Salisbury Support 4 Autism Limited

Albert Road

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 27, 28 and 29 March 2018 and was announced. Albert Road has been registered under the provider, Salisbury Support 4 Autism Limited since 16 August 2017. Salisbury Support 4 Autism offers a service to adults on the Autistic Spectrum Disorder, complex needs and challenging behaviour who require care and support in a progressive life-long learning environment. This was the first inspection of Albert Road under their ownership.

This service provides care and support to people living in five 'supported living' schemes, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Each setting was a large house which accommodated up to five people and these were located in north and south London. In total, there were 21 people using the service at the time of our inspection.

Houses in multiple occupation are properties where at least three people in more than one household share toilet, bathroom or kitchen facilities. Each setting had a manager in post, and the registered manager overlooked the five settings. 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 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.

Our findings during the inspection show that the provider did not have effective arrangements to protect people against the risks associated with the management of medicines. We saw that appropriate action was taken to rectify this before the end of our inspection.

There were systems in place to assess and monitor the quality of the service, but these had not always been

effective and had not identified the issues we found during our inspection.

We found breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Safe care and treatment and Good governance. You can see what action we have told the provider to take at the back of the full version of this report.

Notwithstanding the above, there were other systems and processes in place to help protect people from the risk of harm. There were enough staff on duty to meet people's needs and there were contingency plans in the event of staff absence. Employment checks were in place to obtain information about new staff before they were allowed to support people.

Care plans and risk assessments were reviewed and updated whenever people's needs changed. People and relatives told us they were involved in the planning and reviewing of their care and support, and felt valued.

The risks to people's safety and wellbeing were assessed and regularly reviewed. People were supported to manage their own safety and remain as independent as they could be. The provider had processes in place for the recording and investigation of incidents and accidents.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice.

Staff had undertaken training in the Mental Capacity Act 2005 (MCA) and were aware of their responsibilities in relation to the Act. The provider had liaised with the local authority when people required Court of Protection decisions with regard to being deprived of their liberty in the receipt of care and treatment.

People lived in a comfortable environment which was clean and free of hazards. People were protected by the provider's arrangements in relation to the prevention and control of infection. The provider had a procedure regarding infection control and the staff had specific training in this area.

The provider ensured people's nutritional needs were met. Some of the people using the service shopped for ingredients and cooked their own food.

People were supported by staff who were sufficiently trained, supervised and appraised.

People's healthcare needs were met and staff supported them to attend medical appointments where support was required.

People's care plans were comprehensive and detailed people's individual needs. They were personalised to reflect people's wishes and what was important to them.

A range of activities were arranged that met people's individual interests and people were consulted about what they wanted to do.

Staff were caring and treated people with dignity, compassion and respect. Support plans were clear and comprehensive and included people's individual needs, detailed what was important to them, how they made decisions and how they wanted their care to be provided.

Throughout the inspection, we observed staff supporting people in a way that took into account their

diversity, values and human rights. People confirmed they were supported to make decisions about their activities.

Information about how to make a complaint was available to people and their families, and they felt confident that any complaint would be addressed by the management.

People, relatives and staff told us that the registered manager was supportive, approachable and hands on. Staff were supported to raise concerns and make suggestions about where improvements could be made.

The provider had effective systems in place to monitor the quality of the service and where issues were identified, these were addressed promptly.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The provider did not have effective arrangements to protect people against the risks associated with the management of medicines.

The provider had systems in place to manage incidents and accidents and took appropriate action where required to minimise the risk of reoccurrence.

There were systems designed to protect people by the prevention and control of infection.

There were procedures designed to safeguard people from abuse.

The risks to people's safety and well-being had been assessed and planned for.

There were sufficient numbers of staff to support people to stay safe and meet their needs.

Is the service effective?

Good

The service was effective.

People's individual needs had been assessed and recorded in their care plans prior to receiving a service, and these were regularly reviewed.

Consent to care and treatment was sought in line with legislation and guidance.

People were supported by staff who were well trained, supervised and appraised.

People's health and nutritional needs had been assessed, recorded and were being monitored. People's healthcare needs were met.

Is the service caring?

Good

The service was caring.

Feedback from people and relatives was positive about both the staff and the management team.

People and relatives said the care workers were kind, caring and respectful.

