# Spectrum (Devon and Cornwall Autistic Community Trust)

# Chylidn

## 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 well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

We carried out a focused inspection at Chylidn on 02 June 2016, the inspection was unannounced. The previous inspection was an unannounced comprehensive inspection carried out on 2 December 2015. At that time we found breaches of the regulations in relation to staff support, record keeping and risk management. The provider subsequently sent us an action plan setting out what they intended to do to ensure they complied with the regulations. At our next comprehensive inspection we will check to see this has happened.

In May 2016 we received concerns in relation to staffing levels, staff training and the management of the service. As a result we carried out this focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Chylidn on our website at www.cqc.org.uk

Chylidn provides care and accommodation for up to five people who have autistic spectrum disorders. At the time of the inspection four people were living at the service.

There were sufficient numbers of staff to support people to take part in individual activities and carry out daily routines. Staff were experienced and had undertaken a thorough induction and training in areas identified as necessary for the service. Training in areas specific to people's individual needs was not regularly updated.  Staff received regular individual supervision sessions from their line managers.

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. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Mental capacity assessments and best interest meetings had taken place when necessary and were recorded as required. Staff had received training in the Mental Capacity Act (2005) and associated Deprivation of Liberty Safeguards (DoLS).

People were supported to adopt healthy lifestyles and encouraged to eat healthily. However, staff told us the food budget was limited which meant people's choices were restricted but staff also told us people did not go hungry. We observed two people eating lunch and noted the food portions were good.

Staff were friendly and respectful in their approach to people. They demonstrated a concern for people's well-being and a shared approach to support. Staff morale was good and staff told us things had improved recently. A system of core teams and key workers had been identified to help ensure support was consistent. Key workers have responsibility for overseeing an individuals plan of care. A core team is a group of care workers who are assigned to work with a specific individual for the majority of their time.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was safe. There were sufficient numbers of experienced staff to support people with daily routines and activities.

We could not improve the rating for safe from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

### Is the service effective?

**Requires Improvement**

The service was not entirely effective. Staff received regular training in areas identified as necessary for the service. However training specific to people's needs was out of date for a large number of staff.

People were supported to eat healthy diets. However, people's choices were limited by the food available.

Staff worked in accordance with the legal requirements of the Mental Capacity Act and associated Deprivation of Liberty Safeguards.

### Is the service well-led?

**Requires Improvement**

The service was well-led. The staff team were supported to develop a person centred approach to care and support.

We could not improve the rating for well-led from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

# Chylidn

**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 03 June 2016 and was unannounced. This was a focused inspection carried out to look into concerns we had received. The service was inspected against three of the five questions we ask about services: is the service safe, effective and well-led. The inspection was carried out by one inspector.

Before the inspection we reviewed previous inspection reports and other information we held about the service including any notifications. A notification is information about important events which the service is required to send us by law.

We spoke with one person and observed staff interactions with people. We spoke with the registered manager, deputy manager, and five care workers.

We looked at detailed care records for one individual, and other records relating to the running of the service including staff rotas and people's daily logs.

Requires Improvement

# Is the service safe?

## Our findings

We had received anonymous concerns stating that the service was understaffed. The people living at Chylidn have complex needs and it is important they are supported according to their commissioned hours in order to keep them safe. People living at Chylidn had limited verbal communication. We did spend some time talking with people and observed the care and support being provided to them. We saw they were at ease with staff and comfortable in their surroundings.

On the day of the inspection there were sufficient numbers of staff on duty to support people to go out on individual activities, attend appointments and engage in daily chores and routines. We looked at rotas for the previous two weeks and saw the minimum staffing levels were consistently met. Staff told us there were enough staff to meet people's needs. One said; "We are proactive in making sure any gaps are covered." The deputy manager told us; "There are certain bank staff who are usually able to help." We also looked at people's individual daily logs. These showed people had attended activities in the community with the support of two members of staff on most days. It was not unusual for people to go out more than once. For example, on bank holiday Monday one person had gone out for lunch and then again later for a walk and an ice cream. Another had gone shopping during the day and out bowling in the evening. The registered manager told us there was a 10 hour waking night vacancy which was usually covered by bank staff who were familiar with the service. The staff team were experienced and knew the people they supported well. Although two members of the team had only recently completed their induction they both had worked for Spectrum previously. We did not find any evidence to substantiate the concerns received.

