Homes Caring For Autism Limited

Grange Court

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This was the first inspection for Grange Court since the service was registered with us. The inspection took place on 23 and 24 September 2015 and was unannounced. The people living at the home were on the autistic spectrum. At the time of the inspection there were three people living permanently in the home and another person involved in the admissions process. Not all the people living at Grange Court were verbally able to give us their feedback on their experiences of the care and treatment delivered by the staff. A member of staff during the introduction to the inspection advised us that two people at the home were not able to express their experience of the service. They said one person was able to give feedback with support.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Summary of findings

People were not always protected from inappropriate care and treatment as records were not always accurate or up to date.

People were placed at risk of potential harm. Risk assessments and strategies were not up to date or reviewed following aggressive and physically challenging incidents. This meant the management of behaviours was not assessed to ensure staff consistently managed aggression and physically challenging incidents. Reports of incidents and accidents were developed following an event and or analysed to identify patterns and trends.

Care plans were not updated and for some people the plans related to their previous placement. Care plans did not detail the strategies used to encourage people to participate in activities.

People were placed at risk from staff who were not able to manage high levels of physically challenging and aggressive incidents. A member of staff said that at the PBM training they were taught about personal space but not how to protect themselves when they were physically attacked or when protective personal equipment was removed. This meant staff were not following guidance because they became anxious of people becoming aggressive or physically challenging.

People were not having their prescribed “when required” medicines administered consistently. Protocols which gave staff direction and guidance on when to administer these medicines were not in place.

One person said they felt safe and they would tell staff if they were not happy. Members of staff knew the signs of abuse and the expectations placed on them to report their suspicions of abuse.

People were supported by sufficient numbers of staff. Rotas were arranged for people to have the appropriate level of support. For some people three staff were appointed to support them throughout the day. People had their care and treatment delivered by a core team of staff that knew their preferences, their likes and their dislikes. Staff were working to improve the range of community activities some people could experience. One person was able to give us some feedback. They told us the activities they did and the staff who supported them with these activities.

Arrangements were in place for people to maintain contact with relatives and friends. For example, review meetings, weekly updates, newsletters and forums

Quality assurance arrangements were in place to monitor the standards of care. Action plans were developed where standards were not fully met. People’s views were sought through surveys and during care plan review.

Staff said morale was good since structures were strengthened and the area manager was appointed. The manager told us of the learning that happened and about the improvements needed to develop standards and systems.

We made recommendations for the service to seek advice and guidance from a reputable source, about motivators and rewards.

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

Summary of findings

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 safe.

People were not having their medicines administered consistently and when needed. Protocols for medicines prescribed to be taken when required medicines were not developed.

Risk assessments were not reviewed and incident reports were not analysed. Accident and incidents reports were not always analysed to determine if appropriate actions were taken following an event.

Sufficient numbers of staff were on duty to meet people's needs. People had up to 3:1 support during the day.

Safeguarding processes and procedures in place ensured staff were able to identify the signs of abuse and were clear on the expectations placed on them to report suspected abuse.

Is the service effective?

Requires improvement

The service was not fully effective.

People did not benefit from a consistent approach. Positive behaviour plans were not up to date and did not have appropriate guidance for staff to follow during episodes of aggression and physically challenging incidents. PBM training did not provide the staff with the skills needed to protect themselves when they were physically challenge.

Members of staff were not supported to undertake their roles and responsibilities. One to one discussions with their line managers were not taking place regularly.

The training provided ensured the staff had the appropriate skills and knowledge to meet people's needs.

People were supported to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

People received care and treatment that was personalised. Members of staff knew how people liked their care to be delivered.

Members of staff were supporting people to increase their independent living skills. For example, community activities.

People were helped to make decisions. Documented plans were used to ensure people had an understanding of what was happening “now,” “next” and “later”.

Summary of findings

Is the service responsive?

Requires improvement

The service was not fully responsive.

Care plans were not up to date and for some people the plan was from their previous placement. Motivators and rewards were used to encourage people to participate in a specific task or activity but were not person centred.

One person told us the they participated in community activities. Staff were working with people to help them with accessing community activities.

Is the service well-led?

Requires improvement

The service was not well led.

People were not always protected from inappropriate care and treatment as records were not up to date or accurate. For example, care plans, risk assessments and incidents and accident report.

