Hoffmann Foundation for Autism

Hoffmann Foundation for Autism - 4 Park Avenue

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This unannounced inspection took place on 16 and 20 March 2015.

Hoffmann Foundation for Autism – 4 Park Avenue provides accommodation and personal care to up to six people who have a learning disability and who may have an autistic spectrum condition. The service is registered as a care home. At the time of this inspection there were five people using the service.

The previous inspection was 27 August 2014 when the provider was found to be failing to comply with Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because the provider did not have proper systems for protecting people against the risk of unsafe care. This was because they were not assessing risks to people's health, safety and welfare and they were not monitoring the quality of care provided. We served a warning notice on Hoffmann Foundation for Autism for failure to comply with this

Summary of findings

regulation. At this inspection we checked this and found that the provider had made improvements and were visiting the home more regularly and checking on the quality of the service and identifying risks.

There was a registered manager in the home. 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. At the time of the inspection the registered manager told us they were working at the home one day a week and there was a temporary experienced deputy manager working in the home full time.

People were cared for by experienced staff who knew their needs well. Staff supported people to follow their own chosen routines and to take part in activities they liked, such as going to restaurants, cinema, gardening and discos.

Arrangements for looking after people's money did not ensure financial abuse could not take place. Some people did not have privacy in their bedrooms.

The service was managing people's medicines safely and supporting them to maintain their health including attending regular medical appointments. A relative told us that their family member was happy and well looked after. They thought staff were kind and caring.

Staff did not have ongoing training in supporting and communicating with people with a learning disability, behaviour that challenges a service or autistic spectrum condition. People did not fully understand programmes designed to support people with their behaviour and care plans were not person centred. This means the plans did not always show that the person's needs and wishes were at the centre of all decisions made about their care.

We have made recommendations about managing complaints and improving person centred care.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Since 1 April 2015, these Regulations have been replaced with the 2014 regulations. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate 

The service was not always safe. Staff knew how to respond in the event of any abuse but the arrangements to prevent abuse were not always robust. Risk assessments were not always specific to the individual's needs.

Health and safety monitoring was not consistent and first aid arrangements were not satisfactory.

The service managed people's medicines safely.

Is the service effective?

Requires Improvement 

The service was not consistently effective. Staff felt supported but did not have all the ongoing training needed to meet the specialist needs of some people using the service and had no appraisals in the last year. The service did not fully understand the Mental Capacity Act and the need to assess people's mental capacity and act in their best interests.

Staff supported people with eating and drinking and to use health services to maintain their health.

Is the service caring?

Requires Improvement 

The service was caring. Staff were kind to people, knew them well and worked hard to meet their individual needs. The service met people's cultural needs. People's rights were not always respected, for example no action had been taken to ensure people had privacy in their own bedroom.

Is the service responsive?

Requires Improvement 

The service was not consistently responsive. Although people had person centred plan documents these did not always reflect their individual views and wishes. Guidelines for staff did not always reflect people's needs and abilities in enough detail.

Behaviour programmes were difficult for people to understand and did not focus on meeting the person's needs.

The service supported people to follow their personal interests such as going on holiday, to restaurants, cinema and other places they enjoyed and staff responded appropriately to people's requests for support.

Complaints were not always dealt with effectively.

Is the service well-led?

Requires Improvement 

The service was not consistently well led. The provider had been visiting the home to monitor the service regularly since our last inspection and improvements had been made. Staff said the new temporary deputy manager had brought a number of improvements to the home and they felt supported.

Summary of findings

The staff team was caring and committed but lacked leadership in person centred care planning.

Hoffmann Foundation for Autism - 4 Park 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.

This inspection took place on 16 and 20 March 2015 and was unannounced.

The service is a care home for six people who have a learning disability and who may also have an autistic spectrum condition. At the time of the inspection there were five people living at the home.

The inspection was carried out by one inspector and a Specialist Professional Advisor with a specialism in learning disability. We visited the service for two days and contacted representatives of people who used the service to seek their views. We had feedback from one family member and two professionals about the quality of the service.

