Avocet Trust

Avocet Trust - 523-525 Marfleet Lane

Inspection report

523-525 Marfleet Lane
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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

Avocet Trust - 523-525 Marfleet Lane consists of two bungalows which are registered to provide care and accommodation for up to seven adults with a learning disability. Accommodation is provided in two semi - detached bungalows with parking at the front of the building and gardens to the rear. The service is situated within walking distance to local amenities.

We undertook this unannounced inspection on 12 May 2017. There were five people using the service at the time of our inspection. At the last inspection on 22 March 2016 we found improvements were required in the way information was shared, when issues were identified in recruitment checks, We also found the quality assurance system needed to be further developed to show what actions were taken where shortfalls had been identified within the service.

At this inspection we found the registered provider had taken action to address these issues.

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.

The majority of people who used the service had complex needs and were unable to tell us about their experiences. We relied on our observations of care and our discussions with staff and relatives involved. 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 were unable to talk with us.

People who used the service had assessments of their needs undertaken which identified any potential risks to their safety. Staff had read the risk assessments and were aware of their responsibilities and the steps to minimise risk.

The environment was found to be clean and tidy throughout, and bedrooms were personalised in line with people's preferences and personal interests.

Medicines were ordered, stored, administered and disposed of safely. Training records showed staff had received training in the safe handling and administration of medicines.

We found staff were recruited safely and there was sufficient staff to support people. Staff received training in how to safeguard people from the risk of harm and abuse and they knew what to do if they had concerns.

Staff had access to induction, training, supervision and appraisal which supported them to feel skilled and confident when providing care to people. This included training considered essential by the registered provider and also specific training to meet the needs of the people they supported.

Staff had received training in legislation such as the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and the Mental Health Act 1983. They were aware of the need to gain consent when delivering care and support and what to do if people lacked the capacity to agree to it. When people were assessed as not having capacity to make their own decisions, meetings were held with relevant others to discuss options and make decisions in the person's best interests.

We found people's health and nutritional needs were met and they accessed professional advice and treatment from community services when required. People who used the service received care in a person centred way with care plans describing their preferences for care and staff followed this guidance.

Menus were varied and staff confirmed choices and alternatives were available for each meal: we observed drinks and snacks were served between meals. Meals provided to people were varied and in line with risk management plans produced by dieticians and speech and language therapists. People's weight was monitored and referrals made to dieticians when required.

We found staff had a caring approach and found ways to promote people's independence, privacy and dignity. Staff provided information to people and included them in decisions about their scare and support.

People who used the service were seen to engage in a number of activities both within the service and the local community. They were encouraged to pursue hobbies, social interests and to go on holiday. Staff supported people to stay in touch with their families and friends.

There was a complaints process and information provided to people who used the service and staff in how to raise concerns directly with senior managers. Relatives knew how to make complaints and told us they had no concerns.

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.

There were sufficient numbers of staff, available at all times to meet the needs of the people who used the service. Safe recruitment processes were followed.

Staff displayed a good understanding of the different types of abuse that may occur and were able to describe the action they would take if they observed any incident of abuse, or became aware of an abusive situation.

We found medicines were stored securely and administered as prescribed to people.

The service was clean and tidy and equipment used was safe and well-maintained.

Is the service effective?

Good

The service was effective.

People were supported by staff that undertook a range of training, relevant to people's care needs. Staff received supervision, support and appraisal.

Staff understood the principles of the Mental Capacity Act 2005 (MCA), which meant they promoted people's rights and followed least restrictive practices.

We saw people were supported to have a healthy and nutritious diet and to receive appropriate healthcare when required.

Is the service caring?

Good

The service was caring.

We saw staff had developed both positive and caring relationships with people who used the service and were seen to respect their privacy and dignity.

People were supported by staff that had a good understanding

of their individual needs and preferences for how their care and support was delivered.

Is the service responsive?

Good

The service was responsive.

