Hoffmann Foundation for Autism

Hoffmann Foundation for Autism - 45a Langham Gardens

Inspection report

45a Langham Gardens
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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 4 and 5 July 2018. We gave the provider notice of our intention to visit so that they could prepare people with complex needs whose routines might be disrupted by our inspection process.

Hoffmann Foundation for Autism - 45a Langham Gardens is a supported living service for people with a learning disability or autistic spectrum disorder. It provides personal care for people who live in their own accommodation. At the time of this inspection the service provided care for five people.

There was 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 care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

The inspection was prompted in part by concerns that had been raised with us by the local authority.

At this inspection we found that Hoffman Foundation did not provide clear leadership in setting the culture and values of the organisation. The provider informed us that they used Positive Behavioural Support (PBS) as a model to support people who displayed behaviours that challenged the service. However, staff demonstrated that they did not fully understand these values, and their role in achieving them. During this inspection, we observed practices and behaviours that were inconsistent with these values.

People living at the service were not protected and supported to be safe, as the provider did not have full oversight of the service. There was a lack of systems and processes in place to effectively monitor and improve the quality and safety of support provided. There were insufficient auditing systems in place to identify and mitigate any risks relating to the health and safety of people who lived at the service.

People were at risk of unsafe or inappropriate support because the risk assessments were incomplete. Furthermore, people were at risk of harm because not all risks had been identified with appropriate actions taken to mitigate risk. There were no effective systems for analysing accidents and incidents to help minimise the risk of events occurring again. The service did not always make sure staff deployed to support people had the necessary skills and experience.

Staff supported people to eat and drink. However, their food choices were not always taken into consideration.

Where people lacked capacity to make decisions about their care and support the service did not always follow legal requirements to assess their capacity and make decisions in their best interests.

A positive behaviour support (PBS) approach was used to supporting people who displayed or were at risk of displaying behaviours which challenged. However, the environment of the service was not consistent with PBS. People did not always receive individual care and support which met their needs according to their support plans and assessments. We found, although, communication systems had been considered, further improvement was required.

The service had processes in place to manage and administer people's medicines safely. The service was well maintained and kept clean. There were arrangements to protect people from the risk of the spread of infection.
We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to the back of the full version of the report after any representations have been concluded. You can read at the back of the full report what action we have told the provider to take.

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 not safe.

People were at risk of harm because not all risks had been identified with appropriate actions taken to mitigate risk.

There were no effective systems for analysing accidents and incidents to learn from events to help minimise the risk of events occurring again.

The service did not always make sure staff deployed to support people had the necessary skills and experience.

Staff understood their responsibilities in relation to protecting people from harm and abuse. The service was clean and infection control protocols were followed.

The service used safe recruitment practices to ensure people were safe.

Medicines were managed and administered safely.

Is the service effective?

Requires Improvement

The service was not effective.

Staff were not suitably trained to meet all the care requirements of people living at the service. This was also true of agency staff.

When people lacked the mental capacity to make specific decisions by themselves, the principles of the MCA had not always been fully upheld.

Generally, people were supported to have food and drink. However, their food choices were not always taken into consideration.

People accessed health professionals such as psychiatrists and GPs when required.

Is the service caring?

Requires Improvement

The service was not caring.

We noted that the language that was used in the minutes of the meetings and care notes indicated a culture that was not of kindness.

Even though the feedback relating to staff was positive, the concerns we found at this inspection did not demonstrate a caring approach.

The service had a policy on ensuring equality and valuing diversity.

Is the service responsive?

Requires Improvement

The service was not responsive.

People did not always receive individual care and support which met their needs.

We found the environment to be requiring improvement to become more autism friendly.

Although communication systems had been considered, further improvements were required.

There was a system in place to manage complaints. People felt able to make a complaint and were confident they would be listened to and acted on.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The service did not provide clear leadership in setting the culture and values of the organisation.

People living at the service were not protected and supported to be safe as the provider did not have full oversight of the service. There was a lack of systems and processes in place to effectively monitor and improve the quality and safety of support provided.

The service failed to implement effective systems for analysing incidents and accidents to learn from events and introduce changes to the support people received.

Hoffmann Foundation for Autism - 45a Langham Gardens

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 announced inspection took place on 4 and 5 July 2018. The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we looked at information about the service including notifications and any other information received from other agencies. Notifications are information about specific important events the service is legally required to report to us.

