Salisbury Support 4 Autism Limited

Albert Road

Inspection report

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Date of inspection visit:
04 November 2021
08 November 2021

Date of publication:
09 December 2021

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service
Albert Road provides a supported living service to people living in their own flats or shared accommodation within seven 'supported living' schemes. The aim is for people to live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. A manager who was applying to be registered with Care Quality Commission (CQC) oversaw the seven schemes.

People's experience of using this service and what we found
People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. Policies and systems in the service supported this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of safe, responsive and well led

The service was able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support:
• The service used positive behaviour support principles to support people in the least restrictive way. No restrictive intervention practices were used.
Right care:
• People's support focused on them having as many opportunities as possible for them to gain new skills and become more independent. The staff supported people in a person-centred way and respected their privacy, dignity and human rights.
Right culture:
• Staff were responsive to people's individual needs and knew them well. They supported each person by spending time with them and listening to them. They ensured that each person felt included and valued as an individual. People were engaged in meaningful activities of their choice. They were consulted about what they wanted to do and were listened to.

There were systems and processes in place to protect people from the risk of harm. Risks to their safety and wellbeing were appropriately assessed and mitigated. The environment was clean and hazard-free. There were robust systems in place for the prevention and control of infection and the staff followed these. People received their medicines safely and as prescribed.

People who used the service were happy with the service they received. Their needs were met in a personalised way and they had been involved in planning and reviewing their care. People said the staff were kind, caring and respectful and they had developed good relationships with them.
People's needs were assessed before they started using the service and care plans were developed from initial assessments. People and those important to them were involved in reviewing care plans. There were systems for monitoring the quality of the service, gathering feedback from others and making continuous improvements. The provider worked closely with other professionals to make sure people had access to health care services.

Staff were happy and felt well supported. They enjoyed their work and spoke positively about the people they cared for. They received the training, support and information they needed to provide effective care. The provider had robust procedures for recruiting and inducting staff to help ensure only suitable staff were employed.

Rating at last inspection
The last rating for this service was Good (published 22 May 2019). At this inspection, the service remains Good.

Why we inspected
The inspection was prompted in part due to whistleblowing concerns received indicating the possibility of a closed culture in two of the supported living schemes. A decision was made for us to inspect and examine those risks.

We found no evidence during this inspection that people were at risk of harm from this concern.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection. The overall rating for the service has not changed. This is based on the findings at this inspection.

Follow up
We will continue to monitor information we receive about the service.

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.

Details are in our safe findings below.

Is the service responsive?

Good

The service was effective.

Details are in our safe findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our safe findings below.

Albert Road

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors and an Expert by Experience undertook telephone interviews with people who used the service and their relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service provides care and support to people living in seven 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The service had a manager who was in the process of registering with the CQC. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave a short period notice of the inspection because people who used the service needed to be consulted in advance of us visiting the schemes.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
The inspection site visit activity started on 4 November 2021 and ended on 8 November 2021. At the office location, we spoke with the operations lead, operations manager and HR manager and reviewed five staff personnel records, audits and a sample of policies and procedures. We also visited four of the supported living schemes, spoke with people living in their homes and met with the scheme managers and staff, reviewed support plans and checked medicines management. We spoke by telephone with eight people who used the service and ten relatives.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training information and quality assurance records.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse
• People were protected from the risk of abuse. They told us that they were safe. One person said, "I would say I am safe here."
• Care workers told us they would speak to the team leader or manager if they had any concerns or witnessed any practice which put people at risk or was abusive. One care worker told us, "If I saw something which would harm the clients I would talk to my manager."
• People who used the service similarly felt confident that things would be resolved. For example, one person told us they spoke to the manager about a member of staff shouting at them. They told us the person was no longer working at the service. This has been referred to the local safeguarding team and had been fully investigated.
• The service had a safeguarding procedure and care workers received training including annual refreshers to ensure they have up to date knowledge. Staff had access to the whistleblowing procedure and had signed to evidence they had read this.