Arrangements were in place to ensure people had the opportunity to engage in a variety of different activities both within the service and the wider community. People were enabled to maintain relationships with their friends and relatives.

People received person centred care. People had assessments of their needs and care support plans to guide staff in how to support them in line with their preferences and wishes.

There was a complaints procedure in place which was available in alternative formats.

Is the service well-led?

Good

The service was well led.

There were systems in place to enable staff and other stakeholders to express their views. As the people who used the service were unable to be fully involved in completing questionnaires, the way their views and experiences of the service were captured could be further developed.

The registered manager reviewed all accidents and incidents had occurred in the service so learning could take place. Incidents were reported to CQC as required.

Avocet Trust - 523-525 Marfleet Lane

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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care act 2014.

This unannounced inspection took place on 12 May 2017. The inspection was completed by one adult social care inspector.

The registered provider had not yet been asked to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. However, we checked our systems for any notifications that had been sent in as these would tell us how the registered provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection information we held about the service was reviewed and we contacted the local authority's contracts monitoring and safeguarding teams.

People who used the service were unable to communicate verbally with us so during the inspection we observed how staff communicated with them. We also observed staffs approach and how they interacted with people who used the service throughout the day and at mealtimes. We spoke with the registered provider's nominated individual and head of service for the west of Hull, the registered manager and three care support workers.

Following the inspection, we spoke with three relatives of people using the service and two health professionals.

We looked at two care files which belonged to people who used the service. We also looked at other

important documentation relating to people who used the service such as four people's medication administration records (MARs) and monitoring charts for food, fluid, weights, pressure relief and bathing. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

A selection of documentation relating to the management and running of the service was also looked at. These included three staff recruitment files, training records, the staff rota, minutes of meetings with staff and managers, quality assurance audits, complaints management and maintenance of equipment records.

A tour of the service was completed and we spent time observing care.

Good

Is the service safe?

Our findings

People who used the service had communication and language difficulties and because of this we were unable to fully obtain their views about their experiences. We relied mainly on observations of care and our discussions with people's relatives and staff to form our judgements.
Relatives told us, "Yes I feel they are safe, absolutely" and "I have no worries whatsoever."

At our last inspection on 22 March 2016 we found the service required improvements to be made to staff recruitment checks, so that when issues were identified in disclosure and barring service (DBS) checks, records of discussions and risk management plans were shared with the registered manager in order for them to mitigate risks. The registered provider had taken action to address this and risk management plans in relation to this were now in place.

Where a positive DBS disclosure has been made, an interview is held with senior management and an assessment made of any potential risks to people using the service. Following this a decision was made as to whether the applicant would be appointed. Records of decisions made in such situations and safety measures introduced to monitor their performance were now maintained.

We checked the recruitment files for three members of staff. The registered manager described the staff recruitment processes, which consisted of shortlisting from application forms, checking gaps in employment, selection by interview process, obtaining references and completing checks with the DBS. They told us staff were unable to start work until all employment checks had been completed. This helped to ensure only suitable staff were employed to work with people who could potentially be vulnerable to exploitation. Staff we spoke with confirmed this process had been followed when they had been recruited.

We found there was sufficient staff on duty to meet the current needs of the people who used the service. Rotas indicated in the bungalow for four people, they were supported by a minimum of three staff during the day and one staff during the night. Additional staffing was provided at intervals during the week to enable people to go in to the community. In the second bungalow for one person, they were supported by one staff member during the day and night.

During our inspection we saw each person using the service being given the opportunity to go out. One person went out with a staff member to do some shopping, while a second person went out with a member of staff to meet friends, while the remaining people engaged in in house activities, for example, playing their keyboard, listening to music and watching an old film. A relative told us, "What we love about the service is the way they involve her and are constantly offering her new experiences and opportunities for her on-going development."

