National Autistic Society (The)

NAS Community Services (Somerset)

Inspection report

Harp Road
Brent Knoll
Highbridge
Somerset
TA9 4HQ

Tel: 01179748413
Website: www.autism.org.uk

Date of inspection visit:
14 September 2016
16 September 2016
20 September 2016

Date of publication:
30 November 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The National Autistic Society Community Services provides personal care and support to people living in their own homes in North Somerset. At the time of this inspection there were eight people who received 24-hour staff support from the service. The service provided a supported living service. A supported living service is where people have a tenancy agreement with a landlord and receive their care and support from a care provider. As the housing and care arrangements were entirely separate people can choose to change their care provider if they wished without losing their home.

The inspection took place on 14, 16 and 20 September 2016 and was announced.

There was a registered manager in post. 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.

People had communication difficulties associated with their autism. We visited two of the homes where people were receiving services and met four people. We had very limited communication with the people we met. We used our observations and discussions with people's relatives and staff to help form our judgements.

Medicines were not always managed safely. Where risks relating to people were identified these were not always regularly reviewed and updated.

There were sufficient staff available to meet people's needs. Safe recruitment procedures were not always followed.

People's legal rights in relation to decision making were not always upheld. Where people lacked capacity to make decisions for themselves the principles of the Mental Capacity Act 2005 were not always followed.

There were some gaps in staff training but the registered manager had plans in place to address this. New members of staff received an induction which included shadowing experienced staff, they told us this prepared them for the role.

Staff did not always feel supported and commented there was a lack of management presence in some of the services. Staff did not always receive regular one to one supervision with their line manager. Where improvements were identified with staff performance, this was not always regularly monitored and reviewed.

People received good support from health and social care professionals. Staff were skilled at

communicating with people, especially if people were unable to communicate verbally.

People's records did not always include information that promoted dignity and respect. We observed staff were caring in their interactions with people. Relatives told us staff were caring.

Relatives were involved in the planning and reviewing of people's care. Some of the care records we looked at needed reviewing and updating. People were supported to access their community.

All of the relatives we spoke with and staff felt the service was a safe place for people. There were systems in place to protect people from abuse and the staff we spoke with knew how to follow them.

The quality assurance processes in place to monitor care and safety and plan on-going improvements were not always effective.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

Where risks were identified to people they were not always regularly reviewed and updated.

People's medicines were not always stored and administered safely.

There were sufficient staff to meet people's needs. Some important information was missing from staff recruitment files.

People were supported by staff who knew how to recognise and report abuse.

Is the service effective?

Requires Improvement

The service was not fully effective.

People's legal rights in relation to decision making were not always upheld.

People were supported by health and social care professionals. Clear records of health appointments and outcomes were not always kept.

Staff were trained, but did not receive on-going support to make sure they provided effective care to people.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Information relating to people was not always recorded in a way that promoted dignity.

Staff interactions with people were positive. Staff knew people well.

Relatives were involved in decisions about people's care.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People's care plans were not always regularly updated and reviewed.

People engaged in meaningful activities outside of their homes. The service planned on improving the in house activities for people.

Relatives were aware of the complaints procedure and were confident to use it if they had concerns about people's care.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

There were ineffective quality assurance systems in place to make sure any areas for improvement were identified and addressed in a timely manner.

The registered manager had an action plan in place that described the improvements needed to improve the service to people.

People were supported by staff who felt they would benefit from more visible management. The management structure did not meet the needs of the people using the service.

Staff felt able to approach the registered manager and deputy manager with concerns.

NAS Community Services (Somerset)

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 carried out on 14, 16 and 20 September 2016 and was announced. It was carried out by two adult social care inspectors.

People had communication difficulties associated with their autism. We visited two of the services and met with four people. We observed staff interacting and supporting people in their homes. We had very limited communication with people. We also used our discussions with people's relatives and staff to help form our judgements.