People were protected from the risk of abuse because staff had received training to help them identify possible signs of abuse and knew what action they should take. Flyers and posters in the office displayed details of the local authority safeguarding teams and the action to take when abuse was suspected. This information was freely available to staff and visitors to the service.

Requires Improvement

# Is the service effective?

## Our findings

We had received anonymous concerns claiming staff were not trained or supported properly. This meant people could have been at risk of being supported by staff who did not have the appropriate skills or knowledge.

New staff were required to complete an induction process consisting of a mix of training and shadowing more experienced staff. This applied to all staff even if they had worked for the provider previously. The induction process had been updated to include the Care Certificate, a nationally recognised training course, for staff who were new to care. Records showed staff were receiving individual supervision regularly from their line managers although waking night staff did not receive supervision as frequently as the rest of the staff team. A member of staff told us supervisions were, "A real help." Another said; "It's the most supervisions I've ever had."

Training identified as necessary for the service was updated regularly. The week before the inspection some staff had received training in safeguarding, food hygiene and first aid. Staff also had training specific to people's needs such as autism awareness and Positive Behaviour Management (PBM). However, some staff had not received training updates in these areas for some time. For example, five members of the staff's training in PBM had expired. Five member's of staff had not had autism awareness refresher training for some time. Following the inspection the registered manager told us further training in this area was being developed.

People were supported by core teams who were able to meet their needs and preferences. For example, one person preferred to be supported by female staff who were outgoing and active and their core team reflected this. The deputy manager told us this worked particularly well for one person whose behaviour could be difficult for staff to manage. Rotas were organised to help ensure at least one member of the core team was available for the person to turn to for support if they became anxious. As a consequence the occasions when the person became distressed had decreased in both number and intensity. People also had key workers to oversee their care planning. This demonstrated the delivery of support was consistent. We did not find any evidence to substantiate the concerns received.

We had received concerns that people were not getting an adequate diet. People's care plans contained information about their dietary needs and preferences. One person had decided they wanted to adopt a healthier life style and they were being supported to eat a balanced and healthy diet. They had received input from a dietician to help them achieve this. There was fresh fruit available in the kitchen. We looked at the food stored in cupboards and fridges and saw there was not a great deal in stock. The deputy manager told us it was a shopping day and we saw people were scheduled to go shopping. However, staff told us the budget for food was tight and they were often low on food. They told us people's choices were restricted but they did not go hungry. We observed two people having their lunch and noted the portion sizes were good. We did not find evidence to substantiate the extent of the concerns received.

We had received concerns that the provider was not working in line with legislation laid down in the Mental

Capacity Act 2008. This would mean people were at risk of having their liberty unlawfully restricted.

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Mental capacity assessments and best interest meetings had taken place and were recorded as required. Best interest meetings involved staff, families and external professionals where necessary. Staff had received training in the Mental Capacity Act (2005) and associated Deprivation of Liberty Safeguards (DoLS). We did not find any evidence to suggest staff were not working in accordance with the legislation.

Requires Improvement

# Is the service well-led?

## Our findings

We had received anonymous concerns claiming the staff team had not been developed to ensure they adopted and displayed appropriate values and behaviours.

We observed staff interactions with people and saw these were friendly and respectful. Staff offered reassurance to people and took time to listen to them and make sure they understood what their needs were at any time.

The registered manager told us they had developed a robust system of communicating with all staff including the waking night staff who they said; "communicate really well using the team book." Staff meetings were being held bi-monthly and the rotas organised to help ensure as many permanent staff as possible could attend. The deputy manager told us attendance was "quite good." Spectrum's in-house clinical psychologist was booked to attend the next staff meeting to talk to staff about the importance of person centred care.

Staff told us things had improved recently. One said; "Things are going well." The deputy manager commented; "It's visibly noticeable that everyone here has a lot more direction and is a lot happier." They went on to say that staff morale had improved and this had impacted on the quality of support they provided. Comments from staff included; "It's nicer to come to work now" and "Staff are quite open, everyone gets on well."

From our observations and conversations with staff and managers we found the staff team were positive and displayed a shared approach to support which focused on the needs of the people they supported. Staff were supported to deliver consistent care which focused on people's needs. We did not find evidence to substantiate the concerns raised.