The registered manager explained that although funding had been recently reviewed, risk assessments had been completed following this and staffing levels were being funded by the registered provider, to ensure people's safety was maintained. Relatives we spoke with told us, overall they felt there was sufficient staff available to meet their family member's needs and considered them to be well cared for.

The registered provider had policies and procedures in place to guide staff in how to safeguard people from the risk of harm and abuse. Staff confirmed they had completed safeguarding training with the local authority and they were aware of what to do if they had any concerns. They were also aware of the whistleblowing policy and procedure.

In discussions, staff demonstrated knowledge of the different types of abuse and signs and symptoms that may alert them to concerns. Staff told us, "We would tell the registered manager straight away and complete a safeguarding referral and incident record following any incidents" and "If the manager wasn't there, we always know who we can contact out of hours to report anything like this. We have a responsibility to report anything like this."

Discussions with the registered manager confirmed that where safeguarding concerns had been identified, they had been appropriately referred to the local authority's safeguarding adult's team and fully investigated. We reviewed the safeguarding incidents records that had occurred at the service, this confirmed appropriate referrals had been made when required.

Records showed risks were well managed through individual risk assessments that identified the potential risk and provided staff with information to help them avoid or reduce risks. We looked at the care plans for two people who used the service and found these identified potential risk and how this would be managed. These included examples of, choking, managing finances, accessing the local community and activities. We saw risk assessments also included plans for supporting people when they became distressed or anxious and detailed circumstances that may trigger these behaviours and ways to avoid or reduce these.

Discussions with the registered manager and staff confirmed that restraint was not used within the service. Records confirmed that low level interventions and distraction techniques were effective in diffusing incidents of behaviours that were challenging to the service and others. These had been developed with the input from the person, professionals and staff. Staff had completed training with regard to changing behaviours and managing potential aggression.

Medicines were administered as prescribed. We saw the recording was accurate and medicines were checked in and out of the building as required. Regular audits were undertaken to ensure the correct procedures were followed. Medicines were kept securely and stored appropriately. Individual protocols were in place for the use of 'as and when required' medicines such as paracetamol.

Records showed staff received regular training with regard to the safe handling and administration of medicines. We looked at the records maintained for people's medicines and saw that the registered provider completed risk assessments and care plans, which included how people preferred to take their medicine. During our observations of the administration of medicines, we saw people's preferences for the way they wished to take their medication was respected and implemented.

Staff we spoke with told us they were provided with personal protective equipment (PPE) including gloves and aprons. We observed staff using the correct PPE during our observations. This showed us that the registered provider was taking steps to ensure good hygiene practice, reducing the risk of infection or cross contamination.

The registered provider had contingency plans in place to respond to foreseeable emergencies including extreme weather conditions and staff shortages. This provided assurance that people who used the service would continue to have their needs met during and following an emergency situation.

Regular audits were completed, which ensured the safety of the people living at the service. For example, regular fire safety checks and checks of the environment were completed to ensure people lived in a safe environment. We saw certificates and documentation to confirm the building was safely maintained. The registered manager recorded and analysed information about accidents and incidents within the service.

Good

Is the service effective?

Our findings

We saw evidence to confirm staff had completed a range of training to ensure they had the skills and abilities to meet the assessed needs of the people who used the service. This included topics the registered provider considered to be mandatory for example, safeguarding vulnerable adults, moving and supporting people, fire, food hygiene, first aid, medication and infection prevention and control.

Other person specific training had also been undertaken by staff such as the Management of Actual or Potential Aggression (MAPA), epilepsy, changing behaviour, autism, dementia and Makaton [Makaton is a language programme using signs and symbols to help people to communicate].

Relatives we spoke told us, they felt that the staff team were knowledgeable and had a good understanding of people's individual needs.

Staff we spoke with confirmed they received regular supervision and were able to access training. They told us, "We have plenty of training and they always let us know when it needs updating" and "We can request additional training on any topics we think necessary and it will be provided. We also have the opportunity to progress; I am hoping to enrol to do my NVQ 3, after requesting it."