We spoke with six relatives, five care staff, one deputy manager and the registered manager. We looked at five people's care records. We also looked at records that related to how the home was managed, such as staff rotas, staff training records, quality assurance audits and survey results.

We reviewed all of the information we held about the home before our inspection. We looked at notifications we had received. A notification is information about important events which the home is required to send us by law. We reviewed previous inspection reports. The service was last inspected on 3 December 2013 and met all the standards inspected.

We did not request a Provider Information Return (PIR) prior to this inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. The manager therefore provided us with a range of documents, such as

copies of audits, action plans and surveys, which gave us key information about the service and any planned improvements.

Requires Improvement

Is the service safe?

Our findings

Some aspects of the service were not safe.

Where people required support from staff to manage their medicines we found there were systems in place for this. However, we found the systems did not always ensure medicines were safe for people receiving them. For example, one person's medicines had been changed by their GP. They had been prescribed a medicine to be taken 'as and when required'. Whilst the change in the medicines had been recorded in the person's communication book it did not include details for when staff should administer it. We discussed this with staff and they were able to tell us when it should be administered, however this information was not available if there were unfamiliar staff supporting the person. We also found the persons care plan had not been updated with the change in their medicines and it did not reflect their current regime. This meant people were at risk of receiving incorrect medicines. The senior staff member told us they would ensure the person's records would be updated to include accurate and detailed information about their medicines.

Some people were prescribed creams and ointments which were applied by care staff. In the services we visited we found the creams were not always dated when they were opened. This meant staff would not be able to determine if these creams were still safe to use. We spoke to the seniors in both services who told us they would ensure all staff were aware of the need to label creams and ointments with the date once they were opened.

Staff told us one person chewed their medicine. We looked at the persons medicine's and it was clearly stated on the packaging the medicine should not be chewed. The medicine had a special coating that allowed it to pass straight to the stomach which helps avoid it upsetting the stomach. This meant people were at risk because medicines were not administered in accordance with the prescribers' instructions. We discussed this with the senior who was unaware of this. They told us they would contact the pharmacy straight away to discuss if there was an alternative medicine the person could take.

We looked at medicines administration records (MARs) for four people who used the service. The MARs are important because they record whether medicines have been administered, refused or not given and the reason why. We found one person's records included gaps where the staff had not recorded whether the medicine had been administered or not. We were unable to determine if the medicines had been administered because they were in the form of a nasal spray. This meant the person could be at risk of having their medicines administered more often than prescribed because staff would not be aware if the medicine had been administered. The senior told us they thought staff would have forgotten to sign the record and they would ensure this would be raised with the staff team.

Where there were risks to people's safety in their homes staff were aware of these and they could tell us how they supported people to reduce the risk. However, there were not always records of the risks in people's care plans and details of how staff should support people to reduce the risk. For example, staff explained how sharp implements should be locked away to prevent any potential incidents if people became anxious. People's records did not include any reference to the risk and measures in place to reduce this. We talked to

staff about the potential dangers in the kitchen area should people become anxious for example, whilst hot food was being cooked. Again staff were able to describe the action they would take to keep people safe. However there was no documentation to demonstrate this risk had been considered or details of the action staff should take to reduce the risk. This meant people were at risks because the information would not be available if unfamiliar staff were supporting them.

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

We discussed our concerns with the registered manager who showed us an 'in house weekly check' document they were planning on introducing for senior staff to complete. We saw the document included checking medicines and risk assessments to ensure they were accurate, completed and up to date. Only staff who had received training were able to update and write risk assessments and at the time of our inspection this was solely the deputy manager. We saw evidence the deputy manager was in the process of updating people's risk assessments and this was included on the registered manager's action plan for the service. Staff told us there were always familiar staff available to support people.

Medicines were stored securely and staff knew how to use people's prescribed creams and lotions. These were detailed on the MAR charts and the deputy manager had started to include these on body maps to make it clear to the staff where they should be applied.