Quality assurance arrangements were in place to monitor the standards of care. Action plans were developed where standards were not being fully met.

Working relationships between staff were good and the registered manager had identified areas for improving the standards of care.

Grange Court

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 23 and 24 September 2015 and was unannounced.

The inspection was completed by two inspectors. Before the inspection, we reviewed other information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

During the visit we spoke with one person who used the service, the registered manager, the area manager, five members of staff. We spent time observing the way staff interacted with people who use the service and looked at the records relating to support and decision making for three people. We also looked at records about the management of the service.

Requires improvement

Is the service safe?

Our findings

Risk management systems were in place. The registered manager said risk was assessed and the aim was to enable people to take risk safely. For example, planned activities. They said other risk assessments for health were in place. For example, for people with epilepsy. A member of staff said risks were assessed for people to participate in community activities, for access into the kitchen and for people who resisted personal care.

Incident and accident reports were not always analysed. Action plans were not monitored to ensure staff took appropriate action to lower risk or to prevent repeat reoccurrences. We looked at an incident report dated 9 September 2015 where the member of staff acknowledged not following the routine. However, the debriefing section of the incident report did not include the reasons for not following the routines. For another person the incident report the staff had documented the person was “testing boundaries”. The registered manager had recorded “debrief to follow". Need to review support guideline” However, a debrief did not take place and the support guidance was not reviewed. The registered manager said the reports were assessed on a case by case basis and mainly the incidents involved inexperienced staff. They said team leaders were to mentor staff with managing incidents of aggression.

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

Medicines were administered by staff trained according to the Homes Caring for Autism protocol. Medicines were administered by staff competent in medicine management. Staff signed the Medicine Administration Records (MAR) charts following the administration of medicines.

Some people were prescribed with medicines to be taken “when required”. Protocols were not in place for medicines to be taken “when required” For example, medicines for pain relief and to reduce agitation. The protocols for some people did not include the purpose of the medicines. For example, one person was prescribed up to two puffs of their inhaler four times daily when required. The protocol did not tell staff the purpose of the medicine or when the person needed the inhaler.

Evacuation plans had the emergency contact details, fire safety and missing person’s procedures and risk assessments in the event of a “power cuts”. Personal Evacuation Plans (PEP) which provide information on the support needed to safely evacuate people from the premises in the event of an emergency were not in place. The manager said they were not up to date.

The safeguarding of vulnerable adults systems in place ensured people were protected from harm. A member of staff during the introduction to the inspection advised us that two people at the home were not able to express their experience of the service. They said one person was able to give feedback with support. We asked this person if they felt safe with the staff and their response was affirmative. Members of staff knew the signs of abuse and the expectation placed on them to report suspicions of abuse. Two safeguarding referrals were made and it was evident there was learning from these incidents. For example, staff received training.

Members of staff knew it was their duty to report poor practice they may witness from other staff. A member of staff said if they witnessed poor practice by other staff they would report it to their line manager. There was an expectation the manager took appropriate action by reporting the incident.

Staffing levels were arranged to meet people’s needs. People had the support appropriate to their needs. For example, three staff to one person throughout the day. The area manager said following feedback staffing rotas were to be arranged for people to have more opportunities to participate in evening activities within the community. A member of staff said where vacant hours existed staffing rotas were arranged to ensure the staff working in the home during the day knew people. There were occasions when agency staff were used at night only.

Vacant posts were advertised at Job Centres and on Open Days. Recruitment procedures ensured suitable staff were recruited. A member of staff said they had to complete an application form and there was a telephone interview followed by a face-to-face interview and a home visit day

Requires improvement

Is the service effective?

Our findings

Where people used aggression and physically challenging behaviour to communicate and assessed using the time intensity model (TIM). TIM described the possible triggers of aggression, the signs which show an escalation of difficult behaviours, how to identify the person was in crisis and the behaviours showing they were recovering.

Positive Behaviour Management (PBM) techniques were used by staff to manage difficult behaviours. For example, diffusion and distraction techniques. PBM reports were not always reviewed following incidents. The registered manager had recorded in an incident report dated 13 September 2015 “need to review support guidance.” However the PBM plan was dated 14 April 2015. This meant the plan was not reviewed.

Members of staff were not always following PBM guidance. Incident and discussions that occurred during our visit demonstrated staff had not followed guidance in place. .

