

National Autistic Society(The) NAS Community Services (Central London)

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 inspection took place on 22 and 24 April 2015 and was announced. NAS Community Services (Central London) is a domiciliary care service providing support to people living in their own homes. The service also operates an outreach service in the London area, providing support to adults at home and when out in the community, 30 people were using the service at the time of our visit.

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

The service received referrals directly from family members and/or from social workers providing support

Summary of findings

to people on the autistic spectrum. An initial assessment was carried out by two senior staff members who had received specific training in the provider's internal assessment process. Some people's initial assessments had not been completed or were missing from the care records we reviewed.

Care plans were developed in consultation with people and their family members. Where people were unable to contribute to the care planning process, staff worked with people's relatives and representatives and sought the advice of health and social care professionals to assess the care needed. This ensured people's support needs could be identified and met before an individual support plan was developed and staff were allocated to work with people.

People's risk assessments were completed and these covered a range of issues including guidance around accessing the community and personal safety. People using the service and their relatives expressed positive views about the service and the staff. Relatives felt their family members were safe and trusted the staff providing support and care.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act (2005) (MCA) and DoLS, and to report upon our findings. DoLS are in place to protect people where they do not have the capacity to make decisions and where it is regarded as necessary to restrict their freedom in some way, to protect themselves or others.

Staff had received training in mental health legislation which had covered aspects of the MCA and DoLS. Senior staff understood when a DoLS application should be made and how to submit one.

Staff were familiar with the provider's safeguarding policies and procedures and able to describe the actions they would take to keep people safe. Staff supported people to attend health appointments and had received training in first aid awareness. There were protocols in place to respond to any medical emergencies or significant changes in a person's well-being. These included contacting people's GPs, social workers and family members for additional advice and assistance.

People's independence was promoted and staff actively encouraged people to participate in activities. People were supported to attend colleges and day centres and to take up work placements. People visited parks and museums, took part in exercise classes, took trips out and went away on holidays.

Staff were required to support people to complete shopping tasks, design menu plans and prepare meals. Staff were aware of people's specific dietary needs and preferences and offered people choices at mealtimes. Where people were not able to communicate their likes and/or dislikes, staff sought advice and guidance from family members.

There were arrangements in place to assess and monitor the quality and effectiveness of the service. However, we noted that responses to proposed action plans dated February 2015, were still outstanding and therefore there was no clear indication as to how or when service improvements would be undertaken.

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?

Aspects of the service were not safe. There was a high turnover of staff which impacted on the service provided to people. Managers were not always available to manage staff teams effectively and provide support to staff when needed.

Appropriate arrangements were in place to protect people from the risk of abuse. Staff had completed training in adult safeguarding prior to working with people who used the service.

Care plans contained up to date risk assessments that identified risks to people's safety and/or that of others.

People and their relatives were sometimes involved in the recruitment process of new staff members.

Requires improvement



Is the service effective?

Aspects of the service were not effective. Staff were required to complete online training in autism awareness. Health and social care professionals expressed concerns about the inadequacies of staff training programmes.

Not all care plans contained copies of people's initial assessments and information about people's lives, past and present was not always completed in full.

Staff had received training during their probation period which covered aspects of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were supported to maintain their health and independence and to access appropriate healthcare services.

Requires improvement



Is the service caring?

The service was caring. Relatives told us they were happy with the care their family members were receiving.

Staff were able to explain and give examples of how they would maintain and promote people's dignity, privacy and independence.

People and their relatives were encouraged to make decisions about the care and support they wished to be provided with.

Staff used a range of communication methods to support people to make choices in their daily lives in areas such as activities, meals and personal care.

Good



Is the service responsive?

Aspects of the service were not responsive. Initial assessments were not always in place in the care and support records we reviewed.

Requires improvement



Summary of findings

Staff accompanied people to annual health reviews with their GPs and made appropriate appointments to other healthcare professionals as and when needed.

The service had a behaviour co-ordinator who worked closely with a multi-disciplinary team to develop positive behaviour support plans for people using the service.

Is the service well-led?

Aspects of the service were not well-led. Health and social care professionals expressed concerns relating to poor communication between the provider and themselves and internally within the service itself.

The service had quality assurance systems in place although checks lacked clear information as to when recommendations would be actioned and service improvements made.