Assessing risk, safety monitoring and management
• People who used the service were protected from the risk of avoidable harm. Risk in relation to people receiving care was assessed and comprehensive plans to manage and minimise such risks were developed. People who used the service told us they had been involved in this process. For example, one person liked to use the kitchen regularly to prepare food and needed to be adequately supervised in particular when using a knife or the kettle. there was an environmental risk assessment in place stating the hazards and level of risk prior to measures being in place to reduce the risk.
• We also found if people were unable to communicate their relative or advocate was consulted. One person told us, "The staff are very good, they make sure that I am safe."
• Risk assessments were detailed, clear and comprehensive. They contained clear instructions for staff to follow to keep people safe in the home or out in the community. For example, one person was at risk of being distracted and putting themselves at risk of traffic. We saw their risk assessment described clearly how to prevent this from happening, such as staff to brief the person before leaving, clearly explaining what was expected, what to do if the person became distressed or agitated and for staff to carry a mobile phone with them for all outings.

• People who used the service had complex needs and sometimes displayed behaviours that challenged. The provider employed a behaviour specialist who worked across all the supported living schemes providing support to staff to develop robust behaviour intervention plans for people. The plans focussed on supporting people who challenged the service and addressed the triggers and causes of such behaviours prior to them escalating. For example, we observed how staff reassured people when they became anxious.

Staffing and recruitment
• Overall, there were enough staff in each scheme to support people and meet their needs. People who used the service and care workers told us there were sufficient staff deployed to meet people's needs. Care workers told us, "We normally have enough staff" and "If we need more staff, we can discuss this with the manager." During our inspection we observed that staffing level reflected the staffing rota. However the operations manager told us the staffing levels had been down recently and they were currently recruiting new staff. They said, "We are currently recruiting for support workers. Agencies have increased their fees and also find it more difficult to recruit staff." The HR manager told us they were planning to introduce a trainee programme so staff would get the chance to progress through their career path.
• The service ensured safe recruitment practices were followed, and new staff underwent recruitment checks such as references from previous employers and police checks. We saw evidence that new staff were supported to undertake a thorough induction process and received the necessary training to be able to meet the needs of people they supported.

Using medicines safely
• People received their medicines safely and as prescribed. People said that care workers helped them with taking their medicines safely. One person said, "They [staff] remind me to take my tablets so I don't forget."
• Care workers said that they had training in the administration of medicines and their competency had been assessed. Training records viewed confirmed this.
• We sampled medicines administration records which were all judged to be of good standard and completed in accordance with the provider's medicines administration procedure.

Preventing and controlling infection
• People were protected from the risks associated with poor infection control because the service had processes in place to reduce the risk of infection and cross contamination. Care workers were supplied with appropriate personal protective equipment (PPE), including gloves and aprons. They also completed training in infection control prevention.
• People told us care workers followed appropriate procedures for minimising risks that could arise from poor hygiene and cleanliness.
• During our visit we visited four supported living schemes, we noted that the service followed current government infection control guidance, such as temperature checks and lateral flow tests of people visiting the schemes.

Learning lessons when things go wrong
• There were processes in place to monitor any accidents and incidents. The provider kept a log of all incidents and accidents which occurred at the service. These included date and time, nature of the incident, action taken how to minimise the risk of reoccurrence. Each incident and accident were discussed in team meetings and when necessary with the behaviour specialist to analyse what happened and what to put in place to support the person and reduce risk. We saw evidence this had successfully reduced a person's anxiety which was the trigger for episodes of aggression.
• The operations manager told us they ensured they communicated well with staff and people who used the service when things went wrong. They said, "In the past, after discussion and reflections, other people like consultants have been involved to help us get solutions." The HR manager added, "For myself, I need to see managers introduce new procedures at the service level to make improvements. For me it's always about introducing new ways of working, listening to staff and have a clear and transparent two-way conversation. We are working towards the same goal."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

• People who used the service received care which was person centred and needs led. We saw evidence people who used the service were involved in the formulation and review of their care and support plans. These were detailed and related to the person's needs, skills and future goals. Care and support plans were reviewed regularly and updated to ensure people's changing needs were reflected. They used pictures and symbols to ensure people were able to understand them if they were unable to read.