People and their relatives were involved in decisions about their care and support.

Is the service responsive?

Good

The service was responsive.

Care plans contained enough detail for staff to know how to meet peoples' needs.

There was a wide range of activities available that met people's needs and preferences.

There was a complaints policy and procedures in place. People's concerns were addressed appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There were systems in place to assess and monitor the quality of the service, but these had not always been effective and had not identified the issues we found during our inspection. They took action to mitigate these risks following our inspection visit.

People and their relatives found the management team to be approachable and supportive.

The provider encouraged good communication with staff and people who used the service, which promoted a culture of openness and trust within the service.

Albert Road

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 was partly prompted by information of concerns we had received about the service. While we did not look at the circumstances of the specific concerns, we have looked overall about how the provider was ensuring the health, safety and welfare of people using the service by answering the five key questions we asked of provider.

This inspection took place on 27, 28 and 29 March 2018 and was announced.

We gave the service 3 days' notice of the inspection visit because people using the service lived in supported living schemes and we needed to ask people's permission if we could visit them in their homes as part of the inspection process.

The inspection was carried out by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience undertook face to face interviews with some of the people using the service and made telephone calls to other people and their relatives over two days.

Prior to our visit, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service. We also reviewed information we held about the service. This included notifications we had received. A notification is information about important events that the provider is required to send us by law.

We visited the office on 27 March 2018 to meet with the registered manager and the office staff. We reviewed

five staff personnel records and training files, incident and accidents records, audits and policies and procedures. We visited people living in their homes on 27 and 28 March 2018 where we met with the scheme managers, reviewed support plans and checked medicines management. We returned to the office on the 29 March 2018 to gather further information and discuss our findings with the registered manager.

During the inspection, we visited three supported living schemes. We reviewed nine people's records, including their care plans, risk assessments, health records, and daily logs. We spoke with three support staff, three managers of supported living schemes, the registered manager, the quality assurance officer, and met with the chief operations officer. We spoke with six people who used the service and observed staff interaction with people in three of the supported living schemes.

Following the inspection, we spoke with six people's relatives. We also liaised with a social care professional to obtain their feedback about the service.

Requires Improvement

Our findings

People we spoke with indicated they felt safe in their environment and trusted the staff who supported them. Their comments included, "Just talking to staff helps me feel safe", "I feel very safe. Staff look after me and take care of us and support us." Relatives echoed this and added, "Yes it's safe. They make them aware of safety guards. No mishaps. I was involved with risk assessments in the past. [Family member] has their own secure door to the garden. It is checked before they retire to bed", "The environment is safe. I have no concerns", "Yes it is safe and I do raise concerns. Everything seems to be going well at the moment. [Family member] seems safe as there are carers 24/7 all the time" and "I can tell [family member] is well looked after."

We looked at the medicines' management in three of the supported living schemes and found some discrepancies in all of them, including a medicines error at one of the schemes. On 27 March 2018, we checked the medicines administration record (MAR) charts for all the people living in one of the schemes. We saw that a medicine which was due to be given on the evening of 26 March 2018 had not been signed for. We discussed this with the manager and checked the amount of tablets left in the pack. This confirmed that the tablet had not been given. We asked the manager if they thought it necessary to speak with the GP and pharmacist to seek advice and to inform the local authority's safeguarding team. We saw evidence that the registered manager had been informed and appropriate action had been taken.

Another person's prescribed medicine had not been signed on the morning of 27 March. However, when we checked stock, we found that there were two tablets over. We checked another medicine for this person and found that the pack was short of one tablet. The scheme manager was not able to offer an explanation for these discrepancies which showed that people might not have received their medicines as prescribed.

During our visit to the other two supported living schemes on 28 March 2018, we found additional discrepancies. For example, in one of the schemes, one person was prescribed a medicine to be given 'as required' (PRN). Staff were required to record the reason for administration at the back of the MAR chart. We saw that this was done, however, according to the staff's signatures, this medicine had been administered twice on 12 March, although the back of the MAR stated this was only given once. Staff had also recorded at the back of the MAR that the medicine had been administered on 16 March but the MAR had been signed on 17 March. The manager was not able to offer an explanation for this.

