Autism Hampshire

The Bungalow

Inspection report

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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

The Bungalow is registered to offer support and accommodation for up to 5 people with learning disabilities and autism. On the day of our visit there were 5 people living at the home. Care was provided on one floor; each person had their own room and shared a kitchen, lounge and garden.

There was no registered manager in place, although there was a manager in place who has applied to the Commission and is having their interview with us shortly. 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.

This inspection took place on 7 December 2015 and was unannounced.

The service had robust systems in place to maintain people's safety at all times. Risk assessments were carried out to identify and minimise risks to people.

People were safe because staff supported them to keep safe and staff knew how to manage risk effectively. Recruitment practices ensured staff were suitable to work with adults at risk. There were sufficient numbers of care staff with the correct skills and knowledge to keep people safe.

Medicines were administered, recorded and stored in line with company policy and good practice. Staff were aware of the importance of medicines management and showed knowledge of the medicines they administered and their purpose.

Staff underwent a comprehensive induction period and ongoing training which enabled them to effectively support people in their care.

People and their relatives were involved in making decisions about their care and support. Their care plans were individual and contained information about how they preferred to communicate and their ability to make decisions. The service was aware of and met the legal obligations around mental capacity and deprivation of liberty.

Staff had good relationships with people who used the service and were attentive to their needs. People's privacy and dignity was respected. People were encouraged to take part in activities that they enjoyed, and were supported to keep in contact with family members. When needed, they were supported to see health professionals and referrals were put through to ensure they had the appropriate care and treatment.

Relatives and staff were complimentary about the management of the service. Staff understood their roles and responsibilities in providing safe and good quality care to the people who used the service.

The management team had systems in place to monitor the quality of the service provided.

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

People were protected against risks to their health and wellbeing, including the risks of abuse and avoidable harm.

There were sufficient numbers of suitable staff to support people safely and meet their needs.

People were protected against risks associated with the management of medicines. They received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the knowledge and skills needed to carry out their responsibilities.

Staff obtained people's consent to their care and treatment. They followed legal guidelines to make informed decisions in people's best interests where people lacked capacity to make certain decisions themselves.

People were supported to have a balanced diet. Their health and welfare was maintained by access to the healthcare services they needed.

Is the service caring?

Good

The service was caring.

People had positive relationships with the staff who supported them.

People were able to make their views and preferences known. They were encouraged to take part in reviews of their care.

People's independence, privacy and dignity were respected and promoted.

Is the service responsive?

Good

The service was responsive.

Staff delivered care, support and treatment that met people's needs, took into account their preferences, and was in line with people's assessments and care plans.

People were able to take part in individual and group activities that took into account their interests and choices.

A procedure was in place to manage complaints and relatives told us they had used it to raise recent concerns about the home.

Is the service well-led?

Good

The service was well led.

The providers' values were clear and understood by staff. The management team adopted an open and inclusive style of leadership.

People, their representatives and staff had the opportunity to become involved in developing the service.

Systems were in place to monitor, assess and improve the quality of a wide range of service components. These included regular audits and unannounced spot checks by the provider.

The manager understood the responsibilities of their role and notified the Care Quality Commission (CQC) of significant events regarding people using the service.

The Bungalow

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The inspection took place on 7 December 2015 and was unannounced. The inspection was carried out by one inspector who had experience of mental health and learning disability services.

Before the inspection we reviewed information we had about the service, including previous inspection reports and notifications the provider sent to us. A notification is information about important events which the provider is required to tell us about by law. The provider completed a Provider Information Return (PIR). This 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. This is information that helps us to assess the service. The manager and their line manager gave us additional information on the day of the inspection.

We spoke with or observed care and support being given to three of the people who lived at the home. We spoke with the manager, service manager and four members of support staff. We spoke with the families of three people who live at the home.

We looked at the care plans and associated records for three people. We reviewed other records, including the provider's policies and procedures, emergency plans, internal and external checks and audits, staff training, staff appraisal and supervision records, staff rotas, and recruitment records for three members of staff.

Good

Is the service safe?