During the inspection we spoke with four relatives of people using the service to obtain feedback about their experiences of the service. We spoke with the registered manager, the head of operations, the deputy manager and seven staff members. We examined five people's care records. We also looked at personnel records of 13 staff, including details of their recruitment, training and supervision. We reviewed further records relating to the management of the service, including quality assurance processes, to see how the home was run.

Requires Improvement

Is the service safe?

Our findings

During our most recent inspection in November 2017, we found the service was safe and was rated Good in this key question. At this inspection we found that improvements were required.

Relatives told us they were confident people were safe. One relative said, "Yes my relative is safe." Another relative said, "My relative is very safe." However, we found concerns related to the safekeeping of people's money.

The arrangements for managing people's money were not clear, safe and accountable. The service supported five people with autism and other complex needs. We established from speaking with staff that all five people using the service did not have capacity to manage their money.

We looked at their financial records and saw that there were no adequate systems in place for the safe handling of their money. Although we saw good practice in relation to day to day transactions, the overall management of big expenditures were unclear.

The service did not ensure there were safeguards in place to protect people's financial interests. People had not been assessed in accordance with the code of practice of Mental Capacity Act 2005. For example, one person using the service had been paying the provider an average of 1719.35 per month since January 2016. The deputy manager explained that the person owed the organisation some money. However, there were no records to indicate precisely what was owed and any agreements that were in place with the person in relation to the repayment terms.

In another example, we established that the provider was the appointee for financial matters relating to two people receiving care. The money belonging to one of the people was paid into the provider's account. There was no evidence regarding this or if this arrangement was in the best interest of this person.

The service operated a lease car, which was used by people receiving care. People were charged for using the car to commute to the day centre and other places. The day centre is in Wood Green, which is about 11 miles away from the service. This day centre is owned by the provider and people also paid to use this. We were concerned that this presented a conflict of interest and that people may not have been given real choice to make the most efficient use of their money. No mental capacity assessments for this decision had been completed to make sure the best interests of people were fully considered.

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

We made a referral to the local authority safeguarding team as we were worried that the arrangements to look after people's money was not operating in a transparent and safe way.

People were at risk of unsafe or inappropriate support because some risk assessments were incomplete.

The service had recognised the need for risk assessments to be reviewed following incidents. For example, one person was indicated to display behaviours that challenged. There were recorded incidents since November 2017. However, the risk assessments had not been reviewed and updated following the incidents. As a result, we did not feel assured that risks were effectively mitigated and therefore placed staff and people at risk.

People were at risk of harm because not all risks had been identified with appropriate actions taken to mitigate risk. We saw that the kitchen was accessible to people without supervision. However, we were concerned that no risk assessments had been completed as there was a risk of harm due to some behaviours that challenged the service. For example, a care plan of one person highlighted that dangerous objects should be kept away. The cupboard where knives were kept had a lock but when we checked on three occasions throughout the day, we established it was not locked. Therefore, this did not mitigate the risk of people accessing sharp objects. We enquired from the registered manager and the deputy manager whether there was a policy relating to knives and other sharp objects and they told us this was not in place.

There were no effective systems for analysing accidents and incidents to help minimise the risk of events occurring again. We reviewed the accident and incident records of one person. There had been 18 recorded incidents relating to this person since November 2017. These ranged from property damage to causing risk of injury to self and others. Whilst these incidents had been recorded, we saw that there had been no overall analysis subjected to them. The service failed to produce records to demonstrate this had been completed. Although the deputy manager told us the incidents were collected centrally, there was no evidence to show the provider's oversight. This meant that incidents had not been investigated and analysed to assess triggers or trends with a view to reducing the risk of such incidents occurring again.

The service did not always make sure staff deployed to support people had the necessary skills and experience. All five people using the service displayed behaviours that challenged the service and required additional support. The service employed four staff to work in the morning and afternoon. They also had a staff member working between 10 and 6pm. Two people required 1:1 support whilst indoors and two others required 2:1 whilst in the community. We observed that one person displaying behaviours that challenged could not be taken outside, as recommended in their behavioural plan, because there were no sufficient staff to provide additional support. Eventually the person was taken out. However, this meant an agency staff without the required skill set was left to provide 1:1 support. Relatives of people gave us mixed feedback. One relative told us, "There are enough staff all the time." Another relative said, "I hope they have enough staff."

