Avocet Trust

Salthouse Road

Inspection report

199a-203a Salthouse Road
Hull
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Date of inspection visit:
16 March 2017

Date of publication:
07 April 2017

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?	Requires Improvement

Summary of findings

Overall summary

199a – 203a Salthouse Road Lane is located in the east of the city of Hull and is registered to provide care and accommodation for up to a maximum of eight people with a learning disability. Accommodation is provided in three purpose built bungalows.

We undertook this unannounced inspection on 16 March 2017. At the time of our inspection there were 7 people living at the service.

At the last inspection on 5 February 2016, the overall rating for the service was 'Requires Improvement'. This related to making improvements to medicines management, stopping the practice of wedging doors open and the safe storage of disposable gloves and aprons. Further action also needed to be taken to promote good infection control practices when washing clothing and other items. Some minor incidents between people had not been assessed and scored using the specific risk management tool provided by the local safeguarding team. Risk assessments were completed; but further detail was needed to be included for staff about recognising the signs of changing behaviours. When accidents or incidents had occurred in the service, records of actions taken to review and investigate these were not always in place.

At this inspection we found automatic closures had been fitted to doors so they were no longer wedged open. Disposable gloves were stored away from clients. Records were being maintained of all incidents and the action that had been taken following these and any referrals made to the local safeguarding team and the Care Quality Commission. Risk assessments had been updated and included information to guide staff on how to recognise potential triggers and changes in behaviour. Processes had been introduced to ensure accidents and incidents were analysed within the service by the manager, and further reviews of these were completed by the quality assurance manager and at senior management level.

There was no registered manager in post. The previous registered manager had recently left the service to take up another post within the organisation and a new manager had been appointed to the post in the last month. The service is required to have a registered manager, and as such, the registered provider was not meeting the conditions of their registration. 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. When a service does not have a registered manager in place the rating in well led cannot be rated any more than 'requires improvement'. A manager had been appointed but had not been through the registration process to become the registered manager. They had been at the service for two weeks at the time of our inspection.

We found improvements were required to ensure people's specialist dietary records were completed in more detail to reflect what people had eaten and the texture and presentation of the food.

We found further action was required to ensure that the date was recorded when topical creams were

opened. Individual 'pro re nata' (PRN when necessary) protocols for pain relief needed to be reviewed and include the dosage of the medicine that had been prescribed. These issues were addressed by the manager during the inspection.

Relatives and professionals praised the skills of the core staff team and shared their reservations about the reliance and use of agency staff and lack of continuity of managers in the service.

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.

The environment was found to be clean and tidy throughout. Areas of the service were beginning to look tired. This had been identified by the registered provider's internal auditing system and plans were in place for a refurbishment of the service in April 2017, which included the replacement of the kitchens.

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 provided them with the relevant skills and confidence to provide care to people. This included training considered essential by the registered provider and also specific training to meet any individual 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, best interest meetings were held with relevant individuals and professionals.

We saw arrangements were in place that made sure people's health needs were met. For example, people had access to the full range of NHS services. This included GP's, community learning disability nurses, chiropodists, dentists, speech and language therapists, physiotherapists and occupational therapists. People received their medicines safely, as prescribed and medicines were held securely.

Staff supported people to make their own decisions and choices where possible about the care they received. When people were unable to make their own decisions staff followed the correct procedures and involved relatives and other professionals when important decisions about care had to be made.

People's nutritional and dietary needs were assessed and people were supported to eat and drink to maintain their health. Menus were varied and staff confirmed choices and alternatives were available for each meal: we observed drinks and snacks were served between meals. 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. 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.

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

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 about raising any issues with the staff team or the manager.

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.

Medicines were safely administered as prescribed.

People who used the service were protected from the risk of abuse. Staff spoken with displayed a good understanding of the different types of abuse and were able to describe the action they would take if they observed any incident of abuse, or became aware of an abusive situation.

Safe recruitment processes were followed.

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 practice.

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 observed care was provided to people in a kind and caring way and their independence was promoted.

Staff provided people with information and explanations about the care they provided.

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?

Requires Improvement

The service was not consistently well led.

There was no registered manager in post.

Relatives and professionals considered the turnover of managers at the service did not promote consistency and continuity.

There was structure to the organisation and levels of support and the registered provider was fully involved in overseeing the service.

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.

Salthouse Road

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered provider is meeting the legal requirements and regulations associated with the Health and Social Care act 2014.