Our findings

We observed people who were unable to tell us verbally about their experiences and they demonstrated that they felt safe. We saw one person experiencing anxiety, where they hurt themselves on a wall. Staff remained calm, ensured the person's safety by placing a cushion between their head and the wall and monitoring the situation. Staff were confident in what they were doing. This included talking with the person gently to reassure them and encouraging them to get up from the floor and sit in the lounge, when they gauged this was the right time to say this.

The recruitment process ensured that new staff were of good character and suitable to carry out the role. Disclosure and Barring Service (DBS) checks were completed on all of the staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. We looked at three recruitment files which had a full employment history, references and copies of the questions asked at interview.

We looked at the rotas for the staffing at the home. We had seen from care plans that some people had been assessed as needing support from one or two staff all of the time. The rotas indicated that needs were met and dedicated teams of people helped to support those that needed extra care to enable them to participate in life in the home and in the community. Staff we spoke with said that there were enough staff available.

Staff told us that there were three staff vacancies. The manager told us that they were actively recruiting to these vacancies. They told us these shifts were covered by permanent staff where possible and if not permanent staff, the provider used a team of internal bank staff or agency workers. Staff described how they supported unfamiliar staff during a 'shadow' shift. They confirmed that in an emergency the shadow shift was not always possible so unfamiliar staff never worked on a one to one basis with people.

There were systems in place to protect people from risks, for example one member of staff had the role to test fire alarms weekly, another member of staff's role was to check first aid boxes. There was also a fire safety plan for the home and individual personal evacuation plans for people. Staff were aware of the plan and were able to tell us the action they would take to protect people if the fire alarm went off. There were regular checks regarding Legionella and we saw that some staff were to attend training regarding this, the day after the inspection.

Care plans showed that staff had identified and assessed the risks for each individual; these were recorded along with actions identified to mitigate those risks. They were written in enough detail to provide the information staff required to protect people from harm whilst promoting their independence. For example, one person would break crockery or might use cutlery to harm themselves, and so they used plastic plates and bowls and cutlery. Although this person did not go into the kitchen often we saw that they were protected by cupboard doors being locked. Staff told us that the other people in that house would indicate to staff if the cupboards were left unlocked. They would also indicate to staff when they wanted to have something from those cupboards.

Relatives we spoke with compared recent changes to how this service was earlier this year; one said that they were "Overall pleased with staff", "[name] is safe". Another mentioned an incident in the recent past which they were not informed about at the time, where they were called a day later. They had raised concerns and this has now been looked into but they were very concerned at the time. They now feel their relative is safe.

Where an incident or accident had occurred, there was a clear record of this and an analysis of how the event had occurred and what action could be taken to prevent a recurrence. For example, we saw that one person had an identified risk of choking. Referrals had been made to the speech and language therapists and information from those assessments had been incorporated into individual care plans. Staff we spoke with were aware of this risk and how they should present food to the person to ensure ease of swallowing and protect them from choking.

Accidents and incidents were recorded in a way that allowed staff to identify patterns. These were available for the manager and senior managers to monitor and review to ensure appropriate management plans were put in place.

Staff had the knowledge necessary to enable them to respond appropriately to concerns about people. All staff and the manager had received safeguarding training and knew what they would do if concerns were raised or observed in line with the providers' policy.

Storage arrangements for medicines were secure. The home had a policy and procedure for the receipt, storage and administration of medicines. Staff supported people to take their medicines and these had been administered as prescribed. Two members of staff were involved in the administration of medicines. One person acted as an observer to help ensure safe practice.

Medicines Administration Records (MAR) were up to date with no unexplained gaps or errors. People were prescribed when required (PRN) medicines and there were protocols for their use. MARs showed the dosage given and time they were administered. For example one person was prescribed PRN medicines to help with their seizures and there was a clear flow chart in place about when to consider administering medicines.

All staff said they had completed training in the safe administration of medicines and said they were not able to administer medicines until this had been completed and they had been confirmed as competent. They said this training was updated annually. The training records we saw confirmed this. Staff were able to describe what they would do in the event of a medicines error and told us these were always investigated and action taken by the provider.

Good

Is the service effective?

Our findings

People were supported by competent and trained staff. Staff told us they underwent induction training prior to working independently within the service. The provider assessed staff competency at undertaking certain tasks, for example engaging with people, understanding the fire procedure and reporting incidents. One member of staff said, "The induction programme is good, especially as I had not been a carer before".