Records showed staff received effective levels of one to one support with individual meetings being used to look at areas staff had performed well in, could improve on, discussion of a policy, team work and any additional training staff thought would be beneficial to their role within the service. The registered manager explained, "It is really important that staff have the opportunity to ask things and feel comfortable in asking for help and advice when they need it. It also gives us the opportunity to ensure all staff are given the right level of support they need to do their jobs effectively."

Throughout the inspection we heard staff offering people choices and explaining the care and support they wanted to deliver before doing so. Staff gauged people's reactions and it was apparent that staff understood the communication methods of the people they supported. The staff we spoke with told us, "We have to constantly consider what people are communicating to us. For some people this may be different types of sounds they make or their tone of voice, while other people may express themselves more in different movements they make. There is a lot of information in people's care plans about this."

The registered manager showed us pictorial aids that had been developed with people using the service, in order for them to express their likes, dislikes and personal preferences.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw assessments of capacity and best interest meetings had taken place to discuss the option of the four people who used the service to live together. An independent mental capacity advocate (IMCA)

had been involved in supporting one of the people in this decision.

We saw people had capacity assessments and best interest meetings to discuss proposed medical procedures, health screening which may cause them distress, the use of 'when required' medication and restrictive equipment such as bed rails and safety lap straps. The process of capacity assessment and best interest meetings was also used for decisions about financial expenditure for example holidays. We saw relevant people were involved in decision-making on people's behalf. The best interest meetings were attended by relevant professional and other people with and interest in the person's life such as their families.

In discussions, staff were clear about how they ensured people consented to care and support. They said, "We ask people; they are able to understand", "Even though some people can't verbally tell us, we still talk to them, show them clothes and give other choices and watch for their response." Another told us, "The other day, when I asked [Name] if they would like to have a bath, they burst into tears. I knew this was really unusual for them so I reassured them that it was fine. When I asked them again later on they smiled and gestured towards the bathroom. It is about knowing people well."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had made applications to the local authority for DoLS for each person who used the service but these had yet to be assessed and authorised. The registered manager showed us records to demonstrate they had continued to follow these up with the local authority. At the time of our inspection statutory authorisations were in place for one person using the service.

We found people's health needs were met. The care files showed people who used the service had access to a range of community health and social care professionals. These included GPs, community nurses, social workers, dieticians, occupational therapists, physiotherapists, speech and language therapist, dentists, chiropodists and opticians.

We saw people attended outpatient department when required and had appointments with specialist learning disability services. One person received daily visits by a district nurse to manage their diabetes. Specific health professionals had been involved in providing risk management plans to staff for specific issues such as epilepsy management, seating and posture, and swallowing difficulties. People had been assessed for specialist equipment such as personalised wheelchairs and shower/commode chairs with support to ensure the correct seating position for their needs.

A record of health and social care professional visits and any treatment prescribed was recorded in people's care files. Care files we looked at we saw people had a health action plan which brought together all their health care needs in one document; this helped to guide staff in ensuring people's health needs were met.

Health professionals we spoke with following the inspection told us, that staff were very good at making timely referrals and followed advice and instructions when these were given. They told us they were consulted when best interests meetings were held and found staff approachable and knowledgeable about people's needs.

Staff told us menus were regularly reviewed and updated with the people using the service arranged around people's preferences. We found people had their nutritional needs met and there was plenty of food and

fresh fruit and vegetables in the service. Each person had been seen by a dietician and speech and language therapist to assess their nutritional needs and to provide staff with specific instructions about the texture of food and fluids they could consume to ensure their safety and wellbeing. The file containing the information was held in the kitchen and in discussions, it was clear staff were aware of the special instructions for each person.