Two of the three supported living schemes we visited did not record the date of opening on PRN medicines. This meant that there was no audit trail to check if the stock was correct and people were receiving their

medicines as prescribed. These schemes also did not have a list of staff's signatures and initials to check and monitor on who administered the medicines.

There was a medicines policy and procedures in place in all the supported living schemes we visited. However these were not always adhered to. For example, the policy stated that controlled drugs should be kept in a locked unit within the medicines cabinet, and that there should be a separate record kept of all controlled drugs. None of the managers were able to show us a controlled drug record book, and there was no storage facilities for controlled drugs. A medicine which was believed to be a controlled drug were kept with other regular medicines. Following a discussion and advice from the pharmacist, it was found that this medicine was not a controlled drug. The registered manager took appropriate action before the end of our inspection to manage controlled drugs should they have these in the future, in line with their policy and procedures.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the last day of our inspection, the registered manager showed us a new medicines auditing system which they had put in place after we had discussed our findings with them. They also told us of the actions they were taking with regards to the staff responsible for the medicines discrepancies we had identified.

Notwithstanding the above, there were policies and procedures in place for the management of medicines. Staff had signed the documents, indicating they had read and understood these. Staff received medicines training and regular refreshers.

Each person had a medicines profile which included their details, the name of each medicine, reason for prescribing, dose and frequency and possible side effects.

Where a person was prescribed PRN medicines, we saw that there was a protocol in place, and guidelines for staff. These stated the person's means of communication, signs for staff to look out for which may indicate if the person was in pain, including visual clues. We saw that PRN medicines prescribed for agitation were only administered when absolutely necessary and after other methods were used to help manage the situation.

The provider had taken steps to protect people from the risk of abuse. Staff received training in safeguarding adults and training records confirmed this. Staff were able to tell us what they would do if they suspected someone was being abused. The service had a safeguarding policy and procedure in place and staff had access to these. Staff told us they were familiar with and had access to the whistleblowing policy.

Where there were risks to people's safety and wellbeing, these had been assessed. Person-specific risk assessments and plans were detailed and thorough and based on individual risks that had been identified either at the point of initial assessment or during a review. These included injuring self or others, sharp objects and absconding. Each risk was described and analysed and control measures were in place. For example, we saw that a person who used the service had absconded in the past. We checked and saw that a robust risk assessment had been put in place following the incident and staff were aware of the measures to take to protect the person.

Where people's needs changed, the registered manager told us, "We call the social worker and provide evidence of the increased need, such as incident reports. Based on that, we request additional hours to meet the person's needs." We saw evidence that a person who used the service had been provided with

additional one to one support, and this had made a difference to the person's wellbeing and quality of life.

Staff were clear about how to respond in an emergency. Senior staff were available to help and support the staff and people using the service as required, and involved healthcare professionals as needed. There were staff on duty 24 hours a day and they knew who to call in an emergency.

Incidents and accidents were recorded and analysed by the manager to identify any issues or trends. We saw evidence that incidents and accidents were responded to appropriately. For example, where a person using the service had displayed behaviours that challenged the service, we saw that a 'Post incident support/debrief' had been conducted. This involved talking with the person after the incident and any learning from it to reduce the risk of reoccurrence.

People were protected from the risk of infection. Staff were provided with personal protective equipment such as gloves, aprons, hand washing facilities and sanitisation gels to ensure infection was prevented and controlled. There were systems for reporting maintenance concerns and records showed these were completed in a timely manner.

Relatives told us they were happy with the staffing levels, although some were concerned about the use of irregular staff. Their comments included, "Agency staff are not as knowing but they do their checks", "There is enough staff. [Family member] has a designated key worker. There's night staff too", "There is 24 hour support. The manager has contacted me over the phone" and "Every resident gets one to one during waking hours. They are always there. The registered manager told us they sometimes used agency staff, however they ensured that they used a reputable agency and a core group of staff who were reliable and knew the needs of people who used the service. We viewed the staff rota for four weeks and saw that all shifts were covered appropriately.

Recruitment practices ensured staff were suitable to support people. These included checks to ensure staff had the relevant previous experience and qualifications. Checks were carried out before staff started working at the service. These included obtaining references from previous employers, reviewing a person's eligibility to work in the UK, checking a person's identity and ensuring a criminal record check was completed.