We considered the previous inspection reports in the last two years including the last one from August 2014, a warning notice served as a result of that inspection and notifications from the provider before the inspection.

We interviewed eight staff and the registered manager. We looked at four people's care records and carried out pathway tracking (where we read a person's care plan then checked to see if staff provided the care in accordance with the care plan). We reviewed staff records to look at their training, recruitment, meetings and supervision. We also looked at medicines records, financial records, the provider's reports on the service, accident and incident reports, complaints and compliments and health and safety records.

We were able to speak with two of the five people who used the service but the others were not able to talk with us. We spent time observing how staff interacted with people in the communal areas such as the lounge, office and kitchen/dining area. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Is the service safe?

Our findings

Staff had a good understanding of safeguarding procedures. They knew how to recognise if somebody had been abused and how to report this, however there was less understanding of how the behaviour of one person in the home may have a negative impact on another. People were able to go into each other's rooms without staff assessing whether the person agreed to this.

People were not always protected against the risk of financial abuse. Following previous financial abuse by a former employee, the provider implemented regular checking of people's finances by a representative from head office. The manager told us that nobody in the home was able to give informed consent about their finances. We found that the service had followed a best interest process when planning for holidays as families and/ or professionals were involved in taking decisions about payment arrangements. However, we found that there were no mental capacity assessments in relation to the management of people's finances. We found the manager had autonomy to withdraw large sums of money from some people's accounts to make purchases with no safeguards in place and no best interest process followed on what their money was spent on. We checked a sample of two people's financial records and found they were accurate and clear record of all expenditure made but there had been no record of authorisation or consultation for one person spending over £600 on one purchase. There was no evidence of financial misappropriation but the practice of allowing one employee to be able to withdraw large amounts from people's accounts could leave people at risk from further financial abuse.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Three risk assessments were not personalised to each person and so did not give staff enough information on how to manage the risks to people's safety. There were some risk assessments addressing risks that one person may pose to another but the service had not taken action in all cases to ensure everyone in the home was protected from the negative behaviour of others. The risk assessments for supporting people to go out recorded that a person needed staff support "in a ratio which is appropriate to his level of funding." This did not advise staff on how many staff were needed to support people to go out safely. Another person's risk assessment stated that staff should have training in administering rectal diazepam when this person was not prescribed this medicine, therefore staff did not need the training. The lack of clear guidance for staff about people's individual risks would mean that risks to their safety were not known and managed appropriately.

There were procedures in place to deal with emergencies. Staff had telephone numbers for the registered manager, temporary deputy manager and local safeguarding team if they needed advice or help outside of office hours. However, first aid kits to deal with minor medical emergencies were not fit for purpose. Staff had recorded that these were checked and contained all the recommended contents for several months but we found both first aid kits in the home contained out of date items such as creams and dressings. Some dressings had expired in 2010. Other items such as plasters were missing. The service was therefore not able to respond to emergency first aid incidents appropriately. Staff purchased suitable new first aid boxes the day after our inspection. We noted on the second day of the inspection that first aid kits had been replaced and had been used for a minor injury the previous day.

The above was a breach of of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing levels were meeting people's needs most of the time but there were occasions when staff could not always ensure they could meet people's needs in the early morning. There were three staff on duty during the day with a fourth to support people with going out. At night there was one member of staff awake and another asleep in the home on call for emergencies. Staff told us they thought the staffing level was satisfactory to meet people's needs. One professional said that there were not always enough staff working in the evening for people to be able to go out if they had not planned this in advance. At night the staff member awake was at times busy supporting a person downstairs and would be unable to stop people upstairs

Is the service safe?

from entering others' rooms. Some staff said they were regularly woken up to help when they were sleeping in. During our observations carried out between 7am and 2.30pm there were enough staff to meet people's needs.