Staff received on-going comprehensive training to enable them to effectively carry out their roles. This included the care certificate QCF (Qualifications and Curriculum Framework) which ensures care staff have the skills to work in a care home, or NVQ training. We looked at staff training records and found that staff had undertaken training in safeguarding, first aid, medicine administration, positive behaviour management, epilepsy and health and safety. Staff told us that they found the training helpful and could request further training if they felt they required more.

People were supported by staff who reflected on their working practices to improve their performance. Members of staff received ongoing supervision and were given the opportunity to have time with their line manager to discuss all aspects of their role. We looked at staff files and found that staff were able to direct the supervision covering topics where they felt they either required additional support or they wished to discuss. One member of staff told us, "We use supervision to look at additional responsibilities within the home; I know colleagues have extra roles to do such as weekly medicine audits". Another member of staff said "Supervisions are every month and are generally very good, they ask you if you have any issues, do you need any help, what would you like to achieve and how are you feeling".

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).

Where people lacked the mental capacity to make decisions the home was guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure any decisions were made in the person's best interests. All staff had completed training on the MCA and Deprivation of Liberty Safeguards (DoLS) and were able to tell us how people were supported to make decisions. Legal processes had been followed to ensure the appropriate people were involved in making decisions about people's care and welfare. People were not deprived of their liberty unlawfully. There were applications made for DoLS or completed assessments on the care plans we looked at. The registered manager understood when an application should be made and how to submit one. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards.

Staff promoted decision making and respected people's choices. People's consent to aspects of their care

had been recorded in their care plans. Support plans were also available in an easy to read format. People's families and other representatives had been consulted when decisions were made to ensure that they were made in people's best interests. These were updated yearly in a review of people's care needs or as needed if a new situation arose. One relative told us "I am involved in the care plans and I am always told of changes". Another said "I am sent copies of reviews to comment on after we have been to the meeting; this usually works well although recently whilst the information was correct the name was wrong on the review records".

Relatives told us that they felt staff had the skill and understanding to meet their family members needs and they were satisfied with the care and support they received. Relatives told us, "we were consulted about the care plan and we are invited to reviews, even though we can't always attend." Another said "They always inform us of things they think we need to know."

People were supported to make choices and give consent in a way they understood. Staff told us, "People understand what we say although they may not always be able to verbalise this. For example one person only used one word to communicate, however their tone of voice and body language indicates a positive or negative. We ask questions with a yes or no answer until we can see positive body language and the word they use is sounding positive".

We saw staff adapting how they sought consent depending on the individual. For example, for some people at the home staff needed to be direct as the person sometimes did not realise they needed personal care. For another person whose verbal communication was limited to five words, they used a communication book with pictures of baths and clothes for example.

Staff encouraged people to maintain a healthy diet and supported them to make healthy choices in regards to food and drink. People could access the kitchen with support from staff to choose something to eat. Drinks and snacks were available at all times for people. We saw one person sorting the ingredients with staff to bake the cake for supper. They had already indicated to staff earlier in the day using a recipe book, which cake they wanted to bake and staff had ensured that the ingredients were available. Staff had a clear understanding of the importance of supporting people to maintain a healthy diet. We saw that where there had been concerns people had been referred to the Speech and Language Therapist (SALT) for their advice. Any advice or recommendations had been incorporated into the care plans.

People had good access to a range of health support services. Care planning records covered the person's physical health and mental welfare. The health plans identified if a person needed support in a particular area. Some people required specific healthcare support and there was evidence this was provided. The manager told us how the service dealt with people's changing health needs by consulting with other professionals where necessary. This meant the person received consistent care from all the health and social care professionals involved in their care. All the relatives we spoke with said they were happy that people were supported to access health care as needed.

Good

Is the service caring?

Our findings

All the people at the home were at day services or involved in other activities inside and outside of the home or accessing the community. Staff were respectful and spoke to people with consideration.

Staff recognised the importance of supporting people to develop and maintain their independence. We saw people were provided with the choice of spending time on their own or in the lounge and dining areas. The day centre was next door and people could come back if they chose on their own although the centre would ring The Bungalow as well. One person had their own car and they liked to go out for a drive; they went out twice the day we visited. Records showed they went out when they wanted to. They went shopping with staff on the day we visited but preferred to wait in the car with one member of staff whilst the other went into the shop.