Staff received regular supervision sessions and expressed positive views about the registered manager's approach to managing the service.

Requires improvement



NAS Community Services (Central London)

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 checked 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 22 and 24 April 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in. The inspection was carried out by a single inspector.

Before the inspection took place, we looked at the information the Care Quality Commission (CQC) holds about the service. This included notifications of significant incidents and complaints reported to CQC since the last inspection in October 2013.

During the inspection we spoke with one person using the outreach service, the registered manager and the supported living service manager. Following the inspection we spoke with six relatives of people using the service and seven support workers. Records we looked at included six care plans, 12 staff records and records relating to the management of the service. We sought feedback from two health and social care professionals with knowledge about this service and the people using it.

Is the service safe?

Our findings

Relatives told us that frequent changes of staff and staff absences had a negative impact on the care and support provided to their family members. Healthcare professionals informed us that there was a very high turnover of staff within the service which was detrimental to people's stability and disruptive to people's normal routines. One member of staff told us, "We're short staffed, the money is rubbish, the job is really hard and people are constantly leaving." The supported living manager told us the provider was actively recruiting new staff to fill five vacant positions within the supported living service but there were "recruitment issues."

We were told that some staff were willing to work flexibly and that in the event of staff absences the service asked existing staff to cover shifts or used bank and agency staff who were familiar with the service and the people using it. Health and social care professionals told us that the deployment of managers to work shifts within the supported living service, meant that they were not always available to manage staff teams effectively and/or provide appropriate support and guidance to staff when needed.

The registered manager told us that people who used the service and their family members were sometimes involved in the recruitment of new staff and the interviewing process. The registered manager told us that he looked for staff who could demonstrate "good people skills", had "some degree of autism knowledge" and an ability to be "self-reflective."

Before staff were employed they were required to undergo criminal record checks and provide three satisfactory references from previous employers, photographic proof of identity and proof of eligibility to work in the UK. This information was held at the provider's head office. We requested and received some of the information we asked for which confirmed that people using the service were being cared for by staff who had satisfactorily completed these pre-employment checks.

Appropriate arrangements were in place to protect people from the risk of abuse. One person using the service told us, "I feel safe and staff are kind." People's relatives told us they felt their family members were safe with the staff who supported them.

Staff had received information outlining the provider's 10 key policies relating to areas such as safeguarding adults and children, the use of restrictive physical interventions and whistle-blowing. Staff we spoke with were able to explain their understanding of the key policies and procedures and provide examples of how these policies related to their duties and responsibilities.

Staff had completed training in adult safeguarding prior to working with people who used the service and were able to tell us what they would do if they felt someone they were supporting was being abused. Staff demonstrated they understood how to recognise the signs of abuse and told us they would contact their manager and social workers, and complete the relevant incident forms and body maps if they had any concerns about a person's safety and/or welfare. People's relatives also informed us that they knew how to raise any issues of concern and were aware of who to contact should they need to.

Care plans we looked at contained up to date risk assessments that identified risks to people's safety or that of others. Risk assessments were both generic and specific and covered areas such as accessing the community, road safety and personal safety. For example, some people using the service needed support when going out into the local community and the risks relating to this had been assessed and a plan was in place to minimise the risks.

Risk assessments were reviewed annually or before if required. However, reviews often lacked sufficient evidence to demonstrate how the review process had been conducted and who, other than senior staff had been involved in the proceedings. The registered manager told us, "We need to get better at this; we could improve our risk assessments by having families more involved."

Where staff were responsible for prompting people's medicines, staff had completed training in medicines administration and first aid awareness. Medicines administration records (MAR) were signed accordingly. The supported living service manager told us they audited people's MAR charts on a weekly basis and that any errors or omissions identified were discussed with the relevant staff members. We saw records that verified this auditing process had been completed and staff confirmed that MAR information was checked weekly and collected by senior staff at the end of each month. We noted that since the last inspection, the provider had attended a series of safeguarding meetings with the relevant agencies in

Is the service safe?

relation to medicine errors. We asked the provider to send us a retrospective notification regarding this matter since we had not been informed of the issues at the time they occurred.