We saw there was a range of charts completed so staff could monitor people's needs and actions and contact health care professionals quickly when required. These included food and fluid intake, weight, bathing and showering, behaviours which could be challenging to the person and other people, oral hygiene, bowel management and skin integrity. In discussions, staff had an understanding of the need to monitor people's heath and obtain medical assistance quickly when required. They were able to describe the signs and symptoms of chest and urinary tract infections and were able to describe the signs to look out for and what measures to take if the person with diabetes became unwell.

Food temperatures were routinely recorded to ensure food had been cooked thoroughly to the required temperature. Staff told us they prepared most meals from scratch and involved people who used the service in developing menus and shopping for fresh ingredients. They explained that people who used the service also enjoyed an occasional take away and went out for meals on a regular basis.

We saw the environment had been adapted to meet the needs of people who used the service. The corridors were sufficiently wide to accommodate specialised wheelchairs and hold back devices on doors so they could be left in the open position. There was a ceiling track hoist in the bathroom and some bedrooms and specialist individual bathing equipment was provided for specific people. There were grab rails on corridor walls and in bathrooms and toilets. The flooring was a non-slip cushioned variety to make it easy for wheelchairs to be manoeuvred.

Relatives told us they liked the way the accommodation was set out with lots of space and wide corridors, making it more accessible and easier for people get around.

Good

Is the service caring?

Our findings

Relatives we spoke with told us, "The manager and staff are excellent, they absolutely care, they are aware of [Name] needs and are constantly trying new things to get her involved" and "The staff are kind and thoughtful and I find them to be friendly and welcoming. The staff team show a genuine interest in the people they support. They arranged a birthday party for my relative for a milestone birthday celebration, that just shows the type of people they are." Other relatives told us, "The staff are all very caring, I can't fault them" and "I was really pleased to see staff come back who had been at the service before. Over the years you build up trust and confidence in people."

We observed staff were kind and caring in their approach and interactions with people. We saw staff followed the guidance from people's communication passports in their interactions with people who used the service based on their individual need.

Staff communicated with people in a calm and encouraging way. We noted that staff used their awareness of people's body language and vocal sounds to interpret people's wishes and needs. For example, when the staff member started offering different activities available, they waited for the person to assimilate the information they had offered and waited patiently for a response. They used a similar approach offering further options until the person responded in an excited way when they were asked if they would like to play their keyboard. We observed another member of staff support a person to eat their lunch. They sat nearby to them, made eye contact and chatted to them throughout.

When we spoke with staff they told us, "We are a good team and it is a good place to work. Our new manager has encouraged us to share good practice with each other and we regularly talk about any changes in people's needs, so we can continue to support people to remain as independent as possible."

We found staff supported people to maintain privacy and dignity. Each person had their own bedroom for use when they wanted personal space. We observed staff knocked on bedroom doors prior to entering. Bathrooms and toilets had privacy locks. In discussions with staff, they described how they respected people's privacy and helped to maintain their dignity.

Comments included, "Keep people covered during personal care", "Always knock on doors and ensure curtains are closed", " Make sure everything is ready for people so you don't have to interrupt the delivery of care to go and find something" and "Treat people as you would want to be treated – with respect." The care files we looked at also reminded staff to respect people's privacy and dignity.

We saw staff had supported people to make choices about aspects of their lives. For example, each of the people using the service had been involved in the redecoration of their bedrooms, choosing wallpaper, colour themes, bedding and curtains. People without relatives were supported in decision making processes by an advocate.

People using the service were supported by staff to maintain contact with their family. Some people's

relatives visited the service and staff supported one person to visit their elderly parent at their home. This was confirmed by their relative who told us, "They take her to see Mum every weekend at home, which is really important for both of them."

The staff were aware of the need for confidentiality with regards to people's records and daily conversations about personal issues. They said, "We maintain confidentiality, don't talk about people outside of work or in front of other people here", "Care plans are kept locked away when they aren't being used and locked away afterwards", "We use the office or other private areas if we need to make phone calls or talk to nurses."