The above is evidence of a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The required checks were carried out before staff started to work at the service. There were recruitment and selection processes for new staff. This included carrying out checks to make sure new staff were safe to work with people. Staff were not allowed to start work until satisfactory checks and employment references had been obtained. Staff files included copies of satisfactory references, criminal records (DBS) checks and checks of eligibility to work in the UK.

There were systems in place to protect people and staff from infection. Staff had completed infection prevention and control training and they understood the importance of infection control measures. Information about the appropriate handwashing technique was available in the communal toilets. The washing soap, antibacterial gel and paper towels were available in the bathrooms. Staff used personal protective equipment such as vinyl gloves and other protective measures when handling food or completing

personal care tasks. Wearing such clothing protects staff and people using the service from the risk of cross infection during the delivery of care.

People's medicines were handled safely. The home had a medicines policy and procedure, which it followed. There were suitable arrangements for the recording, administration and disposal of medicines. We looked at four medicines administration records (MAR) charts and found no gaps in the recording of medicines administered. The service had a system for auditing medicines.

Some medicines were prescribed to be taken when needed (PRN), for example for agitation. We saw plans were in place to guide staff on what the medicines were for and how much to give, and we saw that administration was clearly recorded except in one. The service had not updated the frequency of PRN for one person which had been increased from one to two in any 24-hour period. This was immediately addressed by the deputy manager.

Requires Improvement

Is the service effective?

Our findings

During our inspection in November 2017, we found the service was effective and was rated Good in this key question. At this inspection we found that improvements were required.

We looked at the induction of new staff. Two had started work in April 2018. In one file we noted that the weekly feedback that was expected to be completed for four weeks was only partially completed. New staff were required to read and sign people's care records, including risk assessments and guidelines. This was meant to have been completed before staff commenced to work with people but they were not. Other sections on the induction documentation were not signed by the line manager and it was not clear if they met weekly as required in the document. We also looked at the file of another staff, who had completed over 30 shifts since commencing employment in April 2018 and found the same shortfalls. There were no induction records for agency staff. The service could not provide assurances that agency staff had received induction to the service before starting work. This meant staff may not always have had the skills, experience and knowledge for their job role.

The manager showed us a training matrix that listed 15 staff who were required to complete essential training. The training included, equality and diversity, infection control, food and hygiene, mental health, Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS), manual handling, health and safety, first aid and safeguarding. However, not all staff had received training needed for their role. Out of the 15 staff on the training matrix, 11 had completed autism level 2 training. There was no training planned for the other four. This was not consistent with what we were told by the operations manager that all staff should receive autism level 2 training prior to commencing work with people. She told us this training was delivered by a consultant psychologist working for the Hoffman Foundation. The autism training was important because all people using the service had autism as their primary diagnosis. We also saw that three members of staff had not completed dignity in care training. Four staff had not completed epilepsy training.

The skills, training and competencies of agency staff deployed at the service were not being checked to ensure the agency staff deployed were sufficiently trained. We looked at the training records of four regular agency staff. There was no evidence of any specialist training related to autism, mental health, and MAPA (Management of Actual or Potential Aggression). In one example, we saw one agency staff restraining one person from leaving the service. In another example, we observed an agency staff who had not received MAPA training had been assigned to work with a person where this skill was required to make sure the person's needs were being met. There was no effective mechanism in place for checking the skills of staff before they were deployed for the service to be sure that they were able to respond to the needs of people in their care.

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

The 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for people living in their own homes are through Court of Protection orders.

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. We saw that when people lacked the mental capacity to make specific decisions by themselves, the principles of the MCA had not always been fully upheld. We evidenced from care records that people's relatives were involved in decisions about people's care. For example, one person was on a gluten free diet. The family of the person had requested that they be put on this diet to facilitate weight loss. However, the deputy manager told us that in 2012 this diet had been questioned by a dietitian as it did not have obvious benefits to this person. We saw no action had been taken by the service to address this query. The service had also not pursued a mental capacity assessment to ascertain if this was in the best interest of the person.