Good

Our findings

People's care and support had been assessed before they started using the service. People who used the service had been referred and were funded by their local authority. The registered manager told us they assessed people once they had been referred and before they started using the service, to ensure their needs could be met. Assessments we viewed were comprehensive and we saw evidence that people had been involved in discussions about their care, support and any risks that were involved in managing/supporting their needs. People and relatives told us that they were consulted before they moved in and they had felt listened to. One relative told us, "[Family member] has been assessed several times by the borough. Everything was done to the needs of my [family member]. They made sure they knew what he needed. We have meetings when my [family member] has a change of mood. The behaviour specialist is then present" and another said, "A social worker went through the requirements and the place was recommended."

The registered manager told us they ensured they knew and understood a person's needs before they started living at the service to ensure that all staff were confident they were able to meet these. They stated, "We are still a new service. Our priority at present is to get to know people and establish a routine based on people's likes and dislikes."

People and relatives told us the service was responsive to their health needs. One person who used the service told us, "Every month I get to see a doctor. I get my [treatment] in hospital." Relatives' comments included, "He goes to the dentist regularly, to the GP and the chiropodist. He is supported. When he is lethargic and has a temperature, he gets a GP appointment immediately. They are good at recognising signs", "They arrange appointments to the dentist and to the [specialist] doctor. They would ring me to let me know", "They take [family member] to the GP or the GP goes there" and "They brought in a dietician." A staff member confirmed this and said, "We take people to the GP when they are not well, for check-ups and for yearly medication reviews. One service user for example is being taken for blood tests today. They are taken to the optician and dentist yearly."

The care plans contained details about people's health needs and included information about their medical conditions, medicines, dietary requirements and general information. Records showed that advice from relevant professionals was recorded and actioned appropriately and regularly reviewed.

People were supported by staff who had the appropriate skills and experience. All staff we spoke with were subject to an induction process that included shadowing more experienced staff members and a probation

period after which they were assessed before becoming permanent. All new staff were expected to read and sign a range of documents which included the staff handbook, fire procedures, personal emergency evacuation plans (PEEPS), on call procedures, activity timetables and people's communication passports. New staff were supported to complete the Care Certificate qualification. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting.

Staff received training the provider had identified as mandatory. This included moving and handling, medicines administration, health and safety, infection control, food hygiene, safeguarding and Mental Capacity Act 2005 (MCA). They also undertook training specific to the needs of the people who used the service which included Management of Actual and Potential Aggression (MAPA), person centred practice, lone working and equality and diversity. A MAPA course was taking place at the time of our inspection. Records showed that staff training was up to date and refreshed yearly. A staff member told us, "Yes I do get training. I am trained in Makaton so I can communicate with my clients. I've had moving and handling, health and safety, equality and diversity and food hygiene" and another said, "We get yearly medication training." This meant that the provider had taken steps to ensure staff were sufficiently trained and qualified to support people to the expected standard.

People were supported by staff who were regularly supervised. Staff we spoke with told us they felt supported and were provided with an opportunity to address any issues and discuss any areas for improvement. Staff in each supported living scheme received supervision from their line manager. Supervision of staff included discussions about their workload, people they supported, their rota, training, policies and procedures and health and safety. We saw evidence that actions requiring improvement were recorded and followed up with individual staff members. The provider had started staff appraisals and this was ongoing as the service was newly registered.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who use the service and 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.

Care and support was being delivered in line with the principles of the MCA. Assessments were undertaken to establish people's capacity to consent to aspects of their care and support as they arose. 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. We checked whether the service was working within the principles of the MCA. Consent was sought before care and support was offered and we saw evidence that people were consulted in all aspects of their care and support. Staff received training in the MCA and demonstrated an understanding of the principles of the Act.

A number of people lacked the mental capacity to consent to their care and treatment. We saw that the provider had requested the supervisory body to make applications to the Court of Protection in these cases for the people to be deprived of their liberty lawfully to ensure that their care and treatment was in their best interests.

