Salisbury Support 4 Autism Limited

Castleton Avenue

Inspection report

61 Castleton Avenue
Wembley
Middlesex
HA9 7QE

Date of inspection visit:
11 August 2016

Date of publication:
27 September 2016

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

This inspection took place on 11 August 2016 and was announced.

Castleton Avenue provides supported living services for people with Autism and challenging behaviours. The service has three supported living schemes; Burdon Lane, Hollyfied Avenue and 61 Castleton. Each of the three services supports 5 adults.
At this inspection we visited, Burdon Lane and 61 Castleton Avenue to observe care.

The service had a registered manager. 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 and associated Regulations about how the service is run.

People receiving care were safe. Their risks had been assessed and well managed. There were procedures in place for monitoring and managing risks to people. When there were changes in the level of risk, the risk management strategies changed to reflect this. There were appropriate procedures in place to help ensure people were protected from all forms of abuse. Staff had received training on how to identify abuse and understood procedures for safeguarding people.

People received their medicines in a safe manner and staff recorded and completed Medicine Administration Record (MAR) charts correctly.

People were protected from the risks associated with the recruitment of new staff. The service followed safe recruitment practices. People were safe because staffing levels were assessed and monitored to ensure they were sufficient to meet people's identified needs at all times.

Throughout this inspection we saw good examples of person-centred care, which were informed by current knowledge and understanding of autism. The care needs of people had been fully assessed and documented before they started receiving care. Staff were supported to carry out assessments to identify people's support needs and care plans were developed outlining how these needs were to be met. We observed that people received good personalised care and support.

People's nutritional needs were assessed and people were supported to have a balanced and nutritious diet. People's dietary needs were responded to appropriately with support from health care professionals were required. We saw plans from speech and language therapists for people who were at risk from choking.

People were supported to maintain good health. They had access to a wide range of appropriate healthcare services that monitored their health and provided people with appropriate support, treatment and specialist advice when needed. People were supported and encouraged to choose what they wanted to eat and drink.

Staff understood how to support people with dignity. People were dressed appropriately and looked well care for. Staff spoke with people in a respectful way, giving people time to understand and respond. Where people requested personal care, staff responded discreetly and sensitively.

All staff had attended training on the requirements of the Mental Capacity Act 2005 within the last 12 months. Staff were knowledgeable and aware of their obligations with respect to people's choices and consent. Staff told us that people and their families were involved in discussions about their care. Records showed clear decision-making processes, mental capacity assessments and best interests meetings.

Care plans for people using the service were effective, individual and autism specific in capturing the required information. People's individual care needs were recorded in a timely manner which demonstrated that their needs had been met. There was a strong focus on supporting people in becoming more independent by working together with the family, the person and the day service to achieve the best possible outcome.

Complaints were managed well and responded to in a timely manner.

There was an effective quality assurance system in place. The registered manager and staff team were proactive in seeking out ways to improve.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff understood how to protect people from abuse and harm. There were safeguarding policies and procedures and staff knew the action required if they thought someone was at risk.

Staff were able to talk about areas of risk knowledgeably and they correctly explained strategies which had been agreed to protect people.

Appropriate recruitment and selection processes were carried out to make sure only suitable staff were employed.

Medicines were managed and stored safely, and administered by staff competent to do so.

Is the service effective?

Good

The service was effective.

Staff received induction, training and supervision to support them in their roles.

People had access to healthcare services when they needed them. The service manager and staff were proactive in referring to health care professionals.

Staff understood how to apply the Mental Capacity Act 2005(MCA), including the Deprivation of Liberty Safeguards (DoLS) to make sure people were not restricted unnecessarily.

People were supported with a choice of nutritional and healthy menu options.

Is the service caring?

Good

The service was caring.

Staff told us how they ensured people's rights to privacy and dignity were maintained while supporting them.

Relatives were pleased with the care and support their family member received. They told us staff treated with kindness, respect and dignity.

People spent time with their key workers. This helped staff develop meaningful relationships and increase their knowledge of people's likes and preferences.

Is the service responsive?

Good

The service was responsive.

People received personalised care which had been discussed and planned with them, including their relatives where necessary.

People were given choices and supported to take part in activities.

People knew how to complain and felt that they were able to raise any concerns and they would be listened to.

Is the service well-led?

Good

The service was well-led.

The management team worked in partnership with other organisations at a local and national level to make sure they well informed of best practice and able to provide a high quality service.

Staff felt supported by the registered manager who they described as approachable.

There were procedures in place to monitor the quality of the service. Any deficiencies found were quickly rectified.