The provider did not always follow safe recruitment procedures to ensure that staff working with people were suitable for their roles. We looked at six staff personnel files. There were no records of any recruitment checks in two current staff member's files. We therefore visited the provider's human resources (HR) department to see if these staff member's recruitment checks had been kept in their office. They had not been. Following our inspection the providers HR department emailed us information relating to the staff members DBS checks, which had been completed. However they were unable to locate the references. The providers' recruitment policy stated 'The HR Team will request references from two named referees'. The HR department confirmed they would be requesting the references for the two staff members. The provider completed an audit in October 2015 that identified not all staff personnel files were complete. During our inspection we found action had not been taken to rectify these shortfalls which put people at risk of being supported by staff who were not suitable for the role.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider vetted new staff through the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable people. They also applied for references and obtained documents to confirm that staff members were entitled to work in the UK. New staff were not allowed to start work until all satisfactory checks and references were obtained.

Relatives told us they thought their family members were safe. One parent said "I don't worry about [name] at all. If she was unhappy about anything she would ring me and tell me. I can ring her at any time as well; she has her own phone. No worries there". Another parent said "I feel [name] is safe. She can be a very difficult person to care for, but staff are very good with her".

Staff spoken with said people using the service were safe. Staff were aware of indicators of abuse and knew how to report any worries or concerns. They told us this would be reported to the deputy manager or

registered manager and they were confident it would be dealt with appropriately. They were also aware they could report this outside of the organisation to the local safeguarding authority. Staff told us they received training in safeguarding and records confirmed this. Staff were also aware of the whistleblowing policy and felt confident to use it if they had concerns. One staff member told us "I am aware of the whistleblowing policy. Staff would definitely report anything. We are vigilant".

No safeguarding concerns were raised with us during our inspection. Prior to our inspection, the provider notified us they had discovered people's money had gone missing. The provider had investigated this issue and identified clearer protocols were required for staff to ensure people's finances were regularly checked. During our inspection we noted the protocols had been introduced and there had been no further issues.

Where people were involved in accidents and incidents they were supported to stay safe and action had been taken to prevent further injury or harm. We received mixed feedback about how well staff felt supported by managers during incidents. Staff described how they had been through a 'difficult' time with one person displaying high levels of anxiety and expressing this through behaviours that could be challenging for staff. One staff member told us "It's been a tough time, but the staff team have pulled together". Staff however confirmed they could call management for telephone advice and they always received a response.

Staff described how they reviewed incidents for possible causes and the action they took in response to this. One of the seniors told us how one person had experienced regular incidents which could put them and others at risk. They explained how the staff team had reviewed the incidents to look at why they were occurring and arranged for the person's medicines to be reviewed by a health professional. Staff described how following the review and advised change of medicines the person's incidents had reduced significantly. Records seen confirmed this.

Relatives thought there were enough staff members available to meet people's needs. However some of them commented on the amount of agency staff the service had used. One relative said "There have been loads of agency, staff come and go". Another commented "At times I have been concerned about the use of agency staff, but they try to use the same staff".

We received mixed feedback from staff about the staffing arrangement in the services. One staff member told us how staffing had recently improved and they had a consistent and stable staff team. Another staff member told us how they had been using lots of agency staff and described how their team had four members of staff absent for various reasons. They confirmed the agency staff they used were regular staff who knew the people they supported.

We looked at the staff records and discussed staffing levels with the registered manager. We saw that people were receiving The registered manager acknowledged they had used a "Fair amount" of agency staff to cover their vacancies. They explained how the geographical area of the services had caused some challenges with staffing and they described how they were in the process of looking at different staffing structures that would best support the service. They also confirmed they had an on-going recruitment programme and an agreement with an agency that enabled them to use regular agency staff.

Requires Improvement

Is the service effective?

Our findings

The service was not always effective.

People's rights were not fully protected because the correct procedures were not always being followed where people lacked capacity to make decisions for themselves. We spoke to staff and looked at records for people who were unable to make complex decisions independently.