People were supported to maintain relationships with their friends and where possible family members. For example most people visited relatives for weekend breaks or special occasions.

Staff treated people affectionately and recognised and valued them as individuals. During conversations with people, staff spoke respectfully and in a friendly way. They chose words that people would understand or used the method of communication needed by that person and took time to listen. Staff were able to effectively communicate with people at all times.

We observed staff interacting with people using different communication styles, for example staff used not only verbal communication but also their body language to communicate. Staff were observed sharing information in a manner that the person preferred which was carefully detailed in their care plans. A relative told us that there had been a lot of changes recently and their loved one seemed to have coped with the changes. "Staff have helped them cope with changes at the home in a caring way".

We saw that people had support plans which were personalised and reflected in detail their personal choices and preferences regarding how they wished to live their daily lives. Care plans contained guidance for staff which described the steps they should take when supporting people who may become anxious towards other people or their environment.

Our observations and conversations with staff demonstrated that the guidance in their care plan had been followed. One person we noted became very agitated at times, they were reassured effectively by staff and a challenging situation averted by communicating well with the person and focusing them on moving to another area of the house. Staff remained calm and supportive when they had to repeat the same reassurance a number of times on different occasions as the person required a lot of emotional support.

One relative commented "I am kept up to date of achievements [name] has made, [name] has just phoned to let me know [name] went swimming and got in. This has made my year, great news. Just wanted to say thanks for making this happen. I look forward to many more swims". Another relative said the care was "Excellent, [name] is very happy".

People's independence, privacy and dignity were respected and promoted. However we did hear one member of staff be quite directive in the hallway, saying "Let me get some gloves first please as you have a wet …". Whilst the person did respond to this, some consideration could have been given to the language used to protect their dignity.

Daily records were maintained and demonstrated how people were being supported. The staff told us this system made sure they were up to date with any information affecting a person's care and support.

People's bedrooms were individualised and reflected people's preferences. For example, one person did not have bed covers or pictures in their room which was their choice. Staff were gradually introducing things to the communal areas of the home such as pictures. One relative told us that their relative's room was "Homely and personalised". Another relative said they would like the person's bedroom to be different but anything that is there or not there is based on their relative's choice.

Good

Is the service responsive?

Our findings

People and their representatives were involved in assessments and care planning. Care plans had been reviewed and updated. They were structured and detailed the support people required. The care plans were person centred, identifying what support people required and how they would like this to be provided. During the inspection visit we witnessed staff asking people what they wanted to do and how they wished to spend their time. One person was supported to go out on the bus for coffee and cake. For another person, support was about was ensuring that they had ingredients for their cake making, as they had chosen in the morning before going to day services. They had then come back half way through the day and indicated to staff they had changed their mind. Staff made a list of what was needed for the cake and went shopping for ingredients to ensure the person could make the cake they had chosen.

In addition to care plans each person living at the service had daily records which were used to record what they had been doing and any observations about their physical or emotional wellbeing. These were completed daily and staff told us they were a good tool for quickly recording information which gave an overview of the day's events for staff coming on duty. There was also a document to be used when someone went to hospital which would give hospital staff clear instructions on how to care for someone including how they would indicate pain.

Each person had a keyworker picked from the staff team whose role was to support that person to stay healthy, to identify goals they wished to achieve and to express their views about the care they received. Each of the key workers carried out a monthly review with the person of their need. All the relatives we spoke with were aware that there was a particular member of staff involved with their relative. One mentioned they would like more contact with that member of staff. The manager said that they were aware of this request and was encouraging staff to do this.

Relatives were asked their views about the care and support their family members received. One relative told us they were sent copies of reviews after a meeting for them to make amendments or agree to what had been written. When they next visited they found the amendments had been made.

Staff were responsive to people's communication styles. They gave people information and choices in ways that they could understand. They used plain English, repeating messages as necessary to help people understand what was being said. Staff were patient when speaking with people and understood and respected that some people needed more time to respond. Staff communicated with some people in Makaton, a particular form of sign language. Staff told us how people often used a variety of signs to express themselves, and we saw staff were able to understand and respond to what was being said. One member of staff had completed a 'crib' sheet to show staff the signs that the person they were key worker for used, this was displayed in the office for staff to refer to. The sheet of paper was not named but staff were able to tell us who it was for. We saw staff responding to people in a timely manner and they stopped what they were doing for example cleaning, to listen to what the person wanted.