Castleton Avenue

Detailed findings

Background to this inspection

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

The inspection was carried out by two inspectors. We visited the two supporting living services, Burdon Lane and 61 Castleton Avenue.

Before the inspection we looked at information we held about the service. This information included notifications sent to the Care Quality Commission [CQC] and all other contact that we had with the home since the previous inspection. We also looked at the Provider Information Return [PIR] which the registered manager had completed before the inspection. The PIR 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. The PIR was discussed with the registered manager during the inspection.

People using the service had complex needs and most people were unable to tell us about their experience of living in the homes. In order to help us gain an understanding of this we spent a significant part of the inspection observing how people were supported by staff.

During the inspection we spoke with the service manager, newly appointed manager, the registered manager and the manager of the Barnet supported living service. We spoke with seven care workers and one person who used the service. Following the inspection we obtained feedback about the service from speaking with two people's relatives.

We also reviewed a variety of records which related to people's individual care and the running of the supported living homes. These records included; care files of people living in the homes, staff records, audits, and policies and procedures that related to the management of the service.

Good

Is the service safe?

Our findings

People told us they felt safe using the service and they were treated well. Referring to one of the supported living schemes, one relative told us, "Burdon Lane is safe. We are very happy with the service." Another person told us "It's good here, they help me to stay safe, and that's the main thing." Another relative told us, "We are pleased with the placement. We feel our [relative] is well looked after."

Prior to the inspection we received a notification of a serious incident affecting a person using the service. We looked at whether other people were at risk of a similar incident. We found that the provider had taken action to ensure a similar incident would not take place again. They had provided staff with appropriate training and health care professionals had assessed people and provided guidance so that they received safe care and effective support with their health needs. Action had been taken to mitigate the risks of other serious incidents occurring.

Staff had received up to date training in areas related to safety such as safeguarding adults, whistle blowing, working with people who may display behaviours which could challenge the service, diversity and human rights, risk assessment, infection control and medicine management. Staff told us their knowledge around people's safety had been enhanced because of this training.

Staff were able to talk about areas of risk knowledgably and they correctly explained what they would do if they witnessed or suspected that abuse had taken place. We spoke with seven staff and they knew and were able to tell us about signs of abuse, including relevant reporting procedures, such as reporting concerns to their manager, shift leader or where appropriate, the local authority or Care Quality Commission (CQC). Safeguarding notifications had been sent to CQC as required and social care professionals told us that the staff were open and communicative about any safeguarding concerns or events associated with the service.

People were encouraged to raise concerns about their safety in regular resident meetings and in individual consultations with support where necessary. People used a range of methods to communicate, including Makaton and pictures. This ensured that everyone regardless of their needs was supported to have their say.

Written risk assessments were detailed for each person and were managed thoughtfully, taking into consideration the least restrictive approaches and interventions. For example, some people were exposed to risks associated with swimming because they had epilepsy, and there were detailed risk assessments in place to ensure they were supported to enjoy the activities they liked. Some people had risks that limited them to undertake cooking activities, however the service had undertaken detailed risk assessments and put in place plans to ensure they were safely supported. We saw risk assessments for such areas as physical care needs, social or recreational needs and behavioural needs. Throughout the inspection, we evidenced that staff understood the needs of people they supported. A service manager from one of the supported living schemes told us, "We support positive risk taking and believe that an individual should be supported to take risks like we all do. " People with behaviours that challenged the service were supported appropriately. There was a behaviour specialist employed by the provider, this ensured behaviour support was easily available and changes to people's behaviours could be responded to without delay.

Risk assessments for the environments where people lived had been drawn up and were regularly reviewed with the changing needs of the people who lived at the supported living schemes in mind. All incidents were recorded and an outcome based plan was included to minimise the risk of future occurrence. Each person had a personal emergency evacuation plan (PEEP) in their plan of care. This gave guidance to staff to ensure people's safety was protected during the evacuation of the building in the event of fire or other emergency. Up to date fire safety risk assessments and emergency plans were in place. We saw evidence fire drills took place regularly.

People were protected from the recruitment of unsuitable staff. Recruitment records contained the relevant checks. These checks included a Disclosure and Barring Service (DBS) check, evidence of identity, right to work in the United Kingdom, and a minimum of three references to ensure that staff were suitable and not barred from working with people who used the service. This helped to ensure people employed were of good character and had been assessed as suitable to work with people.

Staffing levels were flexible so that if people needed extra support there were staff available for this. We saw examples where staffing levels were adjusted beyond the usual ratio in response to people's needs. Relatives of people told us people regularly went out when they chose to. During the day of our visit we saw people going out for a walk locally, strolling in the grounds accompanied by staff, go swimming, going to the cinema and being supported to visit relatives. There were sufficient staff deployed to support people and to stay with them so that people could enjoy their preferred activities. Each supported living scheme was sufficiently staffed to meet the needs of people they supported.

