Homes Caring for Autism Limited

Hilltop

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

Hilltop is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Hilltop accommodates up to seven people with severe autism. They are non verbal and need high levels of support. They live in a two storey house. There were seven people using the service at the time of this inspection.

At the last inspection in September 2015 the service was rated Good.

At this inspection we found the service remained Good.

Why the service is rated Good:

People were supported to have maximum choice and control of their lives. A high emphasis was put on using technology to help people's understanding and reduce people's anxieties. This widened their opportunities and helped to promote their health because they had been able to access health care which was previously too stressful for them. The service worked closely with health and social care professionals toward achieving good outcomes for people. The provider organisation also ensured experts in the field of autism were available as a staff resource.

People's safety was maintained through adequate staffing levels, which included the use of agency staff, recruitment practice, safe medicines management, premises and adequate infection control. Individual risks were understood and innovative methods used to reduce risk with as little negative effect on the person as possible.

Staff promoted people's dignity and privacy because they were able to pre-empt situations where this might be compromised. Through listening to people's views, using person specific communication methods and a strong staff commitment to the people in their care, the service was centred on each individual. Care plans were very detailed and reviewed with the person, staff who support the person, external professionals and family members. Staff had the time and resources to identify best practise and use this to people's benefit.

The premises was maintained in a safe way and people had a variety of spaces available for their use.

Staff induction and on-going training ensured staff were effective in their role. Staff received a high level of support and regular supervision of their work. Staff were very happy with the level of training they received.

People's legal rights were understood and upheld. People were safeguarded from abuse and harm.

The service was well-led through the example of the registered manager who ran a well organised service. People's views were sought and every opportunity taken to improve the service. Audits and checks were carried out in-house and through the provider so any problem could be identified and rectified.

The registered manager understood and met their legal responsibilities.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service continued to be Good.	**Good**
Is the service effective? The service continued to be Good.	**Good**
Is the service caring? The service continued to be Good.	**Good**
Is the service responsive? The service continued to be Good.	**Good**
Is the service well-led? The service continued to be Good.	**Good**

Hilltop

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 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 was a comprehensive inspection. It took place on 27 and 30 November 2017 and was announced. The reason it was announced was so people who would find our visit a challenge, could be informed that we would be visiting and supported if required.

The inspection team included one adult social care inspector.

Prior to the inspection we looked at previous inspection reports. We also reviewed the information we held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We met each of the seven people using the service and received specific feedback from one of them through a conversation where they were supported by their key worker. During the inspection we also used different methods to give us an insight into people's experience. This included informal observation throughout the inspection. Our observation enabled us to see how staff interacted with people and see how care was provided.

We spoke with two family members and three staff members, two provider representatives and the registered manager.

We reviewed two people's care records, two staff files and looked at quality monitoring information relating to the management of the service and safety records. We received feedback from three health and social care professionals and saw other feedback from questionnaires the service had received during 2017.

Good

Is the service safe?

Our findings

The service continued to be safe because risks were assessed, considered in depth and managed so as to protect people using the service. For example, where people were known to eat inedible objects two staff were required to check, and record that their rooms were safe for them to use.

Each person had in-depth risk assessments in place to protect them from harm. For example, relating to their diet, car use, fire safety and medicines. These were under regular review.

Incidents were closely monitored and opinion sought and used toward increasing safety. An advocate with knowledge of the service said, "I have certainly noticed that once a specific issue is raised, similar episodes rarely reoccur indicating the nature of the Home to prevent repetitions". Both people's family said they had no concerns about (the person's) safety.

There was an equalities and diversity policy in place and staff received training on equalities and diversity. Staff demonstrated that they were aware of their responsibility to help protect people from any type of discrimination and ensure people's rights were protected. For example, one person met a bus driver and was able to first enter the bus whilst empty so they would feel more confident using that public transport.

There were recruitment processes in place. These included pre-employment checks including references from previous employers and Disclosure and Barring Service (DBS) checks. A DBS checks helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with certain groups of people. Staff confirmed that they did not work at the service until all checks had been completed.

People were protected from abuse and harm because staff knew how to respond to any concerns. All staff had received safeguarding training. The registered manager had informed the safeguarding team, appropriately, when there had been a requirement to do so, such as an altercation between people using the service. Safeguarding concerns were handled correctly in line with good practice and local protocols.