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. Any restrictions placed on people should be regularly reviewed. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA. We found where restrictions were placed on people in their homes; the principles of the MCA were not always followed. For example, staff told us how two people being supported by the service had restricted access to their lounge. We saw their lounge was locked and staff held the key. One staff member told us the lounge was locked to prevent people's access to the television, as this could cause an increase in anxiety. They also told us how the two people being supported by the service could not access their lounge together. They explained how the staff team had decided to create a rota for the television access that started with both people being able to watch TV twice a week for two programmes. They explained how they had increased this to four times a week which meant staff were deciding when people could access their lounge and television. We also found people's food cupboards were locked and people had to ask staff if they wanted to eat certain foods. Staff told is this was because people would eat excessively. Staff were restricting people from accessing their belongings in their own home and not conducting best interest decisions which would take into account less restrictive options. Which meant staff were not following the principles of the MCA, making these decisions themselves outside of this process which is in place to protect people from being overly restricted.

We found other restrictions in place for people in their homes with no best interest decisions in place such as access to toilet roll, hand towels and computer access. One person had a movement sensor in their bed because they had epilepsy. Another person received their medicines covertly, which means they are hidden in food or drink. Staff told us this was because the person could refuse their medicines. Staff were not following principles of MCA one of which is to constantly review restrictions to ensure they are the least restrictive option and in the person's best interest.

Whilst staff were able to describe why restrictions were in place, for instance for a person's safety, we found they were making decisions for people without following the principles of the MCA. This was because there was no evidence of the restrictions being in the person's best interest or being regularly reviewed to find less restrictive alternatives. This meant people's rights were not protected and they were at risk of receiving care

and treatment which was not in their best interests.

Staff told us they thought they would benefit from more in depth training around the MCA and how it applied to the people they supported.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

We discussed this with the registered manager who acknowledged they needed to improve their processes around the MCA. They were able to demonstrate they had contacted the local authority in 2015 to seek guidance on how to proceed where people may be being deprived of their liberty and they had contacted them again in May 2016. They also showed us their 'service action plan' which incorporated the improvements required as well as additional staff training. The action plan stated the improvements would be made by December 2016.

People were not supported by staff who had supervisions and annual appraisals (one to one meeting) with their line manager to discuss their performance and any support and training needs. The providers aim for the service stated 'All staff receive bimonthly supervisions with their line manager / more senior member of staff. One of these each year takes the form of an annual appraisal. Supervisions assist in the identification of individual strengths and areas requiring further development, ensures that the individual works in line with service development goals, and also provides a forum in which to raise concerns'.

Staff told us they were receiving supervision with their line manager and felt these were a good opportunity to discuss any concerns they had. However, the records we looked confirmed staff were not provided with regular supervision. For example, two staff members were last supervised in November 2015; another member of staff was last supervised in February 2016. Seven staff had not had any supervisions meetings since April 2016. This meant people were at risk of receiving support from staff who were not regularly meeting with their manager to ensure they were able to carry out the duties required of their role.

The provider had clear staff disciplinary procedures when poor staff practice or poor performance was identified. This was not followed consistently. Discussions with the registered manager and records seen confirmed that two staff member's practice or performance had fallen below the required standard. This had been discussed with them individually and improvement plans put in place. However, the improvement plans had not been monitored effectively and in line with their action plan. For example, one staff member had a disciplinary meeting in May 2016. The areas for improvement in their performance had been discussed and agreed but there had been no follow up meetings since nor any supervision (one to one meeting with their line manager). The last recorded supervision was 22 November 2015. This meant people were at risk of receiving support from staff who were not performing to the required standard as set out by the provider.

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

The registered manager and deputy manager had plans in place to supervise staff in line with the providers' policy.

