Autonomy Healthcare Limited

Autonomy: Victoria & Elizabeth

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 7 February 2017. No breaches of legal requirements were found and the service was rated as 'Good'. On 17 July 2018, in response to concerns we received relating to the 'Safe' and Well-led' areas of this service, we carried out an unannounced focused inspection. This was to check the provider continued to meet their legal requirements in order to provide a 'Safe' and 'Well-led' service.

This report only covers our findings in relation to 'Safe' and 'Well-led'. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Victoria and Elizabeth on our website at www.cqc.org.uk.

Victoria and Elizabeth is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Victoria and Elizabeth provides care and accommodation to up to nine younger adults. The service is based in two separate buildings, one called Victoria and the other Elizabeth. It specialises in the care of people diagnosed with learning disabilities, autistic spectrum disorders, and mental health needs. Accommodation is provided in a range of apartments situated on a private residential estate. At the time of our inspection there were eight people using the service.

The service has a registered manager. This 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.

Ineffective quality monitoring systems had failed to pick up and address shortfalls at this service. Some care plans and risk assessments were not always complete and had not been reviewed and updated as planned or following serious incidents. Serious incidents reports did not always show appropriate action being taken following each incident.

Safety issues at the premises and fire and food safety concerns had not always been addressed despite the registered persons being aware of these. The registered persons had failed to notify CQC about incidents that affected the people using the service.

It was difficult to ascertain the actual staffing levels at the service as staff told us people often declined their allocated one-to-one or two-to-one hours and there were no records of what staff were doing at these times. Staff were not always been safely recruited. Medicines were mostly well-managed.

Staff had good relationships with the people using the service and people and staff were relaxed in each

other's company. Staff reassured people and had a positive approach toward them. The service had an open and inclusive culture. People trusted the registered manager and sought him out if problems arose. People and relatives told us they were satisfied with the service provided.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 consistently safe.

Risks to people were not always assessed and people's safety not always monitored.

Safeguarding incidents had not been reported to CQC as required.

Records did not make it clear if sufficient numbers of staff were on duty to keep people safe and meet their needs.

Improvements were needed to the way staff were recruited to the service.

Medicines were mostly safely managed. Improvements were needed to food hygiene procedures.

Is the service well-led?

Inadequate

The service was not well-led.

The service's governance framework did not ensure that responsibilities were clear or risks and regulatory requirements understood and managed.

There was no comprehensive system in place to monitor the quality of the service.

People and relatives had good relationships with the registered persons and found them approachable and helpful.

The service worked in partnership with other agencies.

Autonomy: Victoria & Elizabeth

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 17 July 2017 and was unannounced.

The inspection team consisted of an inspector, a specialist advisor, and an expert by experience. A specialist advisor is a person with professional expertise in care and/or nursing. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at information received from local authority and health authority commissioners. Commissioners are people who work to find appropriate care and support services for people and fund the care provided.

We reviewed the provider's statement of purpose and the notifications we had been sent. A statement of purpose is a document which includes a standard required set of information about a service. Notifications are changes, events or incidents that providers must tell us about.

We met with four people using the service and spoke with two relatives by phone. We also spoke with the registered manager, two team leaders, and one support worker. Following the inspection we spoke with the managing director by phone. We looked at records relating to the 'Safe' and 'Well-led' areas of this service including staffing, accidents and incidents, and quality assurance records. We also looked at four people's care records.

Requires Improvement

Is the service safe?

Our findings

Risks to people were not always assessed and people's safety not always monitored and managed in order to support them to stay safe.

Serious incident reports for one person stated that in May 2018 a person had twice 'run away'/'absconded' from their flat via a ground floor window. On one of these occasions staff recorded they found the person in the grounds and escorted them back to their flat. On the other occasion records did not show where they had been found and how they had got back to their flat. However both incident reports were clear that the person had used a window as the way out.

The person had a 'missing persons/dangerous behaviour in the community' risk assessment dated 3 April 2018. This told staff to 'remain vigilant at all times and try to be aware of exactly where [person] is at any given time'. It also advised staff to check the person at 60 minutes intervals to ensure '[the person] is there'.

However the risk assessment had not been reviewed or updated since 3 April 2018 to take into account that the person had 'run away'/'absconded' twice via a window. It was therefore not clear whether staff were aware of this risk and whether checks at 60 minutes intervals were enough to keep this person safe.

This person also had a risk assessment for 'physical attacks' dated 13 January 2017, to be reviewed on 13 June 2017. However it had not been reviewed as planned or at all despite serious incident reports showing that two attacks on staff had taken place since 13 January 2017. This meant we could not be sure that the risk assessment remained current and fit for purpose.