People's medicines were handled safely and according to the service's policy and procedure. Staff had received up to date training in handling medicines and were able to tell us about safe practice. They also understood what certain medicines were prescribed for, the side effects they may have on people and the importance of keeping medicines under review. The service had a system for auditing medicines. This was carried out by senior staff. There were no gaps in the medicines administration charts examined. Controlled medicines were stored centrally. We checked that recorded totals tallied with actual medicines stored for a sample of people and there where were no discrepancies.

Good

Is the service effective?

Our findings

One person told us "The staff look after me well and know what they are doing." Relatives of people receiving care told us that people received care which supported them with their health and wellbeing. They told us staff were well trained to meet people's needs. Comments from relatives included, "I feel staff are competent in communication and de-escalating techniques"; "I have seen staff use Makaton signing. They seem to have a grasp of the communication needs of my [relative]" and "They are much specialised. We are pleased our [relative] is receiving good care."

It was notable throughout the inspection that people received effective care, which was based on autism best practice. A service manager of one of the supported living schemes showed us guidance from authoritative bodies including The National Institute for Health and Clinical Excellence (NICE) and the Department of Health (DOH). Proactive approaches were in evidence as the basis for understanding behaviours that challenged in order to inform interventions. A service manager told us, "We are supporting people in such a way the behaviours that challenge are minimised." We noted examples where proactive approaches had been used and incidents of challenging behaviour had decreased as a result. We saw that staff were skilled at meeting the needs of people. For example, one person required four staff for 24 hours when they moved into one of the supported living schemes and this was gradually reduced to one staff at home and two staff when out in the community.

A service manager told us the service was committed at developing staff skills through training for the benefit of people living at all the provider's supported living schemes. Staff had received relevant training to carry out their responsibilities in providing people with the care and support they needed. Staff told us they had received an effective induction prior to commencing their role. This induction included a period of shadowing experienced staff to ensure they were competent and confident before supporting people. The induction followed the Care Certificate induction standards. These are nationally recognised standards of care which care staff needed to meet before they can safely work unsupervised.

Learning and development encompassed both eLearning and face to face training. All staff had a personal development plan and had completed mandatory and specialist training, such as health and safety, moving and handling, food hygiene, safeguarding, epilepsy, medicines, respect and dignity. We found staff to be knowledgeable in relation to these areas. A service manager told us, "We ask all staff to work towards NVQ level three and we also support staff to complete NVQ level five." We saw evidence staff had these qualifications. All this meant that people were supported by staff who had the skills to meet their needs and ensure their safety.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and

hospitals are called the Deprivation of Liberty Safeguards (DoLS). In other settings such as supported living schemes authorisation should be sought from the Court of Protection.

A service manager for one supported living scheme showed us documentation which confirmed that an application to deprive one person of their liberty had been sent to the Court of Protection for which the service was awaiting authorisation. We saw, for example, MCA assessment records were decision-specific to the person's individual needs.

Records showed clear decision-making processes, MCA and best interests meetings. Where delays in authorisations occurred, the service pursued with relevant authorities whilst in the period in-between making certain less restrictive options were followed. For example, for the person whose application was still pending with the Court of Protection, the service ensured a detailed risk assessment was in place for their safety as well as promoting their independence.

People were supported to eat and drink what they wanted for as long as they wished to. The menus provided a varied selection of meals based on what people had told the staff they liked and also on people's individual nutritional needs. Their choices for meals and drinks were regularly adapted in line with their preferences. The meals of the day were displayed in pictures so people who could not read were able to know what the menu was for the day. Those people who did not choose from the menu were offered alternatives.

People were weighed at regular intervals and appropriate action taken to support people who had been assessed as being at risk of malnutrition. This helped staff to make sure people's diet was tailored to their needs. We saw completed charts to record if people were having difficulties with eating and drinking. Care records showed the service was referring people to a dietician or speech and language therapist (SALT) in a timely way if they required support with swallowing or dietary difficulties.

People had access to general health care services. The service consulted with local primary care providers to ensure people who used the service had relevant
healthcare support. People received health checks and had access to a range of health professionals including; GPs, chiropodists, dentists, and opticians to make sure they received effective healthcare and treatment. This ensured people received holistic care through their access to mainstream and specialist services.

Good

Is the service caring?