We found that the provider did not always follow best practice in recruiting staff. We looked at the files of three staff who had been recruited in the last two years. One of the three staff had a verbal reference recorded from their last employer. The other two had written references. Another reference had been accepted without evidence to verify that it was from the employer. The provider had taken out Disclosure and Barring scheme (DBS) check on a recently employed staff member. This was to check they did not have a criminal record making them unsuitable to work with vulnerable people. The other two people had been employed with DBS checks from their previous employer which was carried out over two years ago. They had not been checked again as part of their current employment with the service.

Medicines were managed safely in the home. There had been one medicines error but the service had improved checks on medicines and there had been no further problems. We observed staff giving people their medicines and saw that they checked to ensure they were giving the right medicines, ensured the person had a drink and that they swallowed it and encouraged them. Medicines were kept securely but in a communal room and administered safely. We discussed this with the registered manager to ask if there was any risk of other people distracting staff when the medicines cupboard was unlocked. They said they would carry out a risk assessment and, depending on the outcome, consider moving the medicines to a more private room.

The provider ensured that maintenance checks such as legionella water checks and checks of electrical equipment were up to date so that the building was safe. The electrical wiring was due for inspection in 2015. The Fire Brigade had visited in February 2015 and asked for some improvements to be carried out. The manager assured us these would be carried out by the deadline given by the Fire Brigade. A fire door which was not closing properly in February when the Fire Brigade visited was still not closing fully on the first day of our inspection. This was repaired by the second day of our visit. Staff in the home carried out health and safety checks. The checks on first aid kits had not been carried out and recorded properly but we noted an improvement since the last inspection to the way fridge temperatures were monitored.

Requires Improvement

Is the service effective?

Our findings

Two people were able to tell us that they liked the home and the staff who supported them. They said, "I like it" and "[staff member] helps me."

Staff had undertaken various training courses, some of which were face to face and some were e-learning. The provider did not have complete up to date training records for all staff. The registered manager was not keeping a record of staff training and some certificates were not available as evidence staff had completed training. We were able to obtain information on staff training from head office. We informed the registered manager that the lack of a record of all staff training in the home meant that they could not see which staff need which training at any time.

Staff training did not always support staff enough to meet people's needs. Staff training included three days of autism awareness during staff induction. There was no further training on meeting the needs of people with an autistic spectrum condition. Some people in this service showed behaviour which challenged the service and despite challenging behaviour training, staff did not have sufficient knowledge to be able to support them with this behaviour. We observed all staff to be caring and patient at all times but they did not have the knowledge and support to assess reasons for people's behaviour and work with them to address the challenges. We spoke with staff about the behaviour programmes being followed with two people at the time of the inspection and found that staff had not been appropriately trained or supported to understand, carry out, record or analyse the effectiveness of the programmes. Staff followed instructions but there was a lack of records of monitoring of the key behaviours or achievements associated with the programmes to assess effectiveness of the approach.

The registered manager held regular staff supervisions. Staff said they felt supported in their work by the temporary deputy manager. No appraisals had taken place in the last year. This was a missed opportunity for staff to be able to discuss and plan their learning needs.

The above was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. The registered manager was trained to understand when applications for DoLS authorisations should be made, and in how to submit one. People in the home were deprived of their liberty. They were unable to leave the home without staff support as there was a keypad on the door which they were unable to use. The reason for this was that people in the home were assessed as being at risk of harm if they went out alone. The registered manager had applied for and received deprivation of liberty safeguards authorisations in relation to this restriction. When people wanted to go out they could tell staff verbally or show them by using a point of reference, such as getting their coat or taking staff to the front door.

Staff had attended training but had a limited understanding of the Mental Capacity Act 2005 and how to ensure the rights of people with limited mental capacity to make decisions were respected. People living in the home did not have any mental capacity assessments in their care plans in relation to their capacity and abilities to consent. There was therefore no written guidance to advise staff how each person could be involved in making decisions about their care and who they might like to support them with this process. There was no evidence of the provider seeking people's consent to their care plans or behaviour plans. A relative told us they were fully involved in planning the care for their relative by staff at the home and social workers had been involved in reviewing at least two other care plans so the provider had involved people's representatives. he service did not comply with the requirements of the Mental Capacity Act 2005 so there was a risk that care could be provided without consent.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff supported people with eating and drinking. Everybody was able to eat independently and staff cooked their meals. Staff supported people to make their own hot drinks and some of their own food where they were willing to do this. Staff encouraged people to be involved in

Requires Improvement

Is the service effective?

mealtimes such as setting the table and clearing up afterwards. People ate well and had a varied diet. People had second helpings when they wanted to. Staff supported people to eat in restaurants and experience different types of food. Staff knew and acted on people's preferences, such as drinking out of a favourite cup.