We observed an incident were there was confusion about the staff’s safety. One person presented with high levels of challenging behaviour towards one member of staff. The member of staff used advice from other staff not recorded in the PBM plan which caused confusion and concern about the staff’s safety. Instead of leaving the environment and finding a place of safety downstairs the member of staff found a place of safety in the upstairs office. The member of staff concerned was visibly shaken and said they had sustained an injury to their head for the second time that week.

Other staff then suggested this member of staff use protective equipment, such as hard caps and carry on with providing one to one support to the person concerned. However, the PBM for this person did not advise staff to use hard caps. The member of staff became anxious about this advice, at this point the area manager present took over and advised the member of staff to seek medical attention and not carry on with one to one until the person's behaviour had become calm.

On the second day of the inspection we were present during a discussion with the registered manager and one member of staff. A member of staff was seeking advice from the registered manager regarding inconsistency of approach with people. They said “certain staff do not follow guidance because they are frightened since the incident (physically challenging incident with one person while staff were driving)”.

This meant some staff that followed behaviour management guidance were experiencing higher levels of physically challenging incidents towards them than other staff who were not following the guidance. The registered manager said staff were provided with personal protective equipment (PPE) and radios for people who presented with high levels of physical challenges towards staff. They stated that “consistent and predictability will give the person security and trust".

People were placed at risk from staff who were not able to manage high levels of physically challenging and aggressive incidents. A member of staff said that at the PBM training they were taught about personal space but not how to protect themselves when they were physically attacked or when protective personal equipment was removed. Accident forms described incidents where staff were injured and needed medical attention from hospital staff as a result of physically challenging incidents from people. For example, between August and September 2015 there were 18 aggressive and physically challenging incidents towards staff from one person. The area manager told us where staff sustained an injury the policy of the organisation was to seek medical attention. However, following incidents behaviour management plans were not reviewed. For another person the care records were for a previous placement.

This meant people did not benefit from a consistent approach which placed people and staff at risk from harm.

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

A member of staff said that as this was a new service and that once trust was developed, people were more likely to accept care and treatment from them which increased staff‘s confidence with managing difficult situations. They said a calm approach was used and people were “letting staff know they were not able to figure out how to communicate.”

Members of staff were not properly supported because one to one meetings with their line manager to discuss their personal development, training needs and concerns were not taking place. The registered manager told us

Requires improvement

Is the service effective?

supervisions were not happening monthly according to their organisation's procedure. A member of staff said new staff had weekly one to one meetings with their line manager to discuss their progress.

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

The induction prepared new staff for the role they were employed to perform. Staff told us the induction was thorough and ensured they developed an awareness of the specific needs of people. For example, autism and managing difficult behaviours. They said during their induction visits to the service took place for familiarisation with the environment and for shadow shifts with more experienced staff. Autism awareness, positive behaviour management, fire safety and food hygiene were part of the induction training. A member of staff said at the induction they received training needed to develop their skills to manage aggressive and physical challenging behaviours.

People were supported to maintain their health. Staff said seniors and the registered manager arranged healthcare appointments for people and they were kept informed on the outcomes of the visits.

People were supported to make choices. One person told us they chose their clothing, activities and times to go to bed. A member of staff said people were able to make day to day decisions such as activities, clothing and food. They said information was simplified to help people understand the options available. For example, staff used symbols to inform people of the task to be undertaken and to show refusal of the activity some people removed the symbol from the daily planner. Another member of staff said motivators were used to encourage people to regain composure. For example, to encourage one person to become calm, time with their tablet computer was given. This member of staff said when the person was "struggling to process information" motivators were used. They said "it's not punishing it lets him calm down and using a tablet computer all day is not good."

Good

Is the service caring?

Our findings

A member of staff said relationships were developed over time and people had to be given time to trust staff. They said when people were receptive to interaction, other staff used it as opportunity to engage with people. Another member of staff said by reading care plans and following guidance on how to work with people relationships were developed. Staff used people's preferred method of communications. For example, Makaton and symbols.

Arrangements were in place for people to maintain contact with family members. There were regular relative reviews, some relatives had weekly updates and regular newsletters were sent. People were supported by core support team and relatives were familiar with the core staff which reduces anxiety as well as the incidence of challenging behaviour. Six monthly forums for people and families to meet together with staff were organised.