Our findings

People and their relatives gave us positive feedback about the caring attitude of staff. One person told us they were "happy and alright." Another person told us "Staff are nice and kind and look after me very well." Some people could not speak with us because of their complex needs. However, they were able to express their feelings using gestures, smiles and nodding. We observed they reacted cheerfully and willingly to staff. One person showed us a 'two thumbs up' sign to indicate they were happy. People's relatives told us the service provided good care. One relative told us, "Staff are very caring. When I phoned they always had answers and they supported me to visit my [relative]."

The service had a visible person centred culture, which we observed at the supported living schemes we visited. We spent time in respective communal areas observing care and it was evident that staff knew people well. The atmosphere was calm, friendly and inclusive. The interactions between staff and people were caring, respectful and spontaneous. Staff had relevant knowledge regarding people's routines, likes and dislikes. People were comfortable and happy around staff. People who were in discomfort were attended to with kindness. For example, we observed staff speaking with a person who reported to have a headache, and staff were attentive and responded to their needs. They showed empathy and did not appear hurried.

We spoke with one person who was able to express their views to us but there were others whose views may not have been so easily heard. The service made efforts to make sure people's views were heard and acted on. Staff engaged in a range of ways with people so they were involved, consulted, empowered, listened to and valued. Information was presented in different formats for people to enable them to communicate to the best of their abilities. We saw many examples of communication tools and systems, each tailored to the specific needs of the person, including gestures, Makaton, symbols, objects of reference, PECS (Picture Exchange Communication System), and some that were facilitated by IT technologies. There were examples demonstrating how people's lives had been transformed through increased involvement, choice and independence. For example one person who previously moved frequently between placements and was very unsettled. Since moving to one of the supported living schemes staff told us the person became very settled and told us "If you would come with a suitcase, the person would become very challenging. The person thinks that the person is moving again."

Staff understood how to support people with dignity and respect. This was supported from our observations of the way they engaged with people and in the discussions they had. People looked well-groomed and cared for and dressed appropriately. Staff spoke with people in a respectful way, giving people time to understand and respond. Where people requested personal care, staff responded discreetly and sensitively. We asked staff how they ensured they respected people when they undertook personal care. They told us they ensured people were covered as much as possible, and closed the curtains so nobody could see from the outside. For example, we saw that where appropriate, adhesive privacy screens for windows were fitted to achieve privacy for bedrooms that overlooked busy roads.

People were supported to maintain the relationships they wanted to have with friends, family and others

important to them. Relatives of people and records showed people had contact with family members. Some people received regular visits from family members and some used IT technologies to have video contact with their relatives. Each person had a key worker who had special responsibilities for working with the person. The role of the key worker involved giving the person reassurance to feel safe and cared for and building relationships with their families and relatives. We saw evidence of regular 'keyworker meetings'. This helped staff to develop meaningful relationships and increase their knowledge of the person's likes and preferences. We saw staff shared social and leisure time together with people. A service manager told us she looked at how the likes and hobbies of key workers would match and complement an individual's likes and types of activity. She told us, "I allocate areas of responsibility that match with staff interest." For example, a staff member who liked gardening was allocated to work with a person with the similar interest. The shared interests enhanced people's enjoyment and involvement for particular hobbies and activities.

People were fully involved in planning their care plans. Reviews were centred on them and were held in the way they chose for themselves. Where people were unable to express their views, family members or advocates were involved in decision making processes to ensure people's views were expressed wherever possible. People were able to invite who they wished to the meeting, where it was held and what the topics would be discussed.

We spoke with staff about diversity and human rights. Staff spoke knowledgeably about what they would do to ensure people had the care they needed for a variety of diverse needs, including spiritual and cultural differences.

Good

Is the service responsive?

Our findings

One person told us "I know I have a care plan and talk to [keyworkers] regularly." The relatives of people receiving care told us that the service involved people in their care. They told us the needs of people were placed at the centre of care. One relative told us, "I am always invited to review meetings and always attend." Another relative said, "We are always involved in care. We attend review meetings and are always in contact via emails."

We noted people received personalised care and support. Their care needs had been fully assessed and documented before they started receiving care. The initial assessment involved people visiting respective supported living schemes prior to living there. The assessments identified people's support needs and care plans were developed outlining how these needs were to be met. Multi-component person centred support plans were then created, each containing a communication profile, behaviour support plan, and a risk assessment. Each considered the person as an individual, with their own unique qualities, abilities, interests, preferences and challenges. Care plans were detailed and reflected people's likes and dislikes and included details about people's life histories. This meant if the person chose to live at the respective schemes staff were ready to meet their needs on the day of their arrival.