The service recognised the importance of food, nutrition and a healthy diet for people's wellbeing generally, as an important aspect of their daily life. People told us they chose what to eat and drink and enjoyed their meals. Their comments included, "The food is very nice. Sometimes I help with cooking. Some days I get my favourite, spaghetti Bolognese, chips and pie from the take away shop. When it's chilli con carne, I help cut

up the vegetables", "The food is nice. There is choice of food, spaghetti Bolognese is my favourite", "The food is absolutely delicious. Staff cook it for us. They guide us and help us take part" and "I have pizza. I like it. I have apples too." A relative commented, "[Family member] likes most food. She definitely gets enough food. She will go to the kitchen and get food out of the cupboard." The registered manager told us that staff supported people to cook their own food. They said, "We talk to the residents together and get an indication of the food they like. We encourage healthy options as much as possible. We also encourage people to drink water or diluted juice."

People's individual nutritional needs, likes and dislikes were assessed and recorded in their care plans. One person's care plan stated they liked to cook for themselves two or three times a week and required encouragement to undertake this. Guidelines included, "I need staff to encourage me to do regular food shopping and to cook healthy meals by myself for myself." We observed some colourful and pictorial menus displayed in people's kitchens which reflected people's individual choices.

All staff had received food hygiene training and demonstrated a good knowledge about food safety. One staff member told us, "We keep raw food away from cooked food. We wash our hands, check the fridge and freezer temperatures, use clean utensils and boards. Food checks are done by staff. Food is kept in bags, labelled, and dates are checked. Each service user has a compartment in the freezer. We saw evidence of this during our visit.

Good

Our findings

People were complimentary about the care and support they received and said that staff treated them with kindness and respected their human rights. Their comments included, "Staff are very nice and very helpful", "I want to live here forever. Staff really take good care of me here. They make sure we get all what we want. Staff are really kind. We wouldn't know what to do with our lives without them" and "Staff are nice." Relatives echoed this and said, "Everyone understands [Family member's] quirks", "Everybody likes my [family member]. She gets on well with most of the staff" and "The care is fine. The support workers are understanding."

The staff and management team spoke respectfully about the people they cared for. Staff talked of valuing people and respecting their human rights and diverse needs. They also told us they respected and promoted people's independence. One staff member stated, "The most important thing when caring for a person is health and safety. It is also important to communicate well with them at their level" and "When caring for people we respect each individual's choices. We ask them what they like to have, a bath or a shower, what choice of clothes and do they need help with tidying up their room."

People's cultural and spiritual needs were respected. We were told and records confirmed that staff asked people who used the service if they required anything in particular with regards to their faith and cultural beliefs and if they had a preference in the gender of the staff providing support. One staff member told us, "We have different cultures here. One of the service users is [Nationality]. Sometimes I speak in [Language] to them which they appreciate." The complaints procedure and other documents were available in easy read format and displayed prominently.

We saw staff approached and addressed people in a kind, caring and respectful way. Staff we spoke with were aware of the needs of each person who lived at the schemes we visited and we saw that the culture of the overall service was based on providing care and support that met each person's unique needs. One relative told us, "[Family member] understand basic English. Staff have a pictorial overview and ask what she would like." One person using the service had a personal tutor who visited every two weeks. They supported the person to get accustomed to places in the community. During our visit, we witnessed the person happily going out with their tutor.

People told us that their privacy was respected. During our visits to the supported living schemes, staff introduced us and addressed people by their preferred names, which were recorded in their care plans. We saw that people who used the service knew staff well and looked happy and relaxed in their company. There

was a calm and happy atmosphere in all the supported living schemes we visited.

Good

Our findings

People and their relatives were involved in the development and review of their care plans and records we viewed confirmed this. One person told us, "They write things in a log book. They explain in the morning what will happen during the day." Relatives' comments included, "The caring is very good. I have a copy of the care plan" and "We had a lot of input. I make sure they know the needed information is passed on to new staff. I am always involved with the social worker who puts it in the care plan."

All the care and support plans we looked at were comprehensive, detailed and personalised. They were designed in a way to support people whilst maintaining their independence. Care plans also provided staff with clear guidance on how to meet each person's specific care needs. Each person's care plan included details of their preferences in relation to how their care and support should be provided. They were developed from information provided by people and family members, as well as healthcare and social care professionals involved in people's care. This information was combined with details of people's specific needs identified during initial assessments.