The service supported people with their health needs. We found that staff supported people to go to the GP for health checks, dentist, optician and specialist healthcare professionals where needed.

We looked at the weight records for three people. Staff monitored people's weight regularly but a recent discrepancy in the weight records indicated that two people had either lost a significant amount of weight in six weeks or they had not been weighed correctly. This had not been picked up by the registered manager. We brought this to the registered manager's attention who assured us they would address this discrepancy.

Requires Improvement

Is the service caring?

Our findings

One person told us they liked the staff and they liked their keyworker. They said, “my keyworker helps me.” They said they could make some decisions. This person also told us, , “I can do it if I like to,” and when staff suggested they do something they did not want to do, “I don’t want to. No thank you.” The staff were supportive and encouraged people to express themselves and to be independent in the home. Staff had formed good relationships with people and knew their needs well. People were confident about approaching staff to let them know what they wanted. Staff showed concern and responded to individuals to ensure their wellbeing during our observations. There was a happy friendly atmosphere during the two days of our inspection.

People did not always have privacy maintained when in their bedroom as another person entered their room at times. Two people were known to go into another person’s bedroom during the night on occasions. The provider had not taken action to ensure this could only happen with the other person’s consent. Suitable locks where others could only enter with a key were not provided. There was a record showing that a door alarm had been recommended to ensure staff were able to support one person as soon as they left their room before they could go into another room. This alarm had not yet been purchased and no other action, such as extra staff support at key times, had been implemented . From reading records and speaking with people it was apparent that people did not welcome the intrusion into their bedroom while they were sleeping.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 10 of the Health and Social Care

Act 2008 (Regulated Activities) Regulations 2014.

Staff tried to preserve a person’s dignity by encouraging them to talk in a private room when they were talking about confidential issues, they also supported people to ensure they were appropriately dressed. People chose their own clothes and staff advised them on clothing to protect their dignity but allowed them to make their own choices.

The staff team was from a variety of ethnic backgrounds and a mix of men and women of different ages. The registered manager ensured staff on duty could meet the preferences of people in the home. There was always a female staff member to support the female resident with personal care. Some staff had worked in the home many years and had a good understanding of each person.

Requires Improvement

Is the service responsive?

Our findings

Two people told us about their interests. One person said they liked to go out, visit family and drink tea and another said they liked to go shopping and read books with staff. Staff supported people to follow their interests. One person liked gardening and we saw that staff had gardening activities planned to grow vegetables with this person. There were group activities such as holidays, a weekly disco, visits to a farm, restaurant and pub visits plus individual activities such as cinema and shopping. A relative told us that their relative was happy at the home and their wishes and preferences were respected and that they were supported with a range of leisure interests.

We saw people were comfortable and being supported with their care needs during the inspection. Staff were committed to providing good care and tried to follow the plans in place even though the written care plans were not easy to understand and implement.

Although staff were focussed on supporting people well, the service did not provide a fully person centred way of planning care and supporting people. People had "person centred care plan" documents but these did not always reflect each person's needs and preferences. One person's plan included comments written by staff, in response to the question "what do you like about where you live now?" the response was; "I am encouraged to take my medications as prescribed" and other comments about the home's routine rather than the person's preferences. The care folders did not show evidence that the service had tried to involve people as far as they were able. Some of the documents were written in the first person ("I like") even though the content was not what the person may wish or was able to say.