Functional assessments were carried out before people moved to respective supported living schemes. These ensured the service had an understanding of the function of the behaviours people displayed in order to inform function based interventions. For example, one assessment established a range of possible functions of the behaviours of one person before they moved in. A six week review after the person had moved in showed a reduction in the frequency of the behaviours that challenged compared to previous placements. There were similar examples of people whose initial assessments indicated a high frequency of behaviours that challenged services but which diminished following their move into supported living schemes. A parent told us, "My [relative] went through three placements. [My relative] was here for a month and I can say this service has done more than any other placements."

Relatives of people who used the service confirmed people were involved in planning their own care. They felt people were listened to and their input valued. Records also showed relatives or representatives were involved in the care plan review and were actively encouraged to participate. People were encouraged to input in their care through a number of ways, including participation in their assessments, 'service-user meetings', social stories, surveys and staff's own observations. In one example, we saw social stories were used to enhance the knowledge of two people living at one of the supported living schemes, so that they avoided triggers to behaviours that challenged the service.

The home had a varied programme of activity and entertainment on offer. This included pub night/social evenings, cinema, painting/textile craft, gym, swimming, dance classes, trampolining, gardening, sailing, massage, aromatherapy and other sensory activities. We saw from the recent resident and relatives meeting minutes that people had suggested these activities. People in one supported living scheme told us that they looked forward to their holiday to Butlins in September.

The service had a procedure in place to manage any concerns or complaints that were raised by people or their relatives. The complaints procedure was displayed throughout the service in a style that was easily understood by visitors and the people who used the service. The service manager told us that they encouraged people to raise concerns at an early stage so that they could learn from them and improve the service. Staff knew they needed to take all complaints seriously and report them to the registered manager. Records showed there had been several complaints from neighbours and we saw that these had been dealt with positively. For example one of the supported living schemes invited the neighbours to meet the people and get a better understanding of people's needs. The meeting was also attended by the environmental health officer who commended the service and noted that the service did everything possible to deal with the complaints. This demonstrated that the service took complaints seriously and looked for positive outcomes and solutions. Other records showed that the service had received several compliments about the care provided.

Good

Is the service well-led?

Our findings

People's relatives spoke in a positive manner about the home and the way it was managed. One relative told us, "This is a well-run home [Burdon Lane]. We are happy about our [relative's] placement."

There was a clear leadership structure in place and staff felt supported by management. The manager at Burdon Lane had resigned a few weeks prior to this inspection and we had been notified. We saw evidence a new manager had been appointed and was due to commence work in September 2016. In the interim, arrangements had been put in place for an existing service manager to temporarily manage the service. The service manager had the experience, capacity and capability to run the service. She continued to receive support from the operations manager and behaviour specialist who, we were told by staff, had a visible presence at the home.

There was an open and positive culture within the service. The service held regular monthly team meetings. Open and transparent communication was promoted and encouraged by the service manager. Staff told us the service manager was approachable and always took the time to listen to all members of staff. They described the service manager in positive terms, including 'approachable', 'kind' and 'supportive'. We noted from the minutes that staff had the opportunity to raise any issues and we saw action was taken to improve the quality of the service.

The service promoted a clear vision of promoting people's independence and staff told us that "Residents can achieve anything they want and we will help them as well as we can". This was evident by the examples we saw of people having gained new skills in attending colleges, sailing and the reduction of behaviours that challenged the service. One aspect which stood out was while people were encouraged and supported to achieve these things their safety was paramount. For example, risk assessments had been drawn up for any new activity and additional staff was provided until the person became more confident.

Policies and procedures were up to date. Staff knew about the policies and procedures related to the care of people and the running of the service and how to access them when this was required. The service had an up to date statement of purpose and people and their relatives had access to a service user guide that included a range of information about the service.

Team meeting minutes showed that there was a strong focus on learning from incidents in relation to behaviours that challenged. These were discussed during staff meetings and the team looked to find ways to reduce similar incidents from happening again by finding positive approaches in how to pro-actively respond to challenging behaviours before escalation.

The service manager ensured staff were kept up to date and were knowledgeable about best practice. For example, the provider kept journals and guidance from reputable national organisations for good practice reference. The service had guidance the National Institute for Care and Clinical Excellence for managing behaviours that challenged the service. This ensured staff were kept up to date with the latest developments so they could effectively support people.

The service manager and registered managers from the provider's other services carried out regular quality assurance audits to monitor the quality of care provided and to identify any areas where improvements could be made. For example, we looked at the performance monitoring audit, which looked at human resources and training, health and medication, keeping people safe, environment and health and safety and also record keeping. We saw that improvement plans were put in place where gaps had been identified.