Care plans were regularly reviewed and updated to help ensure they provided staff with sufficient detailed information to enable them to meet people's individual needs. They were divided in 10 sections which included health and physical needs, daily living skills and decision making, positive behaviour support and communication. Each section included an action plan and objectives. For example, where a person tended to avoid breakfast in favour of cigarettes, staff were instructed to encourage the person to enjoy a light and healthy breakfast. Another person's care plan stated how they needed to be supported when out in the community, such as "Don't rush me. I like to take my time."

Each person who used the service had a 'Positive behaviour support plan'. The purpose of this plan was to develop a person's social skills and promote their independence, and reduce the frequency of inappropriate behaviour. Each plan contained a summary of the person, their communication needs and likes and dislikes. It also included a description of any behaviour that challenged, possible triggers, signs to look out for, and interventions. Strategies to deal with behaviours that challenged included proactive [action to take to prevent the behaviour from occurring], active [action to take when the behaviour starts] and reactive [action to take if the active response has failed to de-escalate the behaviour]. The registered manager told us that using these strategies had helped reduce behaviours that challenged.

Each person had a 'Passport' which was divided in three sections including 'About me', 'Supporting me' and 'Communication'. This was detailed and written in a person-centred way, and included people's likes and

dislikes, background and provided a clear picture of each person and how staff were to meet their needs. The registered manager told us they ensured people's passports went with them on appointments to inform healthcare professionals of their individual needs.

Staff completed a daily log twice a day for each person. These were written in a person-centred way and included social interactions as well as tasks undertaken. They also detailed significant observations, health and physical needs, nutrition, any appointments attended and outcomes of these, activities undertaken, choices and decision making and behaviour and mood. These helped to ensure continuity of care between staff and identify any concerns.

Relatives we spoke with told us the service was responsive to their family members' needs. One relative said, "We are satisfied with the service. [Family member] has started gaining some independent skills." The provider operated a bespoke service where they tried to meet the needs of the people who used the service and the staff to ensure mutual satisfaction. One staff member told us, "We do meet people's needs. Some people have highly challenging needs. We listen to people and adapt their daily activities to what they need and want" and another stated, "Person centred care is staged into what they want to achieve into their overall outcome." This indicated that the service was responsive and ensured that people's needs were met by a motivated staff team.

People told us staff provided support and encouragement for them to undertake activities of their choice both in their home and within their local communities and to pursue their interests. Their comments included, "I went to central London. I went on a boat trip in Canary Wharf, I went to the Tate Gallery. I go out for dinner. I go wrestling and boxing. I go for walks in the park or down to the shops. I go on holidays to North Yorkshire, North Wales, Spain and on supported breakaway holidays to the Mediterranean sea stopping at resorts", "I go for a walk in the park, I go shopping, I go to see my [relative] in the car" and "They take me shopping and I go dancing."

Relatives confirmed this and added, "[Family member] needs the outdoors and staff are very much tuned in", "[Family member] is engaged in the community environment. He has a routine. He goes shopping on a Monday. He does educational activities with encouragement. Gradual steps are undertaken and staff steer him towards it", "[Family member] plays music, goes on the laptop and is taken to the airport to see planes going off" and "[Family member] goes shopping using a trolley and is taken to the café. She goes for a pub lunch and is taken out for walks. This happens regularly." A staff member added, "I understand their choices and options and what they prefer. I ask them and give two or three choices in terms of going out."

Each person who used the service had their own pictorial activity plan which was created following discussions with them and their family members. Each person was provided with a copy so they knew what was on offer and when. We viewed a sample of the plans which detailed activities such as swimming, cinema, a walk in the park, bowling, cooking, gym and attending a day centre. The registered manager told us, "We have had to work very hard to get to know people and their preferences. We are getting there. [Person's name] is doing maths and English at the moment. We are also trying to get them engaged to do a cookery course. At first, they would not engage in anything but now, they love going to the gym. Last week they went to Portsmouth and Windsor. [Other person's name] is now using vehicles less and less and walking a lot more."

The service had a policy and procedures for dealing with any concerns or complaints. Details of the service's complaints processes were provided to all the people who used the service and were available in an easy-read format. People we spoke with told us they understood how to report any concerns or complaints about the service. Their comments included, "There's nothing to be unhappy about. I'd tell a member of staff if

there was a problem. I like all of it", "If I am unhappy, I tell my [relative]" and "If I am unhappy I tell my [relative] and the manager." One relative said they would, "Go direct to the manager of the home or to the social worker." A staff member stated, "If a service user wanted to, I would suggest they'd complain to the manager." We saw evidence that complaints were taken seriously and issues were resolved in a timely manner.