Where people had complex healthcare needs or staff were unfamiliar with a specific procedure such as the care of open wounds and bacterial infections, the supported living service manager told us they sought relevant guidance from people's GPs and district nurses. Staff we spoke with confirmed that they would consult people's care plans for

any specific guidance relating to support needs or speak to their manager to ask for advice if they were unsure about anything. Staff confirmed they had access to hand gels and gloves when needed.

We saw evidence in people's care records that emergency 'grab sheets' had been completed. 'Grab sheets' are designed to provide healthcare professionals with up to date information on how best to communicate with people and contain details relating to people's medical needs, medicines and allergies

Is the service effective?

Our findings

Not all care plans contained copies of people's initial assessments and information about people's lives, past and present was not always completed in full. This information provides staff with a better understanding of the people they are caring for and can be used to make suitable matches between staff and people using the service. We also noted that where the provider had asked whether or not people had the capacity to sign their care plans; the relevant responses, signatures and dates were often missing. We were told that most people using the service did not have the capacity to understand the written details of the assessment and decision making process and/or sign the relevant documents.

The registered manager told us that staff received training during their probation period which covered aspects of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time.

We saw that one person had completed a capacity assessment in relation to tenancy agreement issues. However, we saw no other evidence that the appropriate mental capacity tests had been carried out where appropriate. The supported living service manager told us he was aware of this shortfall and had discussed the matter with health and social care professionals. We were told that the service was working pro-actively with staff to alert them to the importance of promoting choice and the recording of these choices.

The registered manager told us that care and support plans were designed to provide details about the individual nature of people's autism and included information about the ways in which people preferred to communicate and strategies for supporting positive behaviour. One family member told us, "The care was worked out very carefully with a psychologist, social workers and staff from NAS. It was joint process with multi-disciplinary involvement."

Some of the care and support records we read contained one page profiles which addressed people's strengths, outlined normal routines and listed people's activity preferences. Care and support plans included people's medical histories and details of whom to contact in an emergency. There was a section outlining people's goals

and the action that was required to meet these goals. For example, one person had stated that they wished to increase their financial independence and a pictorial plan had been developed to show how this goal could be achieved.

Senior staff had completed internal service checklists to identify whether people supported by the service were subject to restrictions relating to issues such as one to one 24 hour support and supervision, locked cupboards and windows and secured appliances. At the time of our visit, nine people had been listed as being subject to these restrictions and were awaiting assessment by the relevant agencies.

People and their relatives/representatives had been shown staff profile information and had been given the opportunity to select staff members who they thought would be best able to meet their needs or the needs of their family members. People and their relatives confirmed that they had received copies of the care and support plans or would request copies if required.

People were supported to maintain their health and independence and to access appropriate healthcare services. The supported living service manager told us that staff accompanied people to annual health reviews with their GPs and made appropriate appointments for dentists and podiatrists as and when needed. We saw evidence of people being seen by healthcare professionals in the care plans we looked at. These included mental health specialists, occupational therapists, dietitians and district nurses. We discussed with relatives how staff monitored whether their family members were unwell or in pain. One relative told us, "We recognise that [our family member] may not be able to ask for help, it's a great concern to us." Staff told us, "We always ask if people are ok, make sure they have regular check-ups and blood tests" and "I pick up on body language and facial expressions. If I have any concerns I speak to my line manager."

Staff were aware of the protocols in place to respond to any medical emergencies or significant changes in a person's health and wellbeing. Staff told us that if someone they were supporting became unwell they would contact staff based in the office and/or contact emergency services. The registered manager told us they would assess the situation and contact GPs, social workers, emergency services and family members. The service operated an out of hours call service.

Is the service effective?

Staff told us they had received training in food hygiene and were aware of food safety issues. Where appropriate, people were supported with menu planning, food shopping and meal preparation. People were supported at mealtimes to access the food and drink of their choice. Where people had been assessed by speech and language therapists and dietitians, appropriate weight and food charts were completed.

Staff were required to successfully complete a six month probation period during which time they received regular

supervision sessions where individual goals were discussed and agreed. Staff were also responsible for completing further training courses in areas such as autism awareness and non-physical approaches to managing behaviour that challenges. Staff were able to develop their leadership skills, attend conferences or complete further relevant training linked to the Qualification and Credit Framework (QCF) in health and social care. The supported living service manager told us the provider actively supported people's professional development.