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. New staff completed an induction when they started work. This provided them with the basic skills and training needed to support the people who lived in the home. The

registered manager told us they had started to link the induction programme to the Care Certificate. (The Care Certificate standards are set by Skills for Care to ensure staff have the skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.) Staff told us the induction included a period of 'shadowing' experienced staff and looking through records. They said this could be extended if they needed more time to feel confident. One staff member said "The induction has been great, it covered all the different aspects and shadowing in the homes, it's built up my confidence making sure I'm happy with what I'm doing".

Staff told us they had on-going training they needed to ensure they were able to meet people's needs. Comments included, "We are always offered training, it has improved recently" and "One of the good things is the training, if you were not comfortable they would offer you more". We looked at the training matrix and saw there were some gaps where staff required refresher training. The registered manager showed us their training plan which included the dates of when the training required had been arranged.

People used various methods to communicate their wishes and choices. These included speech, pictures, signing, vocalisations and body language. Experienced staff knew people well and were able to interpret non-verbal communication. We saw staff used communication individual's responded to well, such as using pictures to offer people choices.

People were not able to tell us their thoughts about how staff supported them with their meals. They relied on staff to help them with the planning and preparation. Staff told us how one person chose the same meals daily and explained how they were planning on encouraging them to try different choices by the use of pictures. In one of the services we saw there was a weekly menu board which was written on by the staff. We saw the majority of the meals written on the board were identical for the two people living in the service. This included the fillings they had for their sandwiches each day. We spoke to staff who told us they completed the board based on people's likes and dislikes and they explained they were 'a guide'. They also confirmed that both people living in the home were unable to read the writing on the board. Staff told us people could choose what sandwich filling they wanted and if they did not want the main meal they could choose other options. Records demonstrated whilst a majority of the meals were the same there were times where people had different meals. The senior staff member told us they had been discussing with the deputy manager how they could introduce individual meal choices for people being supported by the service.

Relatives told us staff understood their family member's health care needs and supported them to access healthcare services One parent said "All of the people involved in [name's] care are working really well together. Staff are very good at liaising with us and I think the liaison with all the agencies is very good". Another parent said "[Name] gets very good support from health professionals. She has a specialist, who is very good. I go to all of the appointments with her so always know what's going on and am able to share my views. I'm involved at every stage really".

Staff supported people to see their GP and dentist where required. However we did not find evidence of one person accessing the optician services. A staff member told us this was arranged by the person's family, although we did not see a record of this. Two people did not have health action plans (HAPs) in place. Where people did have HAPs these were not regularly reviewed and updated. Health action plans are documents that include a personal plan that describes what people can do to stay healthy and the support that is available. The Department of Health states that people with learning disabilities should have a HAP. By not having HAPs in place this meant people did not have accessible and individual information to enable them

to make choices about their health needs.

The service supported people to access specialist support for people, such as from a psychiatrist, epilepsy nurse and psychologist. We found records of the appointments were not easily assessable in care records which made it difficult to find when people last accessed these services and the outcomes of the appointments. By not being easily accessible it could be difficult for staff to keep up to date with this information. The senior staff told us they would introduce records for appointments that would enable easier access to the information.

Requires Improvement

Is the service caring?

Our findings

Some aspects of the service were not caring.

Staff were able to tell us how they respected people's privacy. For example, by closing doors and curtains whilst providing personal care and ensuring people were aware of and happy with the support they were providing. However, we found the service was not always considering people's dignity and respect. For example, in one of the people's homes they did not have access to toilet roll or hand towels. Staff explained how people had to ask the staff for wipes if they wanted to use the toilet. Staff and the registered manager told us these items were kept away from people for safety reasons; however the service had not looked at potential safer alternatives that could be used.

We also saw in one person's care plan it made reference to them being 'demanding'. Another assessment of a person completed by a professional employed by the service made reference to a person being 'stubborn, ridged, impatient' and 'liking their own way'. By using this language to describe people and not allowing access to toilet roll the service was not demonstrating they were treating these people with dignity and respect.