Requires Improvement

Our findings

People and relatives were complimentary about the supported living scheme managers and the registered manager. They felt that they were approachable and they could speak with them at any time. People's comments included, "The manager chats to me every day" and "I see the manager and the head manager who take time to talk to me." Relatives agreed and stated, "No concerns. The manager is very much involved and very understanding. It was a big transition for us all. I trust no one better", "Since the new manager started, my [family member] understands more, is better at organising her clothes, her food intake is managed and is cooked better. There is more contact and more information. I appreciate the manager telling me what is going on" and "There is a new manager. He's helpful. There's been quite a few. This is the third one."

The provider's systems for identifying and mitigating risks were not always effective. We identified concerns about the way in which medicines were managed and these placed people at risk of poor care and harm. We discussed the medicines issues we had found during our inspection with the registered manager and they told us, "What has been missing is the regular medicines audits and daily checks." Following the inspection, they showed us a new auditing system and told us all the scheme managers were now expected to carry out daily medicines audits.

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

There were other systems in place to monitor the quality of the service provided to people. The provider employed a quality assurance officer who undertook monthly monitoring visits. They also met with staff to check their competencies in a range of areas including safeguarding, whistleblowing policy and behaviours that challenged. The quality assurance officer told us, "I do observations on staff and unannounced spot checks. Then I make my own recommendations such as extra training or supervision." Each of the supported living schemes had their own auditing system which was checked by the registered manager each time they visited.

There were systems in place to monitor the standards of care provided and identify any areas in which the service could improve. These included regular meetings in each of the supported living schemes with people who used the service, either in groups or individually. We viewed a sample of these and saw that items discussed included safeguarding, food and nutrition, health and safety, appointments and activities.

The provider issued yearly surveys to people and relatives. We saw that the surveys issued to people who used the service were in an easy read format and were clearly illustrated with pictures. The results of these were analysed and any areas for improvements were discussed and used to improve the service. The results indicated people were happy with the service. Relatives' comments included, "You are taking them out a lot which is a good thing", "Happy with everything" and "Great consistent care."

Records showed there were regular staff meetings. Issues discussed included communication, staffing levels, people who used the service, annual leave and training. These meetings gave staff a forum to raise issues and be involved in the development of the service. One staff member told us, "We have staff meetings every two months. Suggestions are asked and followed up. We have an appraisal meeting every couple of months and a yearly appraisal."

Staff were issued a yearly survey which included questions about management, teamwork, communication, training and development and overall feedback. The results were analysed and used to gather information about staff satisfaction and where improvements were needed.

There were monthly meetings for the managers of the supported living schemes. The registered manager told us, "We discuss everything. Each service has different challenges. We put an action plan in place for each service. This is reviewed every month." We saw evidence of this in the records we viewed.

There was a registered manager in post at the time of our inspection. They were supported by a chief operations officer, a quality assurance officer, a behaviour specialist and an established senior team. The registered manager had joined the service under the previous provider in 2009 as a support worker and had worked their way up to management. They had a background in learning disabilities and held a qualification in Makaton. They also undertook regular training. They told us, "I feel very well supported. My manager is always here for me. I can call her and she comes. If I am struggling, she comes."

The registered manager recognised the importance to keep themselves abreast of changes within the social care sector by attending managers' meetings, conferences and workshops. From these meetings, relevant information was cascaded to the staff team during meetings to improve knowledge and share information.

Staff told us the managers were approachable and they felt well supported by them. One staff member told us, "[Registered manager] is very supportive and cooperative. They make resources available to us. They are good." The scheme managers told us they felt supported by the registered manager. One manager stated, "They will always give you the time of day to sort things out. I get supervision with [Registered manager]. They visit often. At least three times a week."

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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not made suitable arrangements to ensure that medicines were managed safely. Regulation 12 (1) and (2) (b) (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA Regulations 2014 The registered person did not always have effective arrangements to assess, monitor and improve the quality of the service. Regulation 17 (1) and (2) (a) (b) (d)