Another person's support plans for 'skin integrity', 'sexually disinhibited behaviour', and 'physical assaultive episodes' should have been reviewed by 19 June 2018 but had not been. It was therefore unclear whether the risks identified remained current.

Prior to our inspection the local authority raised concerns about this person's apparent weight loss. The person's records stated they should be weighed monthly but the page where their weight should be recorded was blank and we could not find this information recorded anywhere else in the person's records. It was therefore not possible to see whether or not this person had lost weight.

The same person's health file, designed to be taken with them when they attended GP, hospital and other healthcare appointments, was mostly blank with areas such a 'how I communicate' and 'when I am ill' not completed. (Although the section 'how to communicate with me' was filled in.) This meant that health care professionals might not have the information they needed to support this person safely if they were receiving medical attention.

Prior to our inspection the local authority informed us that one person was at risk at night in the event of a fire as they would be unable to hear the fire alarm due to a sensory impairment. (During the day they used an aid that enabled them to hear the fire alarm.) This meant that at night they would be reliant on a staff

member alerting them in the event of a fire. The local authority asked the registered manager to address this risk but at the time of our inspection this had not been done. We advised the registered manager to seek expert advice from the fire department and, if necessary, organisations that support people with sensory impairments in order to resolve this issue. The registered manager said he would do this.

Some improvements were needed to the premises to ensure they were safe. A wardrobe in one person's room, with items stored on top of it, was not secured to the wall. This meant there was a risk of the wardrobe falling on a person. In Victoria a handrail on the stairs was being held up by a strip of metal which came away easily when touched. This could be hazardous if someone put weight on the handrail when using the stairs.

In Elizabeth it was possible to see through glass panels in the foyer into one person's flat. To prevent this staff used a large portable display board to block the view into the flat when the person was undressed. This board was unstable. A more permanent and safer solution must be found to protect this person's dignity.

It was possible to see into some people's bedrooms and communal areas from outside of the premises despite staff putting tinted film on the windows to try and prevent this. One person told us, "There are no blinds or curtains at the windows. I put bed sheets up in my room for curtains. It's not good really but it makes it more private." The registered manager told us some rooms had had curtains, but people had pulled them down, so the windows were covered with film. This was not effective as it was still possible to see in so people were at risk of having their privacy invaded.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. The registered persons had not assessed the risks to the health and safety of people using the service nor done what was reasonably practicable to mitigate any such risks.

People told us staff were knowledgeable about their needs and had good relationships with them. A person told us, "They [the staff] are supportive. They talked to me about going out into the community and helped me do a practice run." A relative said, "When [person] moved here the manager did their homework about [person] and had everything ready and in place before they arrived."

A visiting social care professional told us that on the whole the staff at the service managed risk well. They said, "They have kept [client] relatively safe. They don't throw in the towel and panic if there is a serious issue. They try and manage it themselves." The social care professional said since their client had been at the service there had been a reduction in the number of high risk incidents they had been involved in.

Staff helped to keep people safe because people trusted the staff and confided in them when they were distressed so staff could take action to support them. During our inspection an incident took place and staff were able to keep the person safe under difficult circumstances because they knew how to support the person. They worked closely with the registered manager and external authorities to ensure the person had the support they needed to remain safe.

One person told us how using the service made them feel safe. They said, "I am safe because the staff look out for you and have always got your back even at your bad or lowest point. All the staff are safe and kind." The person also said living at the home protected them from the risk of social isolation. They told us, "If I wasn't living here I wouldn't socialise."

Relatives told us their family members were safe at the service. One relative said, "The site is lovely and my relative feels safe." Another relative told us, "Yes [person] is safe. [Person] has not brought anything to me. If

[person] should feel uncomfortable they would tell me. When I've visited I haven't seen anything that has concerned me."

Records showed staff were trained in safeguarding (protecting people who use care services from abuse). They knew to report safeguarding concerns to the local authority if they believed a person had been abused or was at risk of being abused. However the service's serious incident reports, and information shared with CQC by the local authority, showed that some safeguarding incidents had not been reported to CQC as required. We have addressed this issue in the 'Well-led' section of this report.

It was difficult to ascertain the actual staffing levels at the service as staff told us people often declined their allocated one-to-one or two-to-one hours and there were no records of what staff were doing at these times. For example, one person who should have had two-to-one staffing during our inspection was alone in their accommodation, although one staff member was regularly checking on their well-being.

According to people's recorded needs with regard to staffing levels there should have been eleven staff on duty on the day of our inspection but there were only eight, plus the registered manager.

A visiting professional told us they were unsure if the person they worked with had their designated one-to-one sessions with staff. They said they had asked for documentation to evidence this but hadn't received it.

When one-to-one or two-to-one staffing is provided the service should keep records making it clear which of the staff on duty are meant to be supporting which person or persons. If a person declines their one-to-one or two-to-one staffing this should be recorded and records should show how the person is being supported at that time, for example where staff are located and how often they should check that the person is safe.