• The behaviour support specialists worked with staff at all the supported living schemes where there were concerns with incidents, accidents or episodes of behaviour that challenged. They gathered all the incident reports, behaviour charts and records of the person and analysed these for patterns and triggers. As a result of this, they developed 'Positive behaviour plans' which were detailed and personalised to each person.

• People's care and support plans were detailed and personalised. For example, in one person's one page profile, it was stated the person did not like change, and did not like throwing away old things. It also stated the person was sporty and benefited from going out cycling and swimming. We saw evidence they were supported to access this in the community.

• There was clear evidence the staff promoted people's independence whilst measuring the risks. The staff worked with the individual to develop their skills. Support plans stated what they were able to do by themselves and where they required support, for example during personal care or cooking meals. One person's support plan identified they were able to use household appliances but required support and supervision to keep them safe when using hot appliances.

• People had health plans in place which were detailed and person-centred. These listed their health conditions and how to ensure the person remained safe and well.

• People were supported to manage their money if they were able to. Where this was not possible, staff supported people with this. Money was then kept in a locked tin in the manager's office. A clear record of any transaction was kept and signed appropriately.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• People's communication needs were clearly recorded in their communication care plans and met. The plans provided clear information to staff about how people communicated their needs, likes and dislikes as well as how they made decisions in relation to their care.

• We saw the staff used various tools to communicate with people who used the service. These included, a

picture rota and communication boards. one person was profoundly deaf and we saw the staff were trained in Makaton and provided visual support around the home. Makaton uses speech with signs and symbols to help people to communicate.
• The staff told us they learned how to interpret people's gestures and body language to understand what they wanted to communicate. One staff member told us, "[Person] sometimes takes you to the freezer and show you [they] want more nuggets. [They] brings objects to you to tell you what [they] want.
• People's communication needs were clearly recorded in people's care plans as 'communication passports'. These stated the person's wishes in relation to how staff needed to communicate with them. For example, 'Don't shout at me while communicating to me' and ' Don't talk to me like a child'. The passports included listening and understanding, expression and sensory needs.
• People's sensory needs were recorded in their support plans and included guidelines for staff so they knew how to meet these. For example, one person disliked being touched so staff knew how to limit physical prompting or any need for physical contact.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• People were provided with activities funded by the local authority. Some people went to day centres on nominated days where they undertook activities and met other people who used services. They also had the opportunity to engage in other activities such as going shopping or visiting places of interest. One relative told us, "[Family member] is very active. Loves the gym and sailing. [They] get depressed when [they are] not active."
• People told us they were able to meet their relatives and visit friends. A scheme manager told us, "Their families are wonderful. They speak to them all the time" and "[Person] likes speaking with [their relatives] daily. [Person] is collected every week. They cook together, then [they] go home." They added, "During the pandemic, they kept contact with relatives and eventually managed to get some relatives onboard to coordinate video calls."
• People had individual activity plans which included college, day centres, gym visits as well as work placements if people had chosen to take part in them. One person said, "I don't like to go to the day centre anymore, but I recently went to the gym and will start going more regularly." The service told us of one person who was in regular employment and the positive impact this had on the person's behaviours that challenged the service which had reduced.

Improving care quality in response to complaints or concerns
• The provider had a policy and procedures for dealing with any concerns or complaints. Details of the complaints processes were available to all the people who used the service and were available in an easy-read format.
•The provider kept a log of all the complaints they received. This included a date, summary of the complaint, date the acknowledgment letter was sent, complaint response and closed date. We saw evidence that complaints had been taken seriously and addressed appropriately by the provider. Where necessary, concerns were reported to the local authority's safeguarding team and CQC, and appropriate action was taken. For example, where there had been whistleblowing concerns raised, these had been investigated in line with the provider's policy and procedures, and appropriate actions had been taken in a timely manner.
• People who used the service confirmed when they had raised complaints and concerns, these had been taken seriously and had been resolved promptly.