Care files and other private and confidential information were stored safely. The registered provider's IT systems required personal log in and password details to gain access and staff confirmed that confidentiality was covered in their induction. This helped to ensure unauthorised people did not have access to personally sensitive information.

Some records were held electronically and the registered provider had completed registration with the Information Commissioners Office (ICO) in line with requirements when maintaining computerised records.

Good

Is the service responsive?

Our findings

Relatives told us they considered the service to be responsive to their family member's individual needs. Comments included, "We are involved in all aspects of their life and the decision making process. They always keep in touch and let us know what they are involved in or if there are any changes" and "They are always out and about and have a full and active life."

Relatives told us they felt able to raise concerns. Comments included, "I have no complaints whatsoever. "Another told us, "I can pick up the phone to discuss anything with the manager she is great. It was the same with the previous manager too. I am fully involved with everything. I can't fault the service; they are doing a great job – superb." Another told us, "Mr [Name] is a very nice man and will visit me at home if I need to discuss anything. It was him who asked me to become a member of the care quality group."

We found people were provided with care and support that was personalised to their needs. Staff told us they ensured care plans were followed so that people's needs were met. Evidence confirmed people who used the service and those acting on their behalf were involved in their initial assessment and on-going reviews. Relatives we spoke with confirmed their involvement.

Individual assessments had been carried out to identify people's support needs and care plans developed following this, outlining how these needs were to be met. Staff had completed a life history and profile of each person; relatives had been involved in providing information about life histories, likes and dislikes. There were support plans to guide staff in how to care for people in the way they preferred. People's care plans focused on them as an individual and the support they required to maintain and develop their independence. They described the holistic needs of people and how they were supported within the service and wider community.

Care plans were tailored to meet people's individual needs and promote their safety. For example, we saw for one person this included a positive behaviour support plan that described practical ways of effectively supporting the person when the displayed behaviours which challenged the service and others. The plan clearly described how to manage their behaviours when they became anxious or upset and identified possible triggers, what the actual behaviours were, and how staff should support the person during these.

We observed staff interacting with people; they understood people's needs and were responsive in their approach. Staff told us how one person may present if they became anxious and how they would support them in order to diffuse the situation.

The care plans we looked at for two people using the service were found to be well organised, easy to follow and person centred. Sections of the care plans had been produced in easy to read format, so people who used the service had a tool to support their understanding of the content of their care plan. Easy read information is designed for people with a learning disability and is a way of presenting plain English information along with pictures or symbols to make it more accessible.

We saw people's care plans were reviewed monthly to ensure people's choices, views and healthcare needs remained relevant. When there had been changes to the person's needs, we saw these had been identified quickly and changes made to reflect this in both the care records and risk assessments where this was needed.

When we spoke with staff, they confirmed they read care plans and information was shared with them in a number of ways including a daily handover, communication records and staff meetings. Staff spoke about the needs of each individual and demonstrated a good understanding of their current needs, previous history, what they needed support with, what they may need encouragement to do and how they communicated and expressed their wishes. Staff told us that care plans provided them with sufficient information about people.

Staff told us how they kept relatives informed about issues that affected their family member and ensured they were involved in all aspects of decision making. Relatives were also invited to reviews and if they were unable to attend their views were sought and shared in reviews and other meetings. Records seen confirmed this.

Records of all activities people had engaged in were recorded. We saw people had the opportunity to participate in a variety of different activities they liked. These included, annual holidays, day trips, going shopping, visiting a local farm, visits to the local library to select talking books, meeting up with friends and going out for coffee. A relative spoken with said, "She is going to Butlins soon for a holiday, with two staff, she will enjoy that. Another told us, "They invite me to reviews of her care and they listen to my views and involve me in decisions."

The registered provider had a complaints policy in place that was displayed within the service. The policy and procedure was available in easy to read format to help the people who used the service to understand the contents. In discussions with the registered manager, they told us the service received very few complaints. No formal complaints had been received by the service since our last inspection, but where suggestions had been made to improve the service these had been acknowledged and action taken.