Where families were the appointees of people's finances, it was not clearly documented within people's records who had the power of attorney. Equally, Hoffman Foundation was the appointee for managing the finances of two people receiving care. However, no mental capacity assessments had been carried out for specific transactions that were being paid to the Hoffman Foundation's account. The deputy manager told us this money was owed to the organisation by the person but there was no further information to clarify this. This was important to ensure people were receiving the appropriate support for decisions being made relating to their finances.

There were no decision specific mental capacity assessments in people's care records. The deputy manager told us that some mental capacity assessments had been carried out in April 2017 by a social worker from Brent Local Authority but the reports had not been produced.

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

Generally, people were supported to have food and drink. However, their food choices were not always respected. We saw that people at the service were being given gluten free foods even though this was not justified. On the day of our inspection all people were served a gluten free meal of meatballs and rice, which they all ate. They were given a gluten free meal because one other person had been on this diet for a long time. Staff we spoke with told us, "If [people] are all together, meals are all gluten free." We questioned the reason why people should be served a gluten free meal even though they did not have a medical condition that was affected by the consumption of gluten. The deputy manager told us this did not happen all the time. We established none of the people at the home required gluten free diet for any medically diagnosed condition, therefore people may have been on a restricted diet unnecessarily.

Staff supported people with regular shopping to ensure they buy healthy food. People's care plans contained detailed information about food and drink. However, we observed that the service did not provide a choice of meals. They cooked one meal for people. The deputy manager told us, "We cook one meal and if people do not like it we prepare what they like." This was not a real choice for people.

We also looked at what the service had put in place to address people's religious needs to ensure people were not eating food that was against their religion. A relative told us, "They cook for everyone. They buy

halal meat. We don't want them to give him any pork or alcohol." Another relative said, "We are Muslim, other than no pork we don't have any requirements."

We recommend that the service seeks advice and guidance from a reputable source regarding promoting choices for people receiving care.

We looked at how people were assisted to stay healthy. We could see from people's care records they had accessed health professionals such as psychiatrists and GPs when required. The provider had employed a clinical psychologist and applied behavioural analysts who carried out functional analysis and developed behavioural guidelines for staff. We asked people's relatives what professionals were involved in the care of their relative. One relative told us, "'An allocated social worker and psychologist from Hoffman Foundation, come to see if anything needs to be changed. The staff give him his medication. They also support him to see a GP." Another relative said, "My relative had a medical review recently. The nurse covered everything from all angles."

Requires Improvement

Is the service caring?

Our findings

During our inspection in November 2017, we rated the provider Good in this key question. At this inspection we found that improvements were required.

We noted that the language that was used in the minutes of staff meetings indicated a less caring culture. The language used did not show that people's dignity was respected. For example, the minutes contained the following comments, 'This person's challenging behaviour was unacceptable towards staff' and '[This person] is difficult to control. They have stubborn behaviour'. We also read comments of similar nature in people's care notes, including, '[this person] was made to do colouring today', '[this person has been unsettled and problematic.'

People's relatives told us things had improved and that staff involved them in decisions and that they could make choices about people's care. One relative said, "They listen to us." Another relative told us, "Absolutely, I feel listened to." We saw that a satisfaction survey of the service and care provided had been carried out. Relatives were mostly satisfied with the services provided. However, we found the questionnaires had not been dated and the registered manager had not undertaken any analysis of the comments received.

Even though the feedback relating to staff was positive, the concerns we found at this inspection did not demonstrate a caring approach. The shortage of staff meant that staff may not have had enough time to get to know people and offer them compassionate support. The service was unable to demonstrate that new staff and agency staff had always received the training and support that they required to ensure that they were competent in their roles. This meant staff may not have been sensitive to the needs of people.

The service had a policy on ensuring equality and valuing diversity. This instructed staff to ensure that the personal needs and preferences of all people were respected regardless of their background. Staff spoke about what they would do to ensure people had the care they needed for a variety of diverse needs, including spiritual and cultural differences. People's care records covered their religion and culture. For example, one person was supported with their religious observances, by visiting a local church for prayers. Likewise, as noted, the service ensured that people who had meal requirements related to their culture had these met.

We observed that personal information was stored securely in locked cabinets. Relatives told us their permission was sought before their confidential information was shared with other healthcare professionals and we saw this documented in care files. This meant people could be assured their sensitive information was treated confidentially, carefully and in line with the Data Protection Act 1998.

Requires Improvement

Is the service responsive?