The registered manager acknowledged people's care records needed updating and explained they were in the process of completing this. We saw the records staff had completed referred to people using appropriate language.

Staff told us how they respected people's privacy by knocking on their doors before entering their rooms and we observed this during our inspection. Staff also told us how they ensured doors and curtains were closed whilst they were supporting people with personal care; they recognised the importance of people having their own personal time. They explained how they offered the amount of support required to encourage independence. One staff member told us how what appeared to be "Small steps" that one person was making towards independence were significant to the person's progress.

Relatives told us they were happy with the staff supporting their family members and they thought the permanent staff knew their relatives well. One parent said "I speak to all the staff who care for [name] and know them well. There were a few problems getting a consistent team when the service started but it seems to have settled down now". Other comments included "[Name's] core team of staff are very good; a nice team. The staff team were put together over quite a long time, as you need staff with experience to care for [name]. It's a good, solid staff team now" and "The staff go beyond their duty, they really do care".

People required on-going support from staff; permanent staff clearly knew people well. They were able to explain what was important to each person such as their family members, personal history, chosen activities and having time to process information. Staff described how they assisted people to maintain their independence and they were aware of the importance of this. Staff talked positively about the people they supported. One staff member told us "The best thing about the job is the people we support, we get on really well". We observed staff interacting with people who were supported by the service in a kind and

caring way. People appeared relaxed in the presence of staff.

Relatives told us that they were able to visit their family members at any time. They were made to feel welcome and there was a good atmosphere. One relative said, "We can visit at any time, we don't always tell them, just turn up, it's all been very positive". Another commented "We visit when we want, it's a happy home".

Relatives told us they felt involved in the planning of their family members care. One relative said "I am involved in the care plan and reviews, if I need to know anything they let me know. We work together". Staff told us how people made day to day decisions about their care such as what time they get up, go to bed, what to wear and where they go in the community.

Requires Improvement

Is the service responsive?

Our findings

Some aspects of the service were not responsive.

People had individual care plans and guidelines detailing how staff should support them. We found the care plans and guidelines had not all been recently reviewed and some did not include dates of when they were written. For example, one person had a written routine detailing how staff should support them in the morning, afternoon and evening. Another person had a communication profile that described how staff should communicate with them. There were no dates on either of the guidelines to demonstrate if they were still current or details of who wrote them. One person had a positive behaviour support plan in place that gave staff guidance on how to support them should they become anxious. This had not been reviewed since 2014. Another person had details of how staff should support them; this had not been reviewed since 2013. Whilst we noted these people's needs had not significantly changed this meant there was a risk the information relating to people could be out of date.

We also found where risk assessments were in place some of these had not been recently reviewed. For example, one person had a risk assessment in place relating to living in their own home, this had not been reviewed since 2011. Another person had a personal emergency evacuation plan (PEEP) in place that described how staff should support them to evacuate in the event of an emergency. This had not been reviewed since 2012. We found important information relating to people was not easily accessible because the care plans appeared unorganised. Whilst the staff we spoke with had a good in-depth knowledge of the people they were supporting this information would not be available to unfamiliar staff. Which meant staff did not always have access to up to date information and guidance on how to support people. Staff confirmed there was always at least one regular staff member working with the people they supported.

The senior staff told us they were aware the care plans needed updating, but they did not always have time to complete this. One senior told us "I am working on the care paperwork, but my priority is the people and making sure they are happy". Another told us "I know the care plans need updating, all the information is in there". They described how their team had two senior staff absent from work and how it was not easy to find the time to do this. One of the seniors went on to say "We've got dates set to review the care plans and now have the time to do it".

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

We discussed this with the registered manager who told us they were aware some of the care plans were in need of updating and stated this process had started. We saw evidence of this. The registered manager showed us a new care plan format they were planning on using for all of the people using the service and their service action plan identified this would be completed by March 2017. They told us once the senior management team structure was in place it would enable them to complete the work required.

People's participation in the planning of their care was often limited by their communication difficulties.