This unannounced inspection took place on 17 March 2017. The inspection was completed by one adult social care inspector. The service was last inspected on 5 February 2016 and was rated as 'Requires Improvement' overall.

We usually send the registered provider a Provider Information Return (PIR) before an inspection. 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. We did not send a PIR to the registered provider before this inspection as one had been completed within the last 12 months.
We looked at notifications sent to us by the registered provider, which gave us information about how incidents and accidents were managed. Information we held about the service was reviewed and we contacted the local authority's contracts monitoring and safeguarding teams. Where any issues had been identified, we included them within our inspection.

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

During our inspection, we spoke with four care staff and a visiting professional. Following our inspection we spoke with four relatives and a professional. We looked at the care files for two people who used the service, which included support plans, assessments undertaken before a service commenced, risk assessments and medication records.

We looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty code of practice to ensure that when people were deprived of their liberty or assessed as lacking capacity to make their own decisions, actions were taken in line with the legislation.

We also looked at a selection of other documents relating to the management and running of the service. These included four staff recruitment files, supervision and training records, the staff rota, menus, minutes of meetings with staff and those with people who used the service, complaints, quality assurance audits and policies and procedures.

Good

Is the service safe?

Our findings

At the last inspection on 5 February 2016, the overall rating for the service was 'Requires Improvement'. This related to making improvements to medicines management, stopping the practice of wedging doors open and the safe storage of disposable gloves and aprons. Further action also needed to be taken to promote good infection control practices when washing clothing and other items. Some minor incidents between people had not been assessed and scored using the specific risk management tool provided by the local safeguarding team. Risk assessments were completed; but further detail was needed to be included for staff about recognising the signs of changing behaviours. When accidents or incidents had occurred in the service, records of actions taken to review and investigate these were not always in place.

At this inspection we found the actions from the previous inspection had been completed. Automatic closures had been fitted to doors so they were no longer wedged open. Disposable gloves were stored away from clients. Records were being maintained of all incidents and the action that had been taken following these and any referrals made to the local safeguarding team and the Care Quality Commission. Risk assessments had been updated and included information to guide staff on how to recognise potential triggers and changes in behaviour. Processes had been introduced to ensure accidents and incidents are analysed within the service by the manager, and further reviews of these were completed by the quality assurance manager and at senior management level.

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.

When we asked relatives if they considered their family member to be safe, they told us, "I feel they are, I don't question it at all." and "Yes they are." Others told us that overall they considered their family member to be safe particularly when they were with staff who knew them well, but were not completely assured when they were in the care of agency staff as they felt it took time to build up an understanding and knowledge of their family member.

They also told us that there had been a review of funding undertaken by the local authority which had contributed to some of the staff leaving the service for fear of being made redundant. This had led to bank and agency staff being used to backfill vacancies, while recruitment was being undertaken.

Although the manager and their predecessor had attempted to secure the same agency and bank staff, some relatives told us they considered this to have had a detrimental effect on their family member's well-being. When we spoke to the manager about this they agreed any changes could have an effect on the people who used the service, but had done their best to ensure the same bank and agency staff were used in an attempt to provide as much continuity as possible during the recruitment and induction process.

The manager showed us the staff rota described how staff were allocated for each shift, dependent on people's individual needs. They confirmed that should needs change, or any new admissions were made to

the service staffing levels would be reviewed further. We spoke with staff who confirmed additional staff was provided when required. They told us there had been a need to use agency and bank staff, but the vacant posts had been recruited to and they felt, 'things were getting back to normal.' The manager explained that although funding had been recently reviewed, risk assessments had been completed following this and additional staffing levels were being funded by the registered provider, to ensure people's safety was maintained.

We checked the recruitment files for four staff members. The manager described the staff recruitment process, which consisted of shortlisting from application forms, checking gaps in employment, selection by interview process, obtaining references and completing staffing checks with the disclosure and barring service (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.

During our inspection we found improvements needed to be made to ensure individual 'pro re nata' (PRN when necessary) protocols for pain relief needed to be reviewed and include the dosage of the medicine that had been prescribed. Individual protocols that described people's preferred way to take their medicine also needed to be updated to reflect their current needs. However, we found people received their medicines as required and this was a recording issue.

We found that individual protocols for prescribed 'when required' medicines for pain relief did not detail the dosage that could be given, should it be required. When we spoke with the manager about this they took immediate action to rectify this to ensure that each individual protocol had the correct dosage detailed within the documents. We also found that when topical creams had been opened, the date had not been recorded, so we were unable to ensure the creams were still within their shelf life. The manager offered us assurances that the creams would be replaced and this would be addressed with staff that had responsibility for medication.

We saw medicines were checked in and out of the building as required. Medicines were kept securely and stored appropriately.

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 developed 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.

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, "If we have any concerns in relation to what might be a safeguarding issue, we would report them absolutely." and "We would contact our manager straight away or if they were on leave, they always leave us details of who is covering for them so we would contact them." Another told us, "It is our responsibility is to safeguard clients and if we suspect anything we should ensure it is referred to other agencies immediately."

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.

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. We saw records which showed emergency lighting, fire safety equipment and fire alarms were tested periodically.

During our inspection we met with the estates manager who was in the process of completing an audit when we arrived at the service. The manager explained that when they had started at the service two weeks earlier, one of the first tasks they had completed was an audit of the environment. The estates manager had followed this up and was identifying tasks to be completed on a priority basis. He explained that a full refurbishment of the properties had been planned for April 2017 and this included replacement kitchens.

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.

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 risks and how this would be managed. These included examples of road safety, travelling in a car, going out into the community and activities such as cycling and supporting with cleaning their rooms.

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 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.

Good

Is the service effective?

Our findings

Relatives we spoke with told us, "The staff are very patient." and "The core staff are very skilled and can pre-empt their needs very well, but I'm not so sure about some of the agency staff." Another told us, "The staff support them very well in my opinion and have the skills to do their job well." and "She is very happy, I can't fault them."

The staff we spoke with understood people's preferred routines and the way they liked their care and support to be delivered. Staff described in detail how they supported people in line with their assessed needs and their preferences. We saw staff communicated with people effectively and used different ways of enhancing communication. For example offering people objects to choose from and confirming their choice with them. This approach enabled staff to create meaningful interactions with the people they were supporting.

Care records contained clear guidance for staff on how to support people with their communication and how to engage with this. This supported people to make day to day choices relating to how they wanted to spend their time, activities, meals and about their care and support. One relative we spoke with commented that an agency or bank staff had told them they were unable to understand their family member's verbal communication.
This was discussed with the manager who told us they were in the process of addressing this and had booked additional communication skills training with the Speech and Language team. Staff we spoke with were aware of this and confirmed they had been booked onto the training.

We saw people's nutritional needs were assessed and kept under review and there was a good range of food and drink supplies within the service. Staff confirmed that menus were planned in consultation with people who used the service where possible. Where people were unable to inform staff verbally of their preferences we saw the staff would show people different options to choose from or sign with them in order to establish their wishes.

Staff we spoke with had a good understanding of people's preferences for food and their individual dietary requirements. They gave examples of people's routines around their preferences for food and told us, "We have recently revised the menu's following a change in one person's needs. Their dietary needs were reassessed following an admission to hospital. They now have their meat blended and a fork mash able diet (soft foods that can be mashed with a fork). We always make sure it is well presented though. I would give anybody anything I wouldn't be prepared to eat myself."

During the inspection, we observed a mealtime and saw that people had a choice of where they wanted to take their meal and what they would like to eat. We saw people were supported during the lunchtime experience and staff chatted with them throughout, ensuring they were enjoying their food, whilst offering prompts and encouragement to another person to eat more slowly. This was in line with recommendations made by the Speech and Language team (SALT) and documented within their individual support plan.

People who used the service were supported to maintain good health and had access to health check services for routine checks, advice and treatment. Staff we spoke with told us they supported people who used the service to see their GP when they were unwell and attend appointments with other professionals when this was required such as; dentists, opticians, chiropodists and members of the community learning disability team. Care records seen showed people's health needs were planned, monitored and their changing health needs responded to quickly.

We saw people who used the service had health action plans in place that gave an overview of people's health needs, how they communicated their needs and identified areas of support the individual required with this. This document described what actions professionals and others needed to take to help and support the individual in their approach and what was not helpful to them.

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. 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The previous registered managers had acted appropriately and assessed each of the seven people who used the service as meeting the criteria for DoLS. They had made applications to the local authority for DoLS, The manager showed us emails they had submitted to the local authority to enquire if there had been any further progress with the applications. They told us they would continue to follow these up.

Staff we spoke with they told us they had completed training in the MCA and were aware of the legislation. They were able to provide examples and demonstrate their understanding clearly and how they would apply this in practice. An example was given about a situation where a person used a lap belt while out in their wheelchair and was unable to consent to this, so a best interests meeting had been held with all involved professionals in order to discuss this further.

We looked at staff training records and saw staff had access to a range of training the registered provider considered to be essential and service specific. This included equality and diversity, MCA and DoLS, autism awareness, MAPPA (management of actual or potential aggression), medication, epilepsy, food hygiene and infection control. Staff were also either working towards or had completed an NVQ (National Vocational Qualification in Health and Social Care).

The staff we spoke with confirmed they attended both face to face and e-learning to maintain their skills. Staff we spoke with told us they felt they had adequate training and could request additional training through both the supervision and appraisal systems in place. They told us they were supported through regular supervision, which were used to discuss a number of topics including changes in practice, changes in people's needs, care plans, rotas and training. They told us, "I have never had any issues in accessing any training that I felt I have needed. We also get the opportunity to go on other training if we have a particular interest. For example, I have recently asked to attend the bowel massage training and now have a place booked on the course."

Staff and the manager told us, that after their appointment, all new staff completed a week of induction which covered essential training including; medication, safeguarding and care planning. They then had a period of shadowing experienced staff in the service. Following this they completed a work based induction

booklet during the next three months. Specialist training was also made available to them during this time including epilepsy and autism.

Bedrooms were personalised and reflected people's personalities and interests. The registered manager and staff told us how refurbishment work had been planned to update and replace kitchens in each of the bungalows and further redecoration.

Good

Is the service caring?

Our findings

Relatives told us they considered their family member was well cared for by staff. Comments included, "I have nothing but praise for them", "They are kind and patient" and "I have always been happy with the carers and care delivery."

We saw people who used the service were well cared for and wore clothing that was in keeping with their own preferences and age group. Staff told us people were supported to make their own purchases of clothing and toiletries. We observed staff made sure people's dignity was maintained during provision of their personal support.

During the inspection, we used the SOFI tool which allows us to spend time observing what is happening in the service and helps us to record how people spend their time, the type of support received and if they had positive experiences. We observed staff interacted positively and sensitively towards people who used the service. People who used the service were observed going out of the service to engage in different activities including going out for lunch and to do some shopping.

People were seen to approach staff with confidence; they indicated when they wanted their company, for example when one person who used the service heard the voice of a staff member they liked coming into the service they greeted them excitedly and the staff member responded to them in a kind and friendly way, asking them how they were. We observed staff engage people constantly in conversations using their preferred method of communication.

They also encouraged and motivated people to be involved in tasks they were completing within the service and suggested things they may be interested in for example, whether they would like to go to a local social club after tea to meet up with their friends. Staff were seen to respond quickly to requests from people who used the service. The atmosphere was calm and relaxed and people responded confidently to the communication with staff.

Staff told us they viewed the service as the home of the people who lived there and respected their privacy, always knocking on doors and waiting to be asked to enter. During our observations, we saw people were always asked for their consent before any care tasks were undertaken.

Staff described to us the importance of maintaining family relationships and how they supported and enabled this, for example, supporting people with home visits and to purchase gifts and cards for special occasions. Relatives spoken with confirmed this process to be in place. We saw that arrangements were in place for those people who needed to access advocacy service. One person who used the service had a named advocate.

We saw evidence in people's care files that demonstrated a personalised approach was taken to meet their individual needs. We found this included details about people's personal likes and wishes, together with details about how their independence should be promoted. Relatives confirmed staff consulted them and

involved them in making decisions about their family members support and consideration was shown by staff for people's individual preferences. This included the use of one page profiles, information to help staff understand their individual needs and help people be supported in their preferred way.

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, I am really happy with that side." and "They always keep in touch and let us know what they are involved in or if there are any changes." Another told us, "They are very good with communication and keeping us up to date, they do listen."

Relatives told us they felt able to raise concerns. Comments included, "I have no complaints whatsoever, I would go to whoever is in charge should the need ever arise." And "I am aware of whom to liaise with should I need to, but have never had the need."

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 were seen to have been carried out to identify people's support needs and care plans had been developed following this, outlining how these needs were to be met.

We saw assessments had been carried out to identify the person's level of risk. These included identified health needs, nutrition, accessing the kitchen, choking, changing behaviours and going out in the community. Where risks had been identified, risk assessments had been completed and contained detailed information for staff on how the risk could be reduced or minimised. We saw risk assessments were reviewed monthly and updated to reflect changes in people's needs when required.

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 this situation in order to diffuse the situation. Shortly after our discussion we observed the same staff member support the person when they became anxious and saw the approach they had described to us offered reassurance to the person and reduced their anxieties.

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.

We looked at the care plans for two people who used the service and found these to be well organised, easy to follow and person centred. Sections of the care plans had been produced in an 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.

Details of what was important to people, such as their likes, dislikes and preferences were also recorded and included, for example, their preferred daily routines and what they enjoyed doing and how staff could support these in a positive way were available. We saw that when there had been changes to the person's

needs, these had been identified quickly.
We found that records for one person's food intake indicated items which were not compatible with the mealtime prescription and fork mash able textured diet (soft foods that can be mashed with a fork) advised by the SALT team. When we spoke with the manager they agreed this was not appropriate and investigated with the staff member responsible, to establish what had actually been offered. They were able to establish that the food had been offered in the appropriate texture but details had not been recorded to reflect the way the food had been presented.

The manager offered us assurances that further work would be done with staff to ensure accurate and detailed records were maintained and the importance of doing so.

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. They were also aware of recent changes in needs of individual's they supported. 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 and discussions with relatives confirmed this.

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. 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 and attending social clubs.

The registered provider had a complaints policy in place that was displayed within the service. The policy and procedure was available in an 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 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.

Requires Improvement

Is the service well-led?

Our findings

Relatives told us, "The staff do a fantastic job and are very caring." and "I know I can ring at any time and they will always make time for me." Others told us they had no issues with either of the two previous registered managers or the current manager, but had concerns about the lack of consistency and continuity the frequent changes in management may have on their family member and staff morale.

Following a review of funding by local Commissioners, changes needed to be made at short notice which at the time had a significant effect on the service. The registered provider had met with relatives to explain the situation, sent out newsletters and sought advice from solicitors in relation to people's rights. Although the registered provider had taken action to respond to the situation, some relatives felt their confidence had been knocked by the changes.

Staff told us the previous registered manager had been very supportive of them and that they had no doubts the new manager would be equally supportive. They went on to explain that they had met with the staff team to introduce themselves and ask for their views on where the service needed to be taken forward. The manager had also discussed with them the vacancies the service had been carrying and where they were with recruitments and appointments. Although the manager had only been at the service for two weeks staff expressed they felt that things were getting back on track following a period of instability.

At the time of our inspection there was no registered manager for the service, which is a condition of the service's registration. A new manager had been in post for approximately two weeks and they had only begun the initial stage of application to become the registered manager for the service. When a service does not have a registered manager in place the rating in well led cannot be rated any more than 'requires improvement.'
The registered provider's auditing system covered all aspects of the service including accidents and incidents, recruitment, environment, medication and care planning.

Quality assurance checklists were used to ensure cleanliness and general maintenance of the service. However, the audits failed to identify the shortfalls in individual medicine protocols not being fully completed or kept up to date in line with changes of need. The manager had addressed the shortfalls during the inspection as soon as they were identified and provided assurances that further action would be taken to prevent any further reoccurrences.

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.

There was a survey in place in pictorial format that was completed with people who used the service. Staff had completed the survey with or on behalf of the people who used the service. There was no alternative

means applied to gain people's views.

For example the majority of people who used the service were unable to express their views verbally about the service they were receiving. An observation over an extended period and a record of the results, to demonstrate people's experience of life in the service may be more appropriate.

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, overall action plans had been developed and compliance dates achieved. 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.

Although the manager had only been at the service for two weeks we observed people who used the service were comfortable in the manager's presence and although they did not always approach them directly, they engaged with them confidently when they were approached. During our inspection we observed the manager took time to speak with the people who used the service and staff and assisted with care duties.

The manager told us they were supported by senior managers within the organisation and a board of trustees. 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.

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 organisation was also working through the process to become accredited with the national autistic society, Autism accreditation is an internationally recognised quality standard provided by The National Autistic Society.

When we spoke with the registered manager about their management style they told us, "I consider myself to be fair, but will work to policy. If I observe poor practice I will always address it there and then. Anything that I consider that needs improving, I will bring up in meetings and ensure staff understand the importance of things being done correctly. I like to develop staff in their roles and support them to use their skills. There are lovely clients and staff here, we just need to build up the team and develop the service. I have every confidence that we will."

Staff told us they attended meetings where the manager would inform them of any changes to policies and procedures and to share new guidance on best practice. Staff meetings were held on a minimum of a

monthly basis and records of these were maintained.

We found the 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.