Our findings

During our inspection in November 2017, we found the service was responsive and was rated Good in this key question. At this inspection we found that improvements were required. People's needs were not always met because the approach that was used to support people with behaviours that challenged was inconsistently applied.

A positive behaviour support (PBS) approach was used to support people who displayed or were at risk of displaying behaviours which challenged. The PBS approach identifies early warning signs that challenging behaviour may occur and suggests de-escalation and distraction techniques prior to crisis management. This was not fully understood by staff.

The environment of the service was not consistent with PBS approach. We found the environment to be requiring improvement to become more autism friendly. A checklist that was endorsed by National Institute for Health and Care Excellence (NICE) in September 2016 and by The National Autistic Society (NAS) in November 2017, refers to essential requirements for creating an autism friendly environment. There was a deficit of this at this service, which meant the physical environment was not fully adapted to ensure the needs of people with hyper- or hypo-sensory sensitivities were met.

For example, some people at the service were hyper-sensitive to noise. During the inspection, one person was displaying behaviours that challenged the service, with high vocalisations, which lasted for more than four hours. Whilst this was going on, another person who was hypersensitive to noise was also getting agitated. We saw no action being taken by staff to calm the situation. There was no provision of a quieter space. There was no access to the garden, until we asked staff to open the door to the garden. Access to the garden was locked due to previous reported incidents. The sensory room we were shown was very small and bare. It was about two by two meters, with two exercise balls and four bin bags. The deputy manager told us the equipment had been removed whilst they awaited refurbishments. We saw no alternative arrangements for use by people while the sensory room was out of use.

We looked at how the service was protecting people from discrimination in relation to communication. In particular, we looked at how the service was meeting the requirements of the Accessible Information Standard (AIS). As of 1 August 2016, providers of publicly-funded adult social care must follow the AIS in full. Services are required meet people's information and communication needs. We found although communication systems had been considered, further improvements were required. People's communication was supported by use of symbols, pictures, photos and objects, albeit this was inconsistently applied in practice. For example, the service used the PECS system (picture exchange communication system), which was meant to provide structure. However, we observed staff offering people random activities, which were not consistent with the structure in place. In another example, one person was reported to use black and white widget symbols. We did not see this being used during the inspection. While reviewing the activities cabinet we came across an old book with two symbols in it. The staff explained the original book was in the person's room. However, they needed this accessible to support the person with communication.

People did not always receive individual care and support which met their needs according to their support plans and assessments. The service had a team of behavioural analysts, who produced behavioural guidelines. However, these guidelines were applied inconsistently in practice. For example, a positive behaviour support plan for one person instructed staff to use TEACCH (a structured teaching approach for people with autism), 'now and next boards', among other interventions. However, this programme was not being followed in practice. The deputy manager told us they used to have a board in the person's room but this was pulled down by the person. However, this had not been reviewed. A member of staff told us, "At times what is written in care plans does not fit the reality and staff have to use their flexibility. At times we think on the spot and use different interventions to work with people." This showed a lack of basic knowledge on PBS, which meant staff could not intervene effectively through de-escalation techniques or other agreed good practice approaches in order to meet people's needs.

The volume of paperwork in each file meant that staff may not have had sufficient time to read people's care records or recall information that was fragmented across various documents. Each file contained numerous records including my support plan, person centred plan (pictorial version of my support plan), my health book, annual assessment, behavioural plans and activity passport. We found out that some staff were not aware of guidelines in some documents even though they had signed confirming to have read them. There was also a risk that staff could not access the information in a timely manner if needed in an emergency. Therefore, people's needs may not have always been met.

The service did not carry out regular meaningful reviews. We found that the service carried out a periodic annual review but a 'no change' comment was written in all plans and so did not give much in terms of whether people's needs continued to be met. There was no information as to who had taken part and how the verdict of 'no change' had been reached. For example, the care of one person was reviewed by a psychiatrist in March 2018. The review concluded the person's mental well-being had deteriorated and the frequency of mood stabilizing medicines had been increased, but his care documents had not been updated. Therefore, people might have been at risk of receiving care that was not personalised.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a complaints procedure in place. This set out how people's complaints would be dealt with. There was a process for managers to log and investigate complaints including, recording actions taken to resolve complaints. We asked relatives what they do if they were worried about something or had a concern. Their comments included, "I speak to the manager or the social worker" and "I would tell the manager straight away. He is very approachable. He would deal with it immediately.'