We checked three staff recruitment files to see if staff had been safely recruited. All the staff in question had criminal records checks. One did not have proof of identity, including a recent photograph. The registered manager said the staff member had supplied this but it could not be located at that time. One staff member had not completed a health declaration. None of the staff had written references in place. The registered manager said he had obtained telephone references for all these staff but had not kept a record to show this. The registered manager said that in future he would ensure that the correct documentation is in place before staff began work at the service.

One person told us they thought there were mostly enough staff on duty. They said, "There is enough staff but there are the odd days when they are short staffed but there is always a good reason. I have missed going out the odd time." Another person told us, "If staff need support [with people] they ring for another member of staff to help." A relative said, "There is certainly enough staff to support [person]."

People said they thought the staff were suitable to work at the service. One person told us, "Staff are well trained and they know what they are doing." A relative said, "The staff are well trained but there is always room for more training. They have taken time to get to know my relative and they do follow the plans that have been put in place."

During our inspection we observed that staff had good relationships with the people using the service and people and staff were relaxed in each other's company. Staff reassured people and had a positive approach, reminding people of how far they'd progressed since coming to the service. There was much good humour between people and staff and we saw people enjoying spending time with the staff supporting them.

People told us they were satisfied with how staff supported them with their medicines. One person said, "I

am happy that the staff look after my medication." Another person said if they looked after their own medicines there was a risk they'd get the doses wrong so they thought it was safer for staff to do this. They told us, "I'm glad they (staff) look after it." A relative said, "[Person] gets their medication when needed."

Medicines were kept securely in purpose-designed storage facilities that only authorised staff had access to. Medicines records were up to date and showed people had had their medicines as prescribed. There was limited use of 'as required' medicines for mental health issues which was positive as it showed staff were using other ways of supporting people when they were distressed. One person did not have their allergy status recorded on their medicines charts. Staff said they would address this to ensure the person's records were complete.

Staff and the people using the service, where appropriate, worked together to keep the premises clean. One person said they took turns clean their own accommodation following a rota. A relative told us, "The place is clean. [Person] is expected to take some responsibilities."

The parts of the premises we saw were clean and uncluttered. Cleaning products were kept securely. Staff wore personal protective equipment, including gloves and aprons, when appropriate.

Some improvements were needed to food hygiene arrangements. For example, fridge temperatures had only been recorded sporadically so we could not be sure fridges were operating below five degrees centigrade, as recommended by the Food Standards Agency. In addition we found food in refrigerators that had been opened but not labelled as to when that was. This meant we could not be sure that the food was in date and safe for consumption. Improved systems needed to be put in place to ensure food safety was maintained at the service.

The registered manager gave us an example of how lessons were learned and improvements made when something went wrong. This involved the use of guardianship orders to protect people using the service. The registered manager said that in future these would be applied for if it appeared a person was at risk.

Inadequate

Is the service well-led?

Our findings

The provider's governance framework had failed to ensure that responsibilities were clear and that quality performance, risks and regulatory requirements were understood and managed.

The registered persons had failed to effectively monitor the quality of care plans and risk assessments. Some care plans and risk assessments had not been reviewed and updated as planned or following serious incidents. This meant staff did not always have the information they needed to keep people safe and meet their needs.

Serious incidents reports did not always show appropriate action being taken following each incident. For example, in May 2018 one person left their flat via a window and had to be brought back by staff. An incident report was completed. The staff member completing the form described the incident and under 'Actions Taken' checked a box indicating that the registered manager had been informed. However no other action was proposed and the boxes for informing the person's social worker/other professional, informing CQC, reviewing the person's support plan, and creating/reviewing/revising the person's risk assessment were unchecked and there was no evidence these had been done.

The following day a further serious incident report was completed after the same person again left their flat via a window and had to be brought back by staff. As before, an incident form was completed. On this occasion, under 'Actions Taken', the person completing the report checked the boxes 'Archived (no action needed)' and 'Registered Manager Informed'. However no other action was proposed and the boxes for informing the person's social worker/other professional, informing CQC, reviewing the person's support plan, and creating/reviewing/revising the person's risk assessment were unchecked and there was no evidence these had been done.

Another person's incident report, completed following an incident involving a knife, showed that action was taken to inform the registered manager, social worker/other professionals, and police and a safeguarding referral made. However the boxes for creating/reviewing/revising the person's care plans/risk assessments had not been ticked. We did find a risk assessment referring to this incident but it was dated as having been completed the day before the incident occurred; this was confusing and misleading.