Records showed some people attended a meeting to review their care needs. Others close to them, such as their relatives or other professionals involved in their care, were therefore consulted. People were supported to arrange person centred planning (PCP) meetings. These meetings were used to review what was and wasn't working well for the person and set goals for the future. Where goals were set we saw these were achieved, such as a person having their own key fob for their bedroom. However not all of the people being supported by the service had attended a recent PCP meeting. Staff told us they were in the process of arranging PCPs for people.

Relatives told us they were invited to reviews of their family members care. One relative told us of how they were happy with their family members care plan and they were kept up to date with changes in their care. Other comments included "They do involve me in all the reviews; I go to all of the meetings" and "[Name's] service is quite new. The NAS had been working with us while we were waiting for housing. We have been involved in making sure [name] has the right service".

People were able to take part in chosen activities. Relatives said their family members chose to do things they enjoyed and felt people were well supported in choosing activities and outings. People had access to their own vehicle which meant they were able to access the community when they wished. Records demonstrated people accessed national trust locations, swimming, an allotment, walks, picnics and local shops to complete their grocery shopping.

Although people regularly accessed the community we found there was a lack of in house activities for one person who used the service. Staff told us how the person accessed a 'sensory room' in their home. We saw the 'sensory room' which did not include any sensory items specifically designed to meet the person's needs. The person's care records did not include any information about their sensory needs or how staff should support them to meet these. This meant the person was not always receiving personalised care that was responsive to their needs. The registered manager told us they were in the process of working with health professionals to assess the person's needs and develop suitable in house activities.

Relatives told us they knew how to complain or raise concerns more informally. One parent said "[Name] could say if she was unhappy and she would. I've never needed to complain, but I did raise a concern once. I just didn't feel we were on the same page really [with staff about a health related issue]. It was all sorted out though, so it was fine". Another parent said "At this point, I have no issues at all. I do have all the manager's numbers so I can always ring them if I have a question or are concerned about anything". There had been one complaint received by the service in the past year. We saw this was investigated and responded to in line with the providers' policy.

The service had systems in place to receive feedback from relatives. This was completed on an annual basis. We saw the results of the survey conducted in 2015. Areas covered included relatives feedback on people living with dignity, independence and being a part of their community. All of the feedback they received about the service was positive.

Requires Improvement

Is the service well-led?

Our findings

Some aspects of the service were not well led.

The provider did not have a suitable management structure in place to meet the needs of the service. Not all the staff we spoke with felt supported at difficult times, they told us they acknowledged the managers were busy but they would like to see them more often. They said, at times, they had to "Pull together" as a team. One staff member commented "I know [name of deputy manager] is supporting another service and we never see [name of registered manager]". Another commented "The managers just think we are fine".

We received mixed feedback from relatives about the management of the service. One relative commented on the amount of managers that had been in post and they did not think the service their family member was receiving was well supported by the management. They commented the registered manager rarely visited the service. Other comments included "So far, I think the managers have been good. I usually speak to [the deputy manager] and she keeps me up to date. Sometimes I speak to [the registered manager]" and "I don't usually speak to managers. I speak to staff at the house; I think they are a team leader or a senior. They have very good communication with me".

The registered manager had been in post since February 2015. There was one deputy manager working in the service and one deputy manager vacancy. During our inspection interviews were being carried out for the second deputy manager post. The registered manager described how each service had allocated senior staff that were responsible for overseeing specific tasks including supervising staff. Three of the senior posts were currently vacant for various reason. The registered manager told us since they had been in post they had struggled to fill staff vacancies due to the geographical area of the services. The previous deputy manager left in May 2016, at the same time the service took on a new 24-hour package of support. Senior staff told us they were "Stretched" at times due to the staffing levels and they were unable to complete some of their management tasks.