One person had two behaviour support plans containing contradicting information. These were written in the first person as if the person had been involved in it but the content contained information that the person would not have agreed to, for example "please make sure you do not give me any tea" from a person who liked to drink a lot of tea. The plan was not person centred as it did not address what the person's support needs were and the reason for the behaviour was not recorded nor why certain strategies were being used. There was an incident report showing a clear link between the behaviour strategy and an assault on staff. We saw that there was no action taken or learning as a result of this incident.

Two people's behaviour support programmes were not always effective and were not person centred. We discussed these programmes with staff and the people they were for and found neither understood one of the programmes and it was not being followed as planned. We discussed our concerns about the appropriateness of the behaviour programmes with the registered manager who agreed that these programmes would be reviewed in the light of our findings.

An activity communication board was used with Widgets symbols for all the people living in the home. Widgets are pictorial symbols of words. The use of Widgets was not the best method of communication for everybody as a Speech and Language assessment indicated one person understood pictures better and the registered manager said that two people did not understand the widgets well. Some of the symbols were the same with different writing underneath even though the person had been assessed that they are unable to read. For example a symbol of a plate with cutlery said "eating out" for one person and "lunch at daycentre" for another.

In the morning staff did not refer to the activity board supporting the conversation and preparations for the activity that was about to occur. In the afternoon the staff supported some of the people put up the activity symbols. The staff told them what the activity was going to be and asked them to find the corresponding Widget. There was one board shared between all five people. They had no communication books or boards in their room to show them what was going to happen that day. There was a lack of individualised communication programmes to meet people's needs.

There was a lack of goals and development in care plans which were being worked on to help people develop their skills and aspirations. This was also the view of a visiting professional.

There were some goals that had not been acted on recently with no reason recorded for this.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 of the Health and Social Care

Requires Improvement

Is the service responsive?

Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have a fully effective system for addressing complaints. There was an accessible complaints procedure and complaints were recorded appropriately but a longstanding complaint had not been resolved. There had been a number of complaints about noise. These complaints had been made over a period of more than a year and the last complaint was in February 2015. The service had attempted to address the cause of the complaints but the plan put in place to address the noise problem advised staff to act in a way which on some occasions had made the noise problem worsen. The registered manager advised that there was a plan to provide some sound proofing in the home but there was no date planned for when this would take place.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We recommend that the service seek advice and guidance from a reputable source about good practice in supporting people whose behaviour challenges the service.

Requires Improvement

Is the service well-led?

Our findings

People living in the home were settled there and had good relationships with staff. The staff team were committed to the service and to providing good care to people, but there had been a lack of leadership to ensure a culture that is person-centred and empowering.

Staff said they were well-led and always had a senior person to call for advice and assistance.

We did not look at quality assurance surveys at this inspection but a relative told us they received a survey from the provider twice a year asking if they were satisfied with the service. They also said the service listened to their suggestions and acted on them.

Staff said the new temporary deputy manager had made lots of improvements in the home. The registered manager said that, although he had reduced the hours he worked in the home to approximately one day a week, they believed things were running smoothly due to the appointment of the temporary deputy manager. There was not a clear plan about the management arrangements in the future and we asked the registered manager to notify CQC of permanent plans as soon as possible.

The care records (risk assessments, behaviour programmes, care plan guidelines and person centred plans) caused some confusion as there were a number of documents staff had to refer to which at times contained differing information.

We recommend that the service seeks advice and guidance from a reputable source on how to further develop the service, based on current best practice, to promote a person centred culture.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered persons had not ensured that the equipment used for providing care or treatment to a service user is safe for such use and is used in a safe way. Regulation 12(2)(e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse as there were not effective systems and processes to prevent theft, misuse or misappropriation of money or property belonging to a service user. Regulation 13(1)(2)(6)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered persons did not ensure care was only provided with the relevant person's consent and where a service user was unable to give consent because they lack capacity the registered person did not act in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The registered persons did not effectively operate a system for handling and responding to complaints.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered persons did not always ensure care was appropriate, meeting people's needs and reflecting their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered persons had not ensured that staff receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18(2)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered persons had not ensured service users were always treated with respect as they had not ensured their privacy. Regulation 10(1)(2)(a)