People's needs were met through sufficient numbers of staff because each person's support needs were under regular review. For example, staff attended individual's review meetings to agree their staffing support needs with other stakeholders in the person's care. Each person using the service required one to one or two to one support for a proportion of waking hours. There were two waking night staff and a facility for a sleeping night staff should this be needed.

The service used agency staff to meet staffing shortfalls. There were currently two support worker vacancies and the service was actively recruiting. The registered manager said the agency staff were skilled in meeting the needs of people at Hilltop and described them as "Really, really good". On each daytime shift the registered manager and/or deputy manager were available. There was also a team leader and one nominated staff was on call over a 24 hour period. There were on call managers (from sister homes) over the weekend period. Staff told us they were able to meet people's needs with the staffing arrangements in

place.

People were protected from infection. The service used a coloured coded system for mops and cutting boards and staff had personal protective equipment, such as gloves, to reduce any possibility of cross contamination. Laundry equipment was suitable for the needs of people using the service. For example, washing machines had a sluicing and hot wash cycle. There was an infection control policy and the staff received appropriate training in infection control and food hygiene. An outbreak of stomach bug in 2016 was correctly reported and a protocol was in place should this happen again.

The premises were well maintained through a programme of maintenance and servicing. For example, gas, electricity and water checks were carried out in accordance with the level of risk. Vehicles used by people using the service were checked daily and weekly to ensure they were safe to drive. All staff had received health and safety training. There were arrangements in place for on-going maintenance of the building. General risk assessments were in place, for example, relating to use of the garden, lounge and kitchen. Each hazard was rated against the possibility of risk and a traffic light system indicated whether the risk was red, yellow or green depicting how well the risk was being managed.

There were arrangements in place should an emergency occur. For example, there was a plan which included relevant contact details for emergency maintenance and each person had a personal evacuation plan, should this be necessary.

Medicine management protected people from mistakes. No person using the service was able to manage their own medicines because of the degree of their disability and so staff trained in medicine management did this for them. Each person had a medicine cabinet in their room and medicine storage was secure and safe. Detailed protocols informed staff when medicines could be given and under what circumstances where these were 'as required'. One person's family member said that, when medicines went with the person to the family home, this was done in a well organised and safe way. This showed that medicines were safety managed within the service and in the community.

Medicine records were clear and complete and the registered manager did regular audits to monitor medicine management. Where an error had occurred this was fully investigated and corrective action put into place.

People's finances were protected. People's allowances were kept securely on their behalf, with weekly balance checks in place and detailed record keeping, which was open to scrutiny from people's family.

Good

Is the service effective?

Our findings

The service continued to be effective.

People received care and support in line with individual needs to achieved very positive outcomes. To this end the service used expertise employed by the provider, external professionals and technology. For example, the training manager was undertaking a Master's Degree in Autism. Staff had received training and were supported by two professionals who themselves live with autism. Staff talked of how inspired and enlightened they were hearing from people who could communicate the experience of having autism and its challenges.

Each person's ability to communicate was affected by their disability but the staff had studied each individual's preferred method for communicating their required needs and support. A communication's lead, an employee of the provider, was observed discussing one person's communication options with staff that supported the person. External health care professionals were also heavily involved in ensuring best outcomes for people. One said about the support for one individual, "(The staff) referral is really positive. Staff recognised the importance of getting the communication right and how this fed into (the person's) positive behaviour - holistic and very positive". Another said, "The staff…use the latest technology to help people to communicate".

A third health care professional said, "Hilltops has been very good with their communication, using the latest technology to help people to communicate". People had individual electronic tablets or a 'now and next' folder. Some people used a signing method to communicate their needs. One used a visual calendar which helped reduce their anxiety. They could see what event was to happen next and when that event was over, that information was removed from the calendar. This gave them reassurance. One person's family member said, "He's very happy. (The person) can see what is going to happen. No concerns at all".

The communication aids helped people make choices and understand information, without emphasis or implied expectation by staff. For example, one person showed, on their tablet , which restaurant they wanted to visit and then, from pictures of the restaurant's menu, choose what meal they wanted. This put them in complete control of those decisions.

