can tell if someone is not happy with something. They can tell us by pushing their food away. I try several times or a different choice until I am sure the person is happy with the situation. Every time it can be a different option but that's the person's choice."

People were involved in having person centred care plans as much as possible. One relative told us "It's an open door policy there [at the service] and we go to reviews. Again we are very happy with everything." One member of care staff said, "I like the new format care plans. There is less repetition and more detail about each person. The complexity of people's care is reflected in the complexity of the care plan." Our observations showed us that staff knew each person well and responded to their needs; they spoke passionately about each person they cared for and how they supported them. This showed us that the service considered what really was important to people.

We observed and found in people's care plans how people were supported to determine what they wanted to do each day. Planned pastimes included such as going for a picnic, watching TV or going to a hydro pool. Other options were available if the person changed their minds such as have a chat with staff or spending meaningful times with a favourite hobby such as making arts and crafts for Halloween. People's visual support included those prompts which worked best. This meant that each person was treated as an individual. These included line drawings, real objects or miniature version as well as coloured pictures. The ways in which staff presented these visual objects depended upon the preference of the person.

People were supported with a wide range of their preferred hobbies and interests, social and independent living skills. Our observations of staff supporting people and confirmed in people's care records of the meaningful interests people could take part in. This included going to a gym, swimming and shopping.

People could attend various appointments as many times as it was necessary. This was as long as the person was happy with the support arrangements that gave them the greatest benefit. One relative told us, "Yes, they [staff and managers] are focused on my daughter's needs, and I know who to complain to if I had to. We are sent consultation forms and we are listened too."

All staff saw the positive aspect of each person's care and what the person could, or had the potential to, achieve. For example, taking part in cooking or gardening. We were told by staff and records confirmed how one person had been supported to mow the lawns as well as other people being supported to ride a tricycle on artificial grass to make the ride easier. The deputy manager told us, "It's amazing seeing how people progress from small beginnings to what they can do now."

We saw and found that any concerns or complaints raised by people and their relatives were acted upon appropriately by staff. A complaints process was provided but people had not had to use this as issues and concerns were addressed effectively before they became a complaint. One relative told us "I have raised concerns and they were dealt with effectively; we are invited to reviews and we have an input."

Good

Our findings

A registered manager was in post and they explained to us, with passion, how they determined the required care needs for each person. They did this as a result of their commitment to changing people's lives to bring about lasting change in a positive way. Examples of this were where people's previous placements had not been successful but now people were settled in their home and did things such as going in a car that they had not previously done. The registered manager and staff frequently met with people's relatives and the various support staff included social workers and healthcare professional advice. This was to help ensure that the quality of people's care was as good as it possibly could be. One relative said, "As a parent I feel part of the team, and as a parent I can relax now and stand back to let them [staff] do their job, I think it's very well led at the [service] and I like the consistency of staff."

One particular example of successfully integrating people, relatives and staff was at a recent families day. This had been well attended and lots of improvements had been made such as a tidying up the gardens, new decking and painting as well as a fish and chip lunch for relatives. Care staff told us that the event had been so successful that it had over ran its planned end time much to the satisfaction of people. Various photographs of the event confirmed people's happiness.

The registered manager was extremely passionate about people and was continuously learning new strategies on how best to support people using the service. He had completed a Higher Certificate level qualification at a university that specialised in people, and those, living with Autism including training by teachers living with this condition. The registered manager then passed his knowledge and best practice onto the staff team. One relative told us, "[Registered and deputy manager] are very good and we think it's [the service] managed very well." All staff commented on their love of working at the service. One said, "It's like coming to a second family. It is a relaxed place to work even when people needed support with their [health conditions]."

To support an open, fair and transparent culture the registered manager spent time at all three services he supported including at night and at weekends. This was by spending sufficient time assessing each staff and service performance. This was to ensure that all staff were maintaining the provider's values of "we see the person", "we are brave" and "we are creative". One relative said, "Yes its [the service] well managed as it's a very challenging group. I would give it nine and a half out of ten. Staff do amazingly well." 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, "I have the support I need. I can call the [registered and deputy] managers at any time. I like the reassurance this gives

me, even if the situation appears complex to me. Having their experience means a lot."

Strong links were maintained with the local community and included various trips out by people to arts clubs, music festivals and going to see their friends and relatives. Our observations of people's calendars, with staff's permission, confirmed that this had been consistently provided to people throughout the year. One member of care staff said, "We are going out this afternoon swimming and people do this regularly. If they change their mind it's okay."

Care staff explained to us how the daily contact with people and regular contact with their relatives kept them up to date. This was for those aspects of people's lives that needed changing as well as what worked well such as improvements to people's gardens and outdoor facilities. One relative said, "It's a well-led home and staff all seem to work together. We are very happy with them." Staff who had the responsibility for certain aspects of people's care such as keeping families up to date did this frequently such as letting relatives know about healthcare appointments or where people had achieved an aspiration or done something positive that they had not previously done.

Quality assurance checks were completed by representatives of the provider as well as the registered, and deputy, manager. 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 how staff needed to make sure they accurately recorded each administration of a person's prescribed medicines. We found that they were. A newsletter as well as a calendar which was for each person's family members to see what the person had done during the year. Examples included having a barbecue, going to a farm, attending local country festivals and dressing up at Halloween.

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, "It's one of those things. Have I done the right thing? You have to put people first and I would, always." They said that they would be protected by the provider regarding any potential, or fear of, recriminations.

Staff meetings gave staff the opportunity to comment on any areas they felt would benefit people. For example, welcoming new staff, doing more baking and reminding staff of the correct reporting procedures for safeguarding and recognising where there was a risk of this. We found that as a result of actions the registered manager had taken that staff were fully aware of their responsibilities and that the potential for many recurrence was minimised.

Information from other organisations was used as good practice by the registered manager. This included those organisations which provided advice and guidance to care services such as the National Autistic Society [NAS]. We saw that best practice from the NAS had been implemented in various aspects of people's lives including means to get the best out of people's communication skills. Other areas of good practice were therapies to prevent escalation of people's behaviours which could challenge others. They were also supported with guidance and information from the British Institute of Learning Disabilities and the Social Care Institute for Excellence. This was to help those people who lived at the service with complex health conditions by staff who used approved strategies to reinforce people's positive behaviours. We saw that in some cases these behaviours or use of medicines for them had reduced significantly.

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.

The registered manager visited the various places where people lived at least weekly. This was to assist staff

and mentor them in their roles as well as receiving up-to-date information about each person. Meetings with the provider and its representatives were held every month as well as staff meetings. The registered manager told us that their manager called them every day to make sure they had the resources they needed. At the provider's monthly managers' meetings information was shared regarding good and best practice. As part of these meetings staff were regularly reminded by the registered manager of their roles and responsibilities and how to escalate any issues or concerns. This was through formal supervision, staff meetings or at shift hand overs. We saw that communication handbooks were also used to inform staff about changes to people's care such as new medicines.