People, their relatives and friends were encouraged to provide feedback and were supported to raise

complaints if they were dissatisfied with the service provided at the home. One person told us that that they had recently had cause for concern and felt that senior managers had dealt with it very well and promptly.

There were arrangements in place to deal with complaints which included detailed information on the action people could take if they were not satisfied with the service being provided. There was one issue recorded. We saw that this had been dealt with and the family confirmed this when we spoke with them.

Good

Is the service well-led?

Our findings

At the time of our inspection visit there was no registered manager in place. The provider had recruited someone to undertake this role and they had submitted an application to the Commission to become registered. The previous manager had moved to another home belonging to the provider and a transfer was made in August 2015 when the new manager began work.

There was a clear management structure with a service manager who oversees several of the provider's homes, manager, deputy manager and support workers. Staff understood the role each person played within this structure. The manager encouraged staff and people to raise issues of concern with them, which they acted upon.

Staff we spoke with responded positively to the manager's style of leadership, felt they could go to them at any time if they had a concern about people's care, and felt they were kept up to date and informed. They said they had a good relationship with the manager, and described them as being "supportive" and communications as "good".

There was an opportunity for staff to engage with the management team at the home on a one to one basis through supervisions and informal conversations.

We saw minutes of meetings with relatives and staff and how they were involved in the care being delivered at the home. There was a party planned before Christmas for relatives and people living at the home to attend before people went to their families over the weekend.

The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary. The service manager, registered provider and the manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration.

One relative told us, "They [staff and manager] listen to me and any concerns I have". The manager encouraged an open relationship with staff and people being actively encouraged to go to the office and share their views and be part of the 'team'.

The manager recognised the changing needs of people living at the home including their health. They ensured the service had the necessary facilities available to meet specific needs and closely monitored any changes to ensure the resources were available. Staff relayed their enthusiasm and ambition for caring for the people using the service and were very passionate about protecting them from abuse and ensuring they could lead a fulfilled life according to their wishes and aspirations. The enthusiasm from staff we spoke to came from newer staff who had started work there in the last 12 months and those who had worked at the home for 6 to 20 years

Day to day communication systems ensured any issues were addressed as necessary. For example staff told us they felt the manager acted on their suggestions by showing them emails they had sent to the service manager regarding issues. Issues were also discussed at team meetings and one to one support meetings. The manager or the deputy manager were always available and also spent time supporting people.

The manager understood and complied with their obligations on behalf of the registered provider, from CQC or other external organisations and these were consistently followed in a timely way. Documentation relating to the management of the service was clear and had recently been updated. For example, one person's care and support records we saw an action plan that had been put in place by the manager with several area to be addressed, there was one space left where action was needed. This ensured people's care needs were identified and planned comprehensively to meet people's individual needs.

The manager ensured that either they or other senior staff regularly audited the service policies and procedures to ensure they reflected current good practice guidelines. Some of the audits included medicines, accidents and incidents and maintenance of the home. Further audits were carried out in line with policies and procedures. For example we saw fire tests were carried out weekly and emergency lighting was tested monthly. There was also a system of daily audits in place to ensure quality was monitored on a day to day basis, such as daily audits of medicines and the fridge and freezer temperatures. Any gaps in medicine records were addressed on a daily basis and maintenance issues were reported on the day.

There was a new training system in place which the manager could access to see who was due to repeat training or who was booked. This meant they could monitor training and ensure that staff had appropriate skills and information to care for people.

Staff logged accidents and incidents. These logs were analysed to identify any trends for example medicine issues and if needed the manager would have discussions with individual staff members. There were no concerning trends identified at the time of our visit.

Staff told us that there was an open and transparent approach to information sharing and that information was shared amongst the team through various means. The manager ensured that external health care professionals were involved in decision making for people and actively encouraged partnership working.

People were supported by staff who had clear knowledge of company policy. There were policies and procedures in place to ensure staff had the appropriate guidance to carry out their role. Staff were able to identify where the policies were kept and that they could access these for guidance at any time.