Very detailed and intensive work with people was helping to transform their lives. For example, one person would become distressed, staff believed about injections, but the complete cause was unknown. They put a programme of investigation in place. This involved staff making a 'social story' in the form of a film. This used a photograph of the person completing the activity, so they knew what to do and when. It was a walk-through trip to the training department where they would meet with staff who would be supporting them through the blood test. A similar process used previously with another person had led to successful blood tests. The service had liaised with the local surgery and a phlebotomist who was working alongside the staff and the person to support with achieving blood tests. The phlebotomist attends the provider's training centre and completes blood test there to provide a constant approach to the person and aid in minimising their anxieties. The work was on-going.

A third person's life had, two years ago, been endangered when they began to refuse all care and support. The registered manager said, "It took a lot of determination and support from staff using a real person centred, and upbeat, approach". That person now has a daily bath, eats well, takes their medicines and goes out into the community. We observed them over two days smiling and relaxed with their support worker and with their phone and IPAD.

Staff worked in accordance with the Mental Capacity Act 2005 (MCA). No person using the service had capacity to make all necessary decisions relating to their care and support. The MCA provides a legal framework for making 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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interest and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Each person using the service had a legal authorisation in place to deprive them of their liberty. They were not free to come and go as they might want and each required constant supervision for their safety.

Authorisations were in place for two people. Each could be removed by two staff if necessary. This had been agreed within best interest meetings and was regularly reviewed as part of a positive behaviour support plan. The removal had not been used in over two years. All staff were trained in positive behaviour support.

Staff received a detailed and thorough induction, including the nationally recognised Care Certificate which was integrated into the service's own induction training. One staff member said of their induction, "It was thorough and I enjoyed it". Each new staff spent a minimum of 2 weeks shadowing an experienced support worker to care for an individual whilst receiving initial training in subjects such as safeguarding and autism. When that new staff member and the staff they shadowed agreed that they were ready to work alone with the individual this was signed off by the registered manager.

Staff received thorough and in-depth training. One staff member described it as "brilliant". Training was organised through the provider head office and automatically timetabled into the service rota. This meant that no training would be missed. Staff said they were supported to achieve qualifications in care.

Staff received the support and supervision they needed to achieve good outcomes for the people they supported and for their protection. During probation this was a weekly meeting and following probation, every eight weeks. Supervision was very in-depth covering a wide range of subjects. Those we saw included equality and diversity, medicine management, support for the staff member and about the individuals they supported.

People were supported to enjoy their preferred take away foods but also encouraged to make healthy options. The main meal of our first visit was chicken korma with a stew the second day, using fresh ingredients. One person's specialist diet was being met and the service did not hesitate to involve dieticians and speech and language therapists in the interest of promoting people's health, safety and well-being.

The premises reflected the needs of people using the service. A lounge and dining room provided a space for people to be together should they wish this. A newly completed 'den' provided subtle lighting and textured flooring. Some people had an 'apartment' with kitchen, bathroom and bedroom. Each person's space was designed to their preference, including their preferred temperature where the heat had caused one person

distress. This showed that people's diverse needs were being met.

Staff had sought technical ways to enable people to secure their rooms if they wished. To date no ideal option had been found. This trial had included the use of key fobs toward giving people increased access to areas of the home.

Good

Is the service caring?

Our findings

The service continued to be caring.

People's privacy and dignity were promoted. Some people's dignity was challenged by their social inhibitions and/or incontinence. To protect them staff ensured they would have any spare clothing or a blanket which might be needed when leaving the premises. Staff spoke of people's right to have equal access to the community as those without a disability. The registered manager said, "Staff receive training in dignity and respect and are aware to challenge and question things they feel is not correct".

People using the service were not always able to ensure their privacy and dignity, for example, some would remove the curtains in their room, potentially exposing themselves. Staff therefore made adaptations to the person's environment, such as coloured film fitted to their windows, to prevent people in the street looking in. We observed how people using the service were able to look out.

Staff supported people to maintain relationships which were important to them, and in the manner they chose. One person was supported to visit their sibling. Others were supported to visit their family home, receive visits at Hilltop or go into the community with parents. People's family said (the person) was always happy when they returned to Hilltop which showed they were happy and felt at home there.