People's support plans reflected their social needs. In the dining room in the communal area there was a daily activities board. Each person had a pictorial representation of what they were scheduled to do that day. People's relatives told us, "Sometimes staff take my relative out for a meal", "My relative likes swimming. I would like him to start horse riding again" and "My relative went on holiday recently. He enjoyed it a lot. He was quite happy when he came back."

Requires Improvement

Is the service well-led?

Our findings

During our inspection in November 2017, the service was rated Good in this key question. At this inspection we found that improvements were required.

The service had clear lines of responsibility and accountability. The registered manager was supported by the deputy manager and shift leaders in the running of the service. He also worked closely with the operations manager, who had a regular presence at the service. There was also a separate team which comprised a clinical psychologist and three applied behavioural analysts. Their role involved developing behavioural guidelines for use at the service. Their role also depended on the skills and competence of staff at the service in collecting evidence, and implementing developed behavioural guidelines. However, we found that not all staff were skilled to carry out this task.

Relatives thought the service was well-led. One relative told us, "I am happy with the place. If I need to I have access to the CEO and the management team. I have never had to contact them." Another relative told us, "We can approach the manager at any time." A third relative said, "It's an old house. Things have improved now." A fourth relative said, "I have met with the manager and asked that they have a porch to make it safer for my son. The front door is locked 24 hours a day."

Whilst relatives' views about the service were positive, we judged from our inspection that Hoffmann Foundation for Autism did not provide clear leadership in setting the culture and values of the organisation. The provider used PBS as a model to support people who displayed behaviours that challenged the service. The values of the model included, person centred care, least restrictive approaches and functional analysis. These were used to inform function based interventions. However, we saw that staff did not fully understand these values, and their role in achieving them. During this inspection, we observed practices and behaviours that were inconsistent with these values.

We saw examples where person centred care was not provided to ensure risks were proactively addressed. In one example, we observed a person using the service seated in the conservatory. The room was hot as was the rest of the communal area. We asked why the conservatory door could not be opened and staff told us this was to prevent a person using the service from accessing the garden area because they had been throwing clothes and other items over the fence to the neighbours. The deputy manager told us that this behaviour had stopped but only started again two weeks prior to our inspection. No proactive action had been taken to address this, therefore inconsistent with PBS.

In another example, we read minutes of a staff meeting which reported that windows in the activity room were to be kept locked and windows in the person's bedrooms fitted with metal bars as a safety precaution. This action had been taken because one person had attempted to climb through the window in the activity room. The minutes reported how staff had been impressed with how swiftly following the incident the workman had fitted the bars. This intervention was not consistent with the behaviour support plans, which gave guidance for staff to use least restrictive interventions. There were many other examples of practices that were not consistent with the values of the organisation.

We saw that even though the service used PBS, there were no policies and procedures that reflected best practice and the philosophy base. The National Institute for Health and Clinical Excellence (NICE) had produced guidance for managing autism and behaviours that challenge services, but the service did not have this guidance on site. This was important to create the necessary conditions to support a values-led culture and documents that clearly communicate principles, values and guidelines.

People living at the service were not protected and supported to be safe as the provider did not have full oversight of the service. There was a lack of systems and processes in place to effectively monitor and improve the quality and safety of support provided. There were insufficient auditing systems in place to identify and mitigate any risks relating to the health and safety of people who lived at the service. For example, the service's or provider's own audits had not identified some of the shortfalls we found at this inspection. Also, where areas of improvement were identified, such as improvements in person centred plans, risk assessments, training, and staff shortages, these concerns had remained. The service had not taken sufficient steps to utilise the conclusions of its own audits in implementing improvements.

The service failed to implement effective systems for analysing incidents and accidents in order to learn from events and introduce changes to the support service users received. Between November 2017 and July 2018 there were 18 recorded incidents in relation to one person. There were more incidents recorded in relation to the other people using the service. However, the service could not assure us that these incidents had been thoroughly investigated and analysed to assess triggers or trends with a view to reducing the risk of such incidents occurring again. We asked for the records of this and the service failed to demonstrate this had been undertaken.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured they had done all that was reasonably practicable to mitigate risk .

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from financial abuse.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured they operated effective systems and processes to make sure they assess and monitor the quality of the service, drive improvement and obtain and act upon feedback.