Is the service caring?

Our findings

One person using the service told us, “Staff are kind and I’m happy with the service.” Relatives told us they were happy with the care their family members were receiving. Comments included, “I have nothing but praise for the support staff; they go well beyond the call of duty all the time,” and “It’s the best agency and staff are really good.” The registered manager told us that staff were required to share the provider’s values and working ethos and demonstrate “kindness and a caring nature.” All of the staff we contacted following our visit were informative, courteous and polite.

People’s relatives told us that where possible, family members had been encouraged to make decisions about their care and how they wished to be supported. One person told us “I had a conversation with staff and decided what I wanted.” The registered manager told us they used one page staff profiles to introduce and match people to staff with the appropriate skills and experience. Relatives told us that family members living in their own homes were generally supported by a team of staff. One family member told us that a small number of staff had been there for many years; “They’re a group of people who have worked together for a long time and are very dedicated to giving the service that is needed.”

Staff supported people to make choices in their daily lives in areas such as activities, meals and personal care. In order to facilitate this, staff used a range of communication methods such as, picture exchange, social stories, objects of reference, Makaton and i-pad programmes. Where people were unable to communicate their choices and

preferences using the above approaches, staff consulted family members and understood the importance of observing and interpreting people’s body language, facial expressions and other verbal and non-verbal cues.

The service encouraged staff to deliver person-centred care. Care plans contained information about people’s preferences and staff had built up positive caring relationships with people using the service. Staff we spoke with were well informed about people’s lives, their family members, favourite past times, future goals and past achievements. We asked a member of staff to tell us what one person they supported liked to do with their free time. They said, “[He/she’s] very bubbly, we took [him/her] on the Big Red Bus tour, [he/she] loves it because it’s sensory, [he/she] loves travelling, looking at things. [He/she] loves drawing; likes to play i-spy. [He/she] is a delight to work with.”

Staff told us they entered daily information in people’s diaries and/or daily logs. Information included a brief overview of the support given, places visited, details regarding well-being and behaviour and any plans for future activities. One relative told us, “Everything gets written down and if I want to know about something I can look and read about it.” Relatives told us they were kept updated about any changes in the health and welfare of their family members. Staff told us they checked diary entries to see how people had been getting along. One support worker told us, “I read the diary; I can see what has happened, why they might be feeling low.”

Staff told us that respecting people’s privacy and dignity was an important part of their work and they always made sure they observed good practice such as asking people’s permission, telling them what they were going to do and making sure doors were shut whilst people attended to their personal care.

Is the service responsive?

Our findings

Initial assessments were not always in place in the care and support records we reviewed. The registered manager seemed unsure if this was because initial assessments had been archived or whether assessments had not been completed for some of the people using the service.

We saw that support plans were in place for people using the service. Not all documents had been completed in full and signatures to demonstrate that people and/or their family members were in agreement were often missing. However, relatives told us that they had attended meetings and had discussed their family member's needs before support plans had been agreed and staff had been allocated.

We asked the supported living service manager whether any of the people living in their own homes were supported by or had access to independent advocates. An advocate works in partnership with people with learning disabilities and their families to make sure they are supported with dignity and respect and have the right support to make choices and decisions about their own lives. The supported living manager told us that it was the responsibility of social workers to appoint independent advocates to people who had been identified as in need of this service. We were told that there were currently three people using the service who would benefit from advocacy and that these needs had been discussed and a request made to the relevant agencies.

Records showed that staff had completed mandatory training in areas such as active support and person-centred planning, safeguarding and health and safety. Some staff had completed training in approaches and interventions for managing people's behaviour. The service had a behaviour co-ordinator who worked closely with a multi-disciplinary team to develop positive behaviour support plans for people using the service. These included information about triggers and guidance for staff about how to diffuse situations and manage risks. One relative told us, "[Staff] understand [my family member's] triggers, we discuss it, no-one is left in the dark and we find solutions to the problems." Health and social care

professionals we spoke with told us that staff didn't always possess the knowledge, skills and confidence required to work with people with highly complex behavioural and communication needs.