Staff understood people's individual communicated that they wanted private time, and ensured this was provided at that time. Each person had an individual room or apartment for their use.

Advocacy was used to support people. An advocate said, "(The service is) caring but not smothering; individuals are supported to grow and not 'bubble-wrapped.'

People's views were sought and responded to. In addition to daily and on-going informal communicating each person had a dedicated, monthly meeting with key staff involved in their care. We observed one staff member, through systematically asking appropriate questions and through their understanding of the responses, identify that the person wanted a clothes change.

A new person centred review process was introduced at the service. Staff had recently attended training in how to facilitate people's reviews. A newly devised recording form included prompts toward asking appropriate questions. These included, with whom and under what circumstance personal information could be shared.

Good

Is the service responsive?

Our findings

The service was responsive because staff explored innovative ways to improve people's lives, including the use of technology. A staff member said they used "Creativity and passion" and described how they used 'mind maps' to explore what was possible and how to achieve it for each person.

An advocate with knowledge of the service said, "The (staff at Hilltop) are active and illustrate a total commitment to the residents they support". A staff member said, "Our focus in on the individuals and their lives". In 2017 the staff at Hilltop had produced a Team Charter setting out 'Goals', '(Their) Key Responsibilities' and 'Ground Rules', which included: 'Anything is possible'.

People using the service were supported to achieve active lifestyles where this was what they wanted. These achievements were following intensive work by staff with the individuals. One person had been able to go on holiday for the first time in two years. This was not able to be achieved the previous year due to anxiety levels, however the service had worked closely with local health care professionals to support and help this become achievable. This was a great success. Another person, who would go in a car but not get out of it, had visited Longleat. Three people had been able to access the barbers to have their hair cut. Staff previously supported with hair cuts as the people would not allow anyone near their hair that they were unfamiliar with, so would not allow anyone to cut their hair other than staff Another person had been on a train for the first time following, "Months of desensitization work".

People's care and support plans were very detailed, person centred, in regular use and under review. The plans showed people's goals and inspirations and identified the support needed to meet them. Plans also included detailed protocols to protect people, for example, with regard to managing conditions such as epilepsy, the use of medicines and preventative and responsive action to take in the event of challenging or self-injurious behaviours. An advocate for one person said, "Care plans, notes and records are comprehensive and on-going and regularly reviewed, and I feel that such are an accurate reflection of the experiences had by those they support".

People knew how to make a complaint, inform staff they wanted something, and make their views known. We asked one person who they would tell if they were unhappy and they got up and went immediately to point to a symbol of an unhappy person. Their support worker then asked a couple of relevant questions, interpreting their response, and identified what they were unhappy about. This showed that the service had understood the importance of people being able to say when they were not happy and have their concern/complaint dealt with promptly.

The service reported eight formal complaints made, and resolved, in the previous 12 months. Two people's family members said they felt they could take any concern to the registered manager or staff and, "They would be pretty good" at dealing with it. The Care Quality had received no complaints about the service.

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Good

Is the service well-led?

Our findings

The service continued to remain well-led because dedication to the people they supported was led by the provider and the registered manager.

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.

Systems were in place to ensure the smooth, and safe, running of the service. For example, all staff had on-line access to all policies and procedures. There was a 'policy of the month' and a monthly 'buzzword' to inform them and revise their knowledge.

All available resources were used to gain information and look at best practice. For example, receiving feedback from experts employed through the organisation, visiting professionals, the local authority quality monitoring team and managers from sister homes.

A member of staff said, "Communication is good and we work as a team". Another asked if the service was well-led said, "100% Anything that can be actioned for improvement is". Staff felt their views were listened to through review meetings, team meetings and questionnaires. Areas discussed included what was currently working, what was not working well and what resources were needed. There was a strong emphasis on staff having the time, and physical space, to share views and discuss practice. The provider ensured that staff had the information, expertise and resources needed.

Leadership was visible, capable and inspired staff. Staff knew what was expected of them and had the support they needed. Anything which presented as negative in the service was investigated in depth. Where necessary, staff performance was managed toward improvement.

The provider understood their responsibilities and was effective in supporting the service. For example, an area manager was in day to day contact, there were monthly managers' meetings and monthly provider audits were completed.

Service audits and checks ensