Autism Wessex

Community Wessex - East

Inspection report

Parley One,
Portfield School, Parley Lane
Christchurch
Dorset
BH23 6BP

Tel: 01202853000
Website: www.autismwessex.org.uk

Date of inspection visit:
03 July 2017
05 July 2017

Date of publication:
25 August 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?	Good

Summary of findings

Overall summary

The inspection took place on 3 July and was announced. The inspection continued on 5 July and was again announced.

Community Wessex - East delivers domiciliary personal care to people with learning disabilities, and autism. Personal care was provided to 30 people who lived in their own homes. There was a central office base which had a reception area, four offices and a training room.

The service had a registered manager in place. 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's review meetings and quality monitoring systems were not set up to capture people's feedback, views and opinions based on their progress in achieving goals and experience of the quality of care they received. We were told that these systems would be reviewed to capture actions, outcomes and feedback.

Medicines were managed safely, in people's homes, correctly recorded and only administered by staff that were trained to give medicines. Medicine Administration Records reviewed showed no gaps. However, we found that medicine cabinets were not secured to the walls. This was rectified on day two of our inspection.

Relatives, health and social care professionals and staff told us that the service was safe. Staff were able to tell us how they would report and recognise signs of abuse and had received safeguarding training.

Personalised care plans were in place which detailed the care and support people needed to remain safe whilst having control and making choices about how they chose to live their lives. Each person had a care file which also included outcomes and guidelines to make sure staff supported people in a way they preferred. Risk assessments were completed, regularly reviewed and up to date.

Staff had a good knowledge of people's support needs and received regular mandatory training as well as training specific to their roles for example, autism and epilepsy.

Staff were aware of the Mental Capacity Act and training records showed that they had received training in this. People's records contained assessments of their capacity. Where decisions had been made in people's best interests around their care and treatment these were being recorded fully. This made sure that any decisions made were in people's best interests and were least restrictive as possible.

Staff told us they received regular supervisions which were carried out by management. We reviewed records which confirmed this. A staff member told us, "I receive regular supervisions and find them useful".

People were supported with shopping, cooking and preparation of meals in their home. Menus were created based on people's likes and reflected a good variety of meals to maintain healthy diets.

People were supported to access healthcare appointments as and when required and staff followed GP and community nurses' advice when supporting people with ongoing care needs.

Relatives and health and social care professionals told us that staff were caring. During home visits we observed positive interactions between staff and people. This showed us that people felt comfortable with staff supporting them.

Staff treated people in a dignified manner. Staff had a good understanding of people's likes, dislikes, interests and communication needs. Information was available in various easy read and pictorial formats. This meant that people were supported by staff who knew them well.

People had their care and support needs assessed before using the service and care packages reflected needs identified in these. We saw that plans were regularly reviewed by the service with people (where possible), families and health professionals when available.

People, staff and relatives were encouraged to feedback. We reviewed the findings from quality feedback questionnaires which had been sent to people and noted that it contained mostly positive feedback. However feedback surveys had only been created in a text format. We were told that these would be reviewed so that people with specific communication needs could be more included in these.

There was an active system in place for recording complaints which captured the detail and evidenced steps taken to address them. We saw that there were no outstanding complaints in place. This demonstrated that the service was open to people's comments and acted promptly when concerns were raised.

Staff had a good understanding of their roles and responsibilities. Information was shared with staff so that they had a good understanding of what was expected from them.

Relatives, health and social care professionals and staff felt that the service was well led. The management team and chief executive officer encouraged an open working environment. People and staff alike were valued and worked within an organisation which ensured a positive culture was well established and inclusive. All the deputy managers had good relationships with people and delivered support hours to them.

The service understood its reporting responsibilities to CQC and other regulatory bodies and provided information in a timely way.

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 mostly safe. Medicines were managed safely, correctly recorded and only administered by staff that were trained to give medicines.

There were sufficient staff available to meet people's assessed care and support needs.

People were at a reduced risk of harm because staff had completed safeguarding adults training and were able to tell us how they would recognise and report abuse.

People were at a reduced risk of harm because risk assessments were in place, reviewed and up to date.

Is the service effective?

Good

The service was effective.

People's choices were respected and staff understood the requirements of the Mental Capacity Act 2005. People's capacity was assessed and best interest decisions recorded.

Staff received training, supervision and appraisals to give them the skills and support to carry out their roles.

Staff supported people to maintain healthy balanced diets and dietary needs were assessed where appropriate.

People were supported to access health care services and local learning disability teams.

Is the service caring?

Good

The service was caring. People were supported by staff that spent time with and knew them well.

People were supported by staff that used person centred approaches to deliver the care and support they provide.

Staff had a good understanding of the people they cared for and supported them in decisions about how they liked to live their lives.

People were supported by staff who respected their privacy and dignity.

Is the service responsive?

Good

The service was responsive. Care file's, guidelines and risk assessments were up to date and regularly reviewed. However, people's feedback was not always recorded.

People were supported by staff that recognised and responded to their changing needs.

People were supported to access the community and take part in activities which were linked with their own interests and hobbies.

A complaints procedure was in place which included an accessible easy read version.

Is the service well-led?

Good

The service was mainly well led. Regular quality audits and service checks were carried out to make sure the service was safe. However, these did not always capture actions, learning or feedback from people.

The management all promoted and encouraged an open working environment by including people and recognising staff achievement.

The management were flexible and delivered support hours as and when necessary which in turn gained respect from people and staff.

Community Wessex - East

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 3 July and was announced. The inspection continued on 5 July 2017. The provider was given 48 hours' notice. This is so that we could be sure the manager or senior person in charge was available when we visited and that home visits could be arranged. The inspection was carried out by a single inspector.

Before the inspection we looked at notifications we had received about the service. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We spoke with the local authority quality improvement team to get information on their experience of the service.

We had not submitted a Provider Information Return (PIR) to the service. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We collected this information as part of the inspection.

We visited three people in their own homes and observed one person being supported to attend swimming. We observed care being delivered to these people who were all non-verbal. After the inspection we had phone call conversations with two health and social care professionals and two relatives.

We spoke with four deputy managers, the systems manager and chief executive officer. We met with five staff. We reviewed four people's care files, policies, risk assessments, quality audits and the 2016 quality survey results. We observed staff interactions with people. We looked at four staff files, the recruitment process, staff meeting notes, training, supervision and appraisal records.

Good

Is the service safe?

Our findings

Health and social care professionals, relatives and staff told us that they felt the service was safe. A professional told us, "The service is safe. There are proactive risk assessments in place and staff understand these". A relative said, "My loved one is safe. Staff know them well, follow assessments and guidelines and understand (names) needs". A staff member told us, "It's defiantly a safe service. There is a safeguarding policy in place, we are well trained and follow care plans and risk assessments". Another staff member said, "People are safe. Staff deliver the support hours required and all risks are assessed".

People were protected from avoidable harm. Staff were able to tell us how they would recognise signs of potential abuse and who they would report it to. Staff told us they had received safeguarding training. We reviewed the training records which confirmed this. A staff member said, "Changes in personality, mood and behaviour may be signs as would unexplained marks. I would report any concerns to my line manager, the safeguarding team, police and CQC if I had to". We reviewed the local safeguarding policy which was up to date, comprehensive and included a pictorial easy read version for people who required information in this format. We also reviewed the local whistleblowing policy. This reflected a clear purpose which was to encourage and promote all employees to raise concerns and detailed a process in which to do this.

We reviewed four people's care files which identified people's individual risks and detailed steps staff needed to follow to ensure risks were managed and people were kept safe. We found that one person was at risk when travelling in the car. Steps in place included monitoring behaviour and sitting the person away from the driver. Staff were able to tell us what risks were associated to which people and where to find people's individual risk assessments. This demonstrated that the service ensured safety systems were in place to minimise and manage risks to people.

People had Personal Emergency Evacuation Plans which were up to date. These plans detailed how people should be supported in the event of a fire. There were social stories in place for people who used pictures to communicate. These explained to the person what to do in the event of a fire. We found that one location hadn't been regularly completing regular fire tests or recording them. A staff member told us, "Fire alarms do get tested but I am not sure if they are logged". A deputy manager told us that they would address this promptly.

We were informed by the operations manager that there was a large recruitment drive taking place to recruit new staff. We were told that all support hours were covered and that vacant shifts were covered by relief staff to maintain consistency. A family member told us, "I think there are enough staff. My loved one always has two staff". A health and social care professional said, "There are sufficient staff. (name) has very specific needs and has their own core staff team who all know them very well. This maintains consistency". A staff member told us, "There are enough staff in general. We use relief staff who know (name) to keep consistency". Another staff member said, "There have been a few new recruits. There are gaps in the rota that get filled by either relief, agency staff or permanent staff doing over time. Shifts are always covered and people are never at risk". A deputy manager told us, "During recruitment we ask new staff to complete a one page profile on themselves. We look at the staff member's skills, likes and interests. We then use this

information to best match staff to people". This showed us that the service used creative systems to ensure suitable staff were supporting people and meeting their required needs.

We were told that each staff member had two recruitment folders. One of which was located at the service and another that was located at head office. Files in head office held application, interview and pre-employment check details. The head office submitted to us staff's Disclosure and Barring service (DBS) check numbers. We noted that staff had lone working risk assessments completed.

Medicines were mainly administered safely. However, during the home visits we noted that medicine cabinets were not attached to the walls in people's homes. We raised this with the management at the end of day one. On day two of the inspection we were told that this had been rectified and that all other homes were being checked in light of this. Medicines were signed as given on the Medicine Administration Records (MAR) and were absent from there pharmacy packaging which indicated they had been given as prescribed. We reviewed the last three weeks of MAR sheets in one location which were completed correctly and showed no gaps. Staff were required to complete medication training as well as undergo a competency test by management before administering medicines. There was a comprehensive up to date medicines policy in place which staff were aware of and told us they had read.

Good

Is the service effective?

Our findings

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.

Some of the people receiving support from Community Wessex - East were living with a learning disability and autism, which affected their ability to make some decisions about their care and support. Staff showed a good understanding of the Mental Capacity Act 2005 (MCA) and their role in maintaining people's rights to make their own decisions. During the inspection, we observed staff putting their training into practice by offering people choices and respecting their decisions. Staff told us how they supported people to make decisions about their care and support.

We found that mental capacity assessments were completed and best interest decisions recorded appropriately. A health and social care professional told us, "I am involved in best interest decisions along with the service and people's social workers". We were told about a person who required medical treatment in hospital. A full capacity assessment had been completed and appropriate parties were involved in the best interest decision. We were told that staff had put together a social story for this person. This had been made up of photos explaining the event and treatment. This effective approach had a positive impact on the person by reducing their anxiety.

People were supported by staff that were knowledgeable about their needs and had the skills to support them. Newly appointed staff undertook a comprehensive induction, which followed the Skills for Care, Care Certificate framework. The Care Certificate is an identified set of standards used by the care industry to help ensure care workers provide compassionate, safe and high quality care and support. Following the induction staff shadowed more experienced staff and did not work alone until management were confident they had the right skills to carry out their role. A staff member who was new to care told us, "I am currently doing my induction. I am shadowing today. The first week was made up of e-learning, safeguarding and shadowing staff with people who are either 1:1 or 2:1 staffing. I'm getting to know people's needs. I'm going through files. The guidelines in place are helpful and staff have been really good". Other staff said that inductions gave them confidence in their ability to meet people's needs because they too felt supported. There was a strong emphasis within the organisation on training. A staff member told us, "We receive a lot of training. Recent training has been sign-a-long which has helped us communicate better with people whilst developing their communication skills". This was a good example of how the staff member had put their training into practice. We were told staff could request further training and that some staff were currently completing their level 3 diplomas in health and social care. Records showed staff received regular training in topics the provider considered essential which included safeguarding, medicine awareness, first aid, infection control, moving and handling, food hygiene, intervention. In addition these, staff received specific training in relation to the needs of the people they were working with. This included learning disability, autism and epilepsy.

We reviewed staff files which evidenced that regular supervisions took place and were carried out by management. We noted that three of the four staff files showed that appraisals were outstanding. The deputy managers told us that they were in the process of arranging dates with staff. Staff said that they found supervisions very useful and confirmed that they took place regularly.

People's dietary needs were assessed and where appropriate plans put in place. Staff were aware of any risks and had read guidelines where necessary. People receiving personal care were supported with shopping, cooking and preparation of meals in their homes. A staff member said, "(Name) is involved in the food shop. They can choose their own things like; pasta sauces, vegetables, pasta, fruit, drink and biscuits". We found that menu plans were in place but were told that they were mainly suggestions and that menus could be flexible with alternatives always available. One staff member said, "(Names) menu is being reviewed next week by (name), the keyworker and the deputy manager". We reviewed menu plans in other locations and saw that they were balanced with a variety of nutritious options. We also noted that there were options to eat out on some of the days. During one visit we were told that a person had just come home from having lunch out in a restaurant.

People were supported to maintain good health and have access to healthcare services. We found that health visits were recorded in people's care files and noted that recent appointments included; Community nurses and GP's. One health care professional told us, "The service is always proactive when working with professionals".

Good

Is the service caring?

Our findings

Staff spoke about people in an affectionate way with kindness and compassion. Staff knew how each person liked to be addressed and consistently used people's preferred names when speaking with them. It was clear people had developed good relationships with the staff that supported them. People were relaxed and happy in staffs' presence and it was apparent that staff knew people well. During home visits we observed some smiles, laughter, and affection between people and the staff supporting them. A relative told us, "The staff are very caring of my loved one. They respect (name)". A health professional said, "Staff are very caring. They know people very well. I often see caring, meaningful interactions".

A staff member said, "I think I am caring. I've always enjoyed caring. I am calm, patient and a good listener". Staff told us there was generally good team morale and that the team worked well together. Staff told us that their colleagues were also caring.

Community Wessex - East used a 'My Support Team' document which identified people's skills, interests, hobbies, personalities and characterisms staff working with them needed to have. For example one person required support from male staff that were fun, motivating and would treat them equally. The male staff needed to like swimming, walks and going out. They had to be enthusiastic, respectful and be able to communicate clear simple information. This meant that people always had areas of common ground which in turn maintained positive caring relationships.

We saw that there were clear personal care guidelines in place for staff to follow which ensured that care delivered was consistent and respected people's preferences. The care files included person centred care plans with pen profiles of people, recorded important people involved in their care, goals, outcomes, how to support them, people's likes and dislikes and medical conditions.

Some people who used the service were non verbal. We found that staff used a number of different methods to communicate with people these included; a picture exchange communication system (PECS), signs, objects and mood boards. We saw that people used these methods of communication to make choices and decisions for example food, activities, mood and the environment. We were told that one person had recently chosen to paint their room blue. The staff member said, "We took them to the shop to choose the colour and (name) helped paint some walls". A health and social care professional told us, "They (staff) use choice boards with people. Staff actively use these to promote choice".

People's privacy and dignity was respected by staff. Staff we observed during home visits were polite and treated people in a dignified manner throughout the course of our visit. We asked staff how they respected people's privacy and dignity. One staff member said, "I close doors, close curtains. I keep people informed of what I am doing".

Good

Is the service responsive?

Our findings

Community Wessex - East was responsive to people and their changing needs. Throughout the inspection we observed a very positive and inclusive culture at the service. Promoting independence, involving people and using creative approaches appeared to be embedded and normal practice for the staff. We saw that people received regular reviews. A health and social care professional said, "We have only just recently reviewed one person's plans. We are always involved in review meetings". However, we found that people's feedback, views and experiences were not always captured or discussed in meetings. We discussed this with a deputy manager who told us that they would develop new systems to capture feedback from people as part of care reviews and quality monitoring.

A health professional gave us an example of how the service had been responsive to a person's changing needs during health care treatment. We were told that the service had provided an extra staff member to support the person to hospital appointments. A relative told us, "I have always found them to be responsive to (name's) changing needs. The service informs me of changes and are in regular contact with us". A health and social care professional said, "Staff follow care plans, risk assessments and behaviour support plans. They are always responsive to people's changing needs". A staff member told us, "Since (name) has moved in they are more independent. They can now toilet independently, do not regurgitate food, shred clothing and they have developed in daily living skills (DLS)".

Community Wessex - East used personalised paperwork to capture how people wanted their care and support to be delivered and how goals and outcomes could be captured and broken down in achievable steps. We read that one person who was non-verbal had outcomes such as closing and locking their own front door. We read that steps included, having their own door key and staff prompts. A staff member told us, "It's definitely person centred. Activities on (names) planner are all things they like doing. This has been done with (name); we have observed them and noted what they enjoy". Another staff member said, "its 100% person centred. Everything we do is around people and their needs, likes and interests". A health professional said, "Care delivered is very person centred. Staff know people well which helps".

People were supported to develop and maintain independence through daily living skills(DLS). A staff member told us, "(name) has DLS today. We gave them choices of what to do like, wash up or laundry. They chose laundry". We observed the person being actively supported to make their bed after washing their bedding.

Some people presented behaviour which challenged staff and the service. We found that positive behaviour support plans were in place and up to date. These plans gave staff clear guidelines on approaches to use if people displayed behaviours which may challenge the service. Behaviour (ABC) charts were completed by staff; these detailed what happened before an event, during an event and what preventative actions were taken. These were then monitored by the management and analysed. We found that Community Wessex - East had good working relations with the local learning disability teams and came together with them, and family in response to new trends occurring and/or a set review. However, a health and social care

professional told us that the collation and analysis of behaviour charts could be improved and that they had shared this with the deputy manager.

People were supported to attend and take part in activities of their choice. We found that care files held details and information about peoples, likes, interests and hobbies and that activities were recorded by staff. Each person had an activity timetable and were often supported in the community by staff. We observed one person being supported to go swimming. We were told that they had chosen to swim alone today and saw that the staff were on the pool side ready to support when required. A staff member told us, "We took (name) on holiday to the Isle of Wight last month. To do this we had a planning meeting with their family and the registered manager. It was a real success and (name) loved it". A relative said, "It is great that (name) is now part of the community and getting out more. They are so much more relaxed and happier".

The service had a complaints system in place which captured complaints and reflected the steps taken to resolve them. A deputy manager told us, "Complaints aren't a bad thing. I'd welcome them. It's good to gather feedback. They are a learning opportunity". There was a comprehensive complaints policy in place for staff and a visual easy read version for people. Both versions had contact details of both internal and external agencies including the local authority, CQC and the ombudsman. Staff, relatives and health and social care professionals we spoke to told us that they would feel able to raise complaints with staff or the management. We noted the most recent complaint involved a staff member falling asleep during a waking night shift. This had been fully recorded, a safeguarding had been raised with the local triage team and the matter had been discussed with the staff member in a recorded supervision. This demonstrated that the service welcomed complaints, took them seriously and acted upon them proactively. There were no open complaints at the time of this inspection.

People and relatives were given the opportunity to feedback through an annual quality survey. We read the results of the 2016 surveys and found that the feedback was mainly positive. We noted that one person had written in response to quality of life improvements; "Yes because I have been given the opportunity to make my own choices, try new things, learn and help make me more independent". We found that the questionnaires for people were very wordy and that there was not an easy read version. We discussed this with the deputy managers and chief executive officer who said that they would review these and ensure that they looked at ways of seeking feedback from people less able to read, write and feedback verbally. A deputy manager agreed to lead on this area with the chief executive officer.