People's rights were promoted by giving each one a voice via advocacy, family communication and choices. A member of staff said some people with one to one support will ask for privacy. Another member of staff said people were given space.

People had limited contact with each other. One person's accommodation was separate from the home with no accesses to the common areas. Another person only walked through the hall on her way out from her flat to the community. This person does not interact with other people. The third person has started to access the common areas including the sitting room and kitchen. This person was able to identify the staff on duty from the white board in the hall and asked for interaction with preferred support staff.

Requires improvement

Is the service responsive?

Our findings

Care plans did not reflect all aspect of people's current needs. Care plans were not reviewed on the dates specified for some people and some were from their previous placements. For examples care plans were dated 2014. Care plans followed a format on specific heading for example, "What people like about me," "What makes me happy" and "How I want to be supported". A member of staff said care plans informed staff on people's routines and their preferences but it was their understanding the care planning process was to improve.

A member of staff gave us an example of a risk assessment to support one person to manage their weight. They said exercise and healthy eating was promoted and the person was helped to understand their issues with their weight.

Motivators and rewards were used to encourage people with particular behaviour. Care plans for motivators and rewards were not developed and did not place the person at the centre of their care. A member of staff said some people were not able to process information and motivators helped with self-control.

Rewards were used as a means of motivating one person to accept personal care. The personal care plan in place was from the previous placement and had not been reviewed to ensure it was appropriate. We saw recorded where this person was given an opportunity to choose an activity when they accumulated five rewards for accepting personal care. We saw recorded "XX will have until 10:30 am to have a bath. Staff are to offer a reward of going to see the animals. If XX refuses the bath then at 10:30 am offer a strip wash but explain she will not be going to see the animals because she did not have a bath." This routine was repeated again in the afternoon but in the evening the person "will not have a reward of a chocolate bar and will instead have fruit".

We recommend that the service seek advice and guidance from a reputable source on how to encourage people to accept personal care in a person centred manner.

One person told us how they spent their day. For example, shopping, listening to music. They said they had a vehicle which staff used to support them

One person told us if they were unhappy they would tell the staff. Staff told us some people used key words while others use their body language to tell staff they were not happy. Another member of staff said people were supported to raise concerns and staff used the person's preferred method of communication to seek their feedback.

Requires improvement

Is the service well-led?

Our findings

Records which protected people from inappropriate care and treatment were not appropriately maintained. Personal records for people's care and treatment were not up to date or accurate. For example care plans, risk assessments and reports of incidents and accidents.

The registered manager explained the challenges including establishing a new home which meant records were not always reviewed. They said there had been challenges with getting to know people's complexities which meant administrative tasks were not appropriately completed. The service was working to improve its administrative systems at the time of the inspection. The registered manager acknowledged the needed to undertake one to one meetings with staff and told us there was learning from this period. An action plan was devised by the area manager on improving the recording.

The registered manager said the vision and values was to support people with dignity and respect. They said, "Everything is done in a person centred manner by putting people at the centre. Dignity, respond choice and independence are the core values". A member of staff said the culture of the home was for people to live in a "home" environment where people "are free and safe as possible and where staff do the best for people. It's a home for people."

The manager told us the aim was to develop the staff team by having an open door policy, sharing and passing knowledge and experiences. A member of staff said the registered manager was approachable and staff sought their advice and guidance. Another member of staff said the team morale was good. They said the structure had improved because staff and an area manager were now in post.

The registered manager told us there were close working relationships with the area manager. Staff meetings were taking place away from the home environment to provide a relaxed atmosphere and to share information. Changes with the on call system and separate night and day staff team were to achieve continuity to people.

The area manager conducted a schedule of audits. Reports from the area manager visits were devised on the standards of quality they had assessed. The area manager completed audits at every visit according to a proforma. The reports for September 2015 included an action plan with timescales. For example, updating care plans and risk assessments and ensuring staff have one to one meetings at the required intervals.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected from unsafe care and treatment. Where risks were identified action was not taken to mitigate the risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Action plans to manage aggression and physically challenging incidents were not up to date and did not provide staff with appropriate guidance to manage situations and to protect themselves and others.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Members of staff were not properly supported because one to one meetings with their line manager to discuss their personal development, training needs and concerns were not taking place.