End of life care and support
• Where this was possible and the person was happy to do so, end of life wishes were recorded in care plans. These were person-centred and comprehensive and sensitively written. For example, one person had made

specific requests in relation to their funeral arrangements including the kind of food which should be provided at the wake.
• Although the services did not provide end of life care, they had links to healthcare professionals who were involved in people's care and who would be able to provide advice and guidance should a person become unwell or had life-limiting illnesses.

Good

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• The provider demonstrated how they had supported people with complex needs using positive behaviour support with life-changing results. For example, when admitted to one of the schemes, one person lacked motivation, led an unhealthy lifestyle and displayed behaviours that challenged, including suicidal ideations and aggression towards others.

• We saw evidence with support and time, the person had improved and were able to get employment, become healthier and calmer and the behaviours that challenged dramatically reduced. The provider received the APT-RAID award (An award for Excellence in Working with Challenging Behaviour).

• Another person who was withdrawn and often engaged in verbal aggression was, with staff support, accepting support regarding their mental health. This had enabled them to communicate their fears, stresses and concerns, which were a trigger to the verbal aggression. The manager told us the person was now actively involved in directing their own support, planning and problem solving in order to meet their own life goals.

• There were monthly staff meetings conducted by each scheme manager. There were also monthly managers meetings where they discussed all the current updates from all the schemes, any issues they were facing, possible solutions, procedures and policies, staffing, HR updates. The behaviour specialists attended to give any updates about the people they were supporting. The operations lead told us, "We give people options and choices. Some are able to tell us and initiate what they want to do. They have one to one keyworker, and usually monthly meetings. Other meetings happen weekly, such as choosing activities."

• People who used the service were involved in meetings and debriefs when an incident has occurred. This is to discuss the incident and what went wrong, and to support them to reflect on their actions. This often results in the person understanding that a more appropriate response/action would be better.

• Care workers were knowledgeable about people's needs and were able to describe these. Their knowledge of people's needs was enhanced by the fact they were allocated to the same people regularly. One person told us, "They [staff] help me with the things I need help with like my tablets, but I can clean my room on my own."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

• The leadership complied with the duty of candour. This is a set of specific legal requirements that providers

of services must follow when things go wrong with care and treatment. We had been notified of notifiable events and other issues.
• The operations lead and scheme managers were aware of their legal responsibilities. They were able to explain what type of events they would need to report to the CQC, (for example a safeguarding concern and a serious injury) if they happened.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
• During the year, we were alerted to some concerns in relation to the quality of the service at two of the provider's supported living schemes. This resulted in an increase in safeguarding concerns, and incidents and accidents. Through the provider's internal investigations, they identified the issues and took appropriate action in line with their procedures. This included using their disciplinary procedures effectively. Some staff had left the services and new staff were recruited.
• We saw evidence that the provider had put more robust systems in place to improve the standards in all the supported living schemes. For example, regular quality assurance audits were carried out and any shortfalls were recorded and actioned. The results from undertaken checks were used to reflect on ways to drive improvement. For example, the service had sought support from an external source to review the service delivery and to ensure it was provided in line with the regulations.

Working in partnership with others
• Where external health and social care professionals were involved in people's care this was reflected in their care documentation. The operations lead told us, "If somebody requires specialist service, such as psychiatry, we do support them to access this. We work closely with other organisations like the special schools, MENCAP, colleges. We recently had a program with one of the employers for a SU to work. We do work with the community settings."
• The managers and team leaders told us they worked with health and social care professionals to provide effective care to people. These included behaviour support, speech and language therapy and psychology. The manager told us, "We also work with the safeguarding team when there are issues. We attend meetings and have dialogues with them. At time with the police when there have been incidents."
• People and relatives confirmed that when needed the service reached out for advice and support from external health professionals.