Good

Is the service well-led?

Our findings

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager was not available during the inspection due to annual leave. In their absence the deputy managers facilitated the inspection with the operations manager and the nominated individual (chief executive officer). A Nominated Individual has the responsibility for supervising the way that regulated activities are managed within an organisation.

We saw that Community Wessex - East carried out quality monitoring across all of the services regularly. Some audits were completed by keyworkers and covered areas such as medicines, environment, daily notes and finance. We found that the recording logs used symbol codes to identify whether there were shortfalls or areas which required follow up. However, these forms did not log actions, outcomes or learning. The deputy manager told us that last week they had been informed of a staff member not completing daily notes. They explained their corrective actions to us but hadn't recorded it on the audit. The deputy manager told us audit and monitoring forms would be reviewed and that they understood capturing this information was important. In addition to audits service monitoring visits were carried out by deputy managers. The service monitoring included, paperwork, first aid, health appointment checks. However, seeking people's feedback did not form part of the services quality monitoring systems. We were told that service monitoring visits would also be reviewed and that people's feedback would be sought. Staff competencies were also completed by management on staff to ensure they remained competent in their roles.

We were told that there had recently been a number of management changes recently and that two new deputy managers had been recruited. One of the new deputies told us, "I have found my induction good. I spent two days with the registered manager, half a day with the operations manager and I shadowed an experienced deputy manager during my first two weeks. I have managed to attend two meetings with social workers and community nurses and started to arrange meetings with people and supervisions with staff". They went onto tell us that they had arranged a barbeque at a person's house as a way to bring people together and get to know people and staff in a less formal setting. Another new deputy manager told us, "I have tried to meet as many people as possible to get to know them and I am in the process of arranging staff meetings".

The registered manager, deputies and provider promoted the ethos of honesty, learnt from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment. For example, a relative said, "The management are very good. There have been a number of management changes but we have had continuity of care management and this had not had a negative impact on our loved one". They went onto tell us that the service had been open and transparent about the changes.

We found that deputy manager's management meetings took place regularly. We noted that one took place in November 2016, April and June 2017. There was one booked for July 2017. A deputy manager told us, "Management meetings are more regular now we have a full team of deputies. They are useful and important. They are an opportunity to share ideas, opinions, views and listen. They are chaired well with an agenda, there's a good structure".

During the inspection we found there to be an empowering culture embedded within Community Wessex - East and that the service was well led. One relative said, "I would have to rate them 10/10. They have given us everything we want for our loved one". A health and social care professional told us, "The deputy I work with is very good. They are approachable and come across professional". A staff member said, "My line manager is very good and always available. They also provide support hours which I think is good because it makes sure they know the service and people". Another staff member told us, "The registered manager is nice. My line manager is approachable and easily contactable. I think they lead us well and set good examples". A deputy manager said, "The registered manager is very supportive. I receive regular supervisions with them; they are always available and very open". Another deputy manager told us, "There is such a positive and inclusive culture here. The registered manager listens and always asks for deputy managers and staff input. This is really good so we can all participate. The registered manager has a lot of experience and knowledge. If I am stuck they are always there to offer advice". This told us that people and staff alike were valued and worked within an organisation which ensured a positive culture was well established and inclusive.

We found that the management team and nominated individual all had very good knowledge and were open to learning and further developing the service. They were all responsive throughout the inspection and supported us with questions we had and gathering the evidence we required.

The registered manager had notified the Care Quality Commission of significant events, which had occurred in line with their legal responsibilities. The management team and director were aware of their responsibilities under the Health and Social Care Act 2008, Duty of Candour, that is, their duty to be honest and open about any accident or incident that had caused, or placed a person at risk of harm.