The provider did not have effective systems in place to monitor the quality of care and support that people received. For example, the provider's deputy area manager had completed an audit of the service in October 2015. This audit identified some of the concerns we found during our inspection. For example, important information relating to people was not in care plans and information not being regularly reviewed and updated. We found this still required improvement at this inspection. The audit was not reviewed or used to ensure there was improvement in the service. The local authority also audited the service in July 2016 and identified similar concerns to those we found during our inspection. They made recommendations as part of their report. We found sufficient action had not been taken in response to the concerns they identified. This lack of action put the quality of the service and safety of people at risk.

A quality monitoring visit was carried out on 11 August 2016 by one of the provider's managers from another area. This identified there were issues with risk assessments and health action plans, these were recorded on the audit as having being completed. The audit confirmed restrictive interventions were appropriately recorded and signed off as being in a person's best interest and medicines were being stored in line with the

providers policy. Our inspection found concerns in all of these areas and action had not been taken to address them.

Where concerns were raised about staff performance and improvement plans were put in place, these were not being regularly monitored and reviewed. Staff worked remotely in the services which meant they were not being monitored to ensure they were performing to the required standard. The regularity of staff supervision had been identified as an area of improvement in the providers audit from October 2015. However, we found they had failed to make improvements. This lack of action put the quality and safety of the service provided to people at risk.

The records relating to people were delivered to the main office each month where they were archived. There was no system in place to audit the information received to identify any concerns or staff omissions which would enable the registered manager to make improvements to the service.

Whilst the service had identified the areas of improvement required, we found they had failed to take sufficient and timely action to address the concerns which put the safety and quality of the service to people at risk.

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

The registered manager told us how they were reviewing their management structure for the service and looking at a more effective model to meet the needs of the service. They acknowledged they did not get the opportunity to spend a lot of time in the services and once they had their management structure in place they planned on visiting each service at least fortnightly. They also told us how they were planning on moving their office to a more central location which would be closer to all the services. One staff member told us how they thought the registered manager and deputy manager visited one of the services regularly. All of the staff we spoke with confirmed both the registered manager and deputy manager were approachable and available to speak to on the phone if required.

The registered manager showed us their service action plan which identified shortfalls in the service and the action they needed to take to address these. Timescales were set for when the action points needed to be completed and it covered the areas of concern we identified during our inspection.

Staff meetings were held with each team to address any issues and communicate messages to staff. Staff told us they felt able to voice their opinions during staff meetings. One staff commented the meetings weren't held "Very often". Records demonstrated meetings were starting to be held more regularly. The registered manager told us how staff had individual emails accounts which enabled them to communicate messages to the team.

The key aims of the service were described in the service's statement of purpose. The service aimed to offer 'access to as full, enjoyable and meaningful a life as possible to each individual. Programmes are designed to offer additional help in communication and social skills and to compensate for difficulties in imagination - all barriers to achievement of a full and enjoyable life'. Staff told us the aim of the service was to "Support people to be as independent as possible and have the best lives they can" and "To provide people with support so they can thrive in their community". Which meant staff understood the aims of the service.

Significant incidents were recorded and where appropriate were reported to the relevant statutory authorities. All incidents were entered onto a computer system and the registered manager explained that

these were reviewed regularly so that any patterns or concerns could be identified. The home had notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not always managed safely. Where people were assessed as being at risk the assessments were not regularly reviewed and updated. 12 (2) (a) (g).

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment processes were not always followed. 19 (3) (a)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Persons employed by the service were not receiving appropriate support, supervision and appraisal to enable them to carry out the duties they are employed to perform. 18 (2) (a).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights were not fully protected because the correct procedures were not always being followed where people lacked capacity to make decisions for themselves. 11 (3)

The enforcement action we took:

We have issued a warning notice. They must become compliant by 23 January 2017.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were not effective processes in place to assess, monitor and improve the quality and safety of the services provided. There were not effective processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of services users. 17 (1) (2) (a) (b)

The enforcement action we took:

We have issued a warning notice. They must become compliant by 23 January 2017.