Active participation in the local community was encouraged by people's families and support staff. People were supported to attend day centres, colleges and work placements. For example, we heard that one person practised yoga whilst other people using the service visited parks, shops and restaurants. One person told us "I go bowling, to the cinema and the gym. Sometimes I go out for lunch. I'm happy with the service." Another person had been on several holidays abroad.

The registered manager told us that they contacted people and their relatives on a regular basis to review the care and support they were providing. We were told that people's care was reviewed annually and more regularly if this was required. Relatives we spoke with told us, "We have yearly reviews with the social worker and the manager," and "I give feedback over the phone and by email." Another family member told us, "Reviews aren't very methodical or regular but I'm in touch with staff and we'd contact them if we needed to."

We were told that people were supported to feedback about their care at an individual and group level. We saw copies of returned questionnaires in picture format and other languages and noted that overall people were happy with the support and care they were receiving. We were told that informal meetings took place for people living in the supported housing units and that any requests or complaints were recorded in daily logs.

One person using the service said, "I wouldn't need to complain." Relatives told us they knew how to make a complaint and to whom. They told us, "I'd know how to make a complaint if needed" and "We have no reason to complain." The service had a complaints policy which was available in an easy read format for people using the service and their family members. The registered manager told us that low level complaints were managed as soon as they were received and that no formal complaints had been received in the past 12 months.

Is the service well-led?

Our findings

Health and social care professionals told us that the provider did not always inform them of significant incidents involving people who use the service and/or others and that communication both internally and with themselves was inconsistent and required significant improvement.

The service had quality assurance systems in place but was not always actioning recommendations in a timely manner. The registered manager told us that an appointed visitor carried out an annual quality check. We looked at copies of the findings for checks carried out for outreach and supported living services in February 2015 and July 2014 respectively. Areas that had been reviewed included personalised care and support, respecting and involving people who use services and the quality of management. Recommendations were recorded and a plan had been produced for managers which required a response regarding actions to be taken and timescales. We noted that for the outreach service, responses were still outstanding and therefore there was no clear indication as to when service improvements would take place.

The registered manager told us that staff meetings were held on a monthly basis which gave opportunities for staff to feedback ideas and make suggestions about the running of the service. We noted that the last meeting held for outreach support workers was in October 2014, over six months ago. The registered manager told us that meetings for staff who worked as outreach support workers were not always well attended despite the various initiatives implemented to encourage attendance including telephone conferencing, payment for attendance and flexible scheduling.

We read the minutes for staff meetings organised for supported living staff members and saw that issues such as incidents, medical appointments and people's achievements had been discussed. The service manager for supported living services told us that all day meetings sometimes took place for supported living staff; these were termed 'extraordinary meetings' and were organised to review people's individual needs in detail, discuss new placements and plan activities.

Staff confirmed they received regular supervision sessions and one member of staff told us, "Supervision is helpful, I get good feedback and I feel comfortable approaching [the registered manager] about anything." Another member of staff said, "[The supported living service manager] understands the staff, he listens, he will address the situation and come back to you". We saw evidence in staff records that supervision was conducted on a regular basis and in various different formats. However, a health and social care professional we spoke with told us that staff were not always adequately supported because the supported living service manager was often covering vacant shifts. We heard from one member of staff who told us, "[The supported living service manager] is sometimes too busy to talk, he's always doing something else but when he does have the time he's very helpful."

The registered manager told us he operated an open door policy and that people who used the service, their relatives and staff, were able to contact him at any time during office hours. Relatives expressed positive views about the registered manager's approach to managing the service. Comments included, "I've met [the registered manager], we're very fond of him, he's very kind to our family", "The manager is very helpful", and "[The registered manager] is very supportive when needed." Staff told us that both the registered manager and the supported living service manager were very good.

The service monitored the quality of care through regular contact with people and their family members either via phone, email or meetings. We saw evidence of this in people's care and support records. People's relatives told us, "We're involved in project groups, we meet with staff and social workers at least monthly" and "The feedback is very good, we liaise closely by email and phone."

Staff were aware of the reporting procedures for any accidents or incidents that occurred and told us they would record any incidents in people's diaries or daily communication records and report the matter to senior staff. Senior staff were required to complete an electronic incident form and email this to the behaviour co-ordinator. Incidents and accidents were monitored on a monthly basis and updates provided to health and social care professionals and a senior panel of staff to analyse any trends and devise action plans where required.