Another person's serious incident reports showed that on a number of occasions there had been incidents leading to the person being given 'as required' medicines. On the majority of these reports the section of the form where the 'care manager' was meant to comment to say whether or not the incident was handled correctly was blank. This showed a lack of overview of the actions taken.

With regard to serious incident reports there was no evidence of any of them being checked or audited. This meant possible trends had not been identified, and the quality of the information recorded and the actions taken had not been monitored.

Prior to our inspection the local authority informed us they had visited the service on 19 January 2018 and

found that wardrobes at Victoria and Elizabeth had not been secured to walls. This could put people at risk if they toppled over. We were told that one person had already pulled to door off their wardrobe which could have resulted in the wardrobe falling on them. The local authority brought this to the attention of the registered persons who confirmed on 12 February 2018 that this issue had been addressed. However at this inspection we found that one wardrobe was still free-standing and had not been risk assessed as safe for the person whose room it was in.

The local authority informed us that in June 2018 they received a concern from a relative who had found out of date food in a shared fridge. Records showed a similar concern had been raised in 2017. At this inspection we found food in refrigerators that had been opened but not labelled as to when that was. This meant there was risk of people eating out of date food which could adversely affect their health. We also found that fridge temperatures were not being monitored in line with the service's own systems and Food Standards Agency guidance. There was a lack of systems in place to monitor food safety.

The local authority had also informed us there was a fire safety issue with regard to one person and another person needed their weight monitoring. The registered manager was aware of these issues but had not yet resolved them nor ensured risk assessments were in place to ensure people were protected in the meantime.

It was difficult to ascertain if sufficient numbers of staff were deployed at the service at any one time. This was because records did not make it clear whether some people had accepted or declined their one-to-one or two-to-one staff support. Staff recruitment records were incomplete and this had been identified by the local authority rather than the registered persons themselves.

During our inspection the staff handover from the early to the late shift was taking place in the communal downstairs entrance hall at Victoria. The discussion staff were having could be heard from outside Victoria and also from upstairs in Victoria. This was an infringement of people's right to have their personal information treated confidentially. Staff were also not recording handovers so we could not be sure that all relevant information was being passed on from one shift to another.

At the time of our inspection the service was carrying out some audits and checks of the quality of the service. Team leaders (senior care workers) carried out weekly medicines audits and were auditing people's daily notes. The registered manager told us quality surveys had been sent out to people using the service and relatives and a programme of staff supervision and team meetings put in place. However there was no overarching audit that monitored all aspects of the service including people's health, safety and welfare and the quality of records relating to people's care and support.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance. The registered persons did not have an effective system to regularly assess and monitor the quality of service that people received.

Part of the registered persons' registration responsibilities is to notify CQC about incidents that affect the people using the service. At the time of our inspection we had not received any notifications from the service since 17 May 2017. This means the registered persons had not notified us of a number of serious incidents, including those relating to safeguarding and police involvement that had occurred involving people using the service. We discussed this with the registered manager who said this oversight had occurred because the staff member who had been responsible for submitting notifications had left the service.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

Notification of other incidents.

The registered manager said they would now ensure notifications were submitted without delay. Following the inspection we received a notification for a serious incident that had taken place involving one of the people using the service.

People and relatives told us the service had an open and inclusive culture and they would be happy to raise any concerns they might have with the registered manager or managing director. One person said, "If I was worried about anything I would talk to my [relative] or people higher up like [names of registered persons]." A relative told us, "I haven't needed to make a compliant but if I did need to I would talk to [registered manager]. I have a good relationship with the staff and managers who are very approachable."

During our inspection we saw the registered manager was knowledgeable about the people at the service and they sought him out if there was problem. For example one person, who had been distressed, came to see the registered manager as they viewed him as the staff member who they felt could provide a resolution to the issues they were having. Other people told us they liked and trusted the registered manager. One person said, "[The registered manager] is easy to talk to." Another person told us they could always see the registered manager if they needed to and if the registered manager was busy they could go back later and would be seen then.

People and relatives told us they were satisfied with the service provided. One person said, "It's very good here." A relative told us, "I would rate here as four out of five as I always believe there is room for improvement." People continued to make positive comments about the managing director and the registered manager. One person said, "[Registered manager] is really nice. I tell [them] what I am doing at college and what I am doing for myself like [strategies to dealing with distress]." Another person told us, "[Managing director] is funny and really caring."

Records showed the service worked in partnership with a variety of other health and social care professionals to help ensure people's needs were met. At the time of our inspection they were working with the local authority and the health authority with a view to bringing improvements to the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered persons must notify the Commission without delay of incidents specified in this Regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had not assessed the risks to the health and safety of people using the service nor done what was reasonably practicable to mitigate any such risks.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons did not have an effective system to regularly assess and monitor the quality of service that people received.

The enforcement action we took:

Warning notice