Good

Is the service well-led?

Our findings

At our last inspection on 22 March 2016 we found the quality assurance system needed to be further developed to show what actions were taken where shortfalls had been identified within the service. At this inspection we found the quality assurance system had been further embedded and included action plans with timescales to address any issues identified. Further audits were made by the quality assurance lead to ensure these timescales were met.

Relatives told us they were very happy with all aspects of the service and couldn't fault it.

We observed people who used the service were comfortable in the registered manager's presence and although they did not always approach them directly, they engaged with them confidently when they were approached by them. During our inspection we observed the registered manager took time to speak with people who used the service and staff and assisted with care duties.

The registered manager told us they were supported by senior managers within the organisation and a board of trustees. The quality monitoring programme also included a structured programme of compliance reviews by the quality assurance manager. These were completed every two months and covered all aspects of service provision. The records showed that, where shortfalls had been identified, action plans had been developed and compliance dates achieved.

We saw an organisational wide system was in place to monitor the quality of the service people received. This included a range of audits, meetings and surveys to gather feedback from people who used the service and their relatives, and observations of staff practices. Relatives we spoke with confirmed they were involved in this process. As well as being invited to attend relative's meetings and receiving newsletters, they were also invited to various social events, arranged by the registered provider.

Records showed the registered manager completed a range of internal checks of areas including the care plans, personal financial accounts and medication management. Results of these checks were positive. A redecoration/refurbishment plan was in place that identified a plan for any improvements required within the service.

Accident and incident records were maintained and demonstrated immediate appropriate actions were taken following these. The registered manager confirmed how all accident, incident and safeguarding reports were sent to the senior management team for analysis and review in order to identify any emerging patterns and outcomes to inform learning at service and organisational level.

Staff we spoke with told us, "[Name of registered manager] helps me a lot actually; she is approachable and understanding and is always willing to help with any care duties." Another told us, [Name of registered manager] is very good, we get regular supervision and she observes our practice and gives us feedback. It is also good to have the opportunity to raise issues and get them resolved."

The registered provider encouraged good practice. For example, there was a system in place to nominate staff for specific awards for recognition of good practice. Staff were provided with handbooks which explained the expectations of their practice and described the registered provider's vision. This was described as promoting a 'lifetime support to vulnerable people to enable them to live fulfilled and valued lives through making personal choice, an inclusive society where people have equal chances to live the life they choose.' Staff also received long service awards.

The registered manager told us they were working through the process to become accredited with the national autistic society, which was due for Autism accreditation is an internationally recognised quality standard provided by The National Autistic Society

The registered manager told us that they liked to spend as much time as possible in each of the two services they managed. They explained they shared their time across both services and when they were not there, a senior member of staff would be based there. This ensured management support was available at all times.

Observations of staff practice were completed by the registered manager and they told us they liked to spend as much time as possible working alongside staff, in order to support them in any way possible, led by their example and to promote good practice. They told us they encouraged their staff team to develop new skills and to progress.

Professionals told us, "The manager has worked really well with [Name], she has established firm, clear consistent boundaries with them and staff have been supported to promote this approach, which has had a positive effect on their behaviour."

Meetings took place for all registered managers in the organisation to share information and best practice guidance. Registered managers also had the opportunity to network with external care providers to share best practice initiatives and share experience. A group of registered managers had recently attended an autism conference. The registered manager told us that these meetings and networking opportunities were both useful and informative.

Staff told us they attended regular meetings where the registered manager would inform them of any changes to policies and procedures and to share new guidance on best practice. The meetings also gave staff the opportunity to discuss and share information about any changes in people using the service needs.

We found the registered manager was aware of their role and responsibilities and notified the Care Quality Commission and other agencies, of incidents which affected the welfare of people who used the service. We have found the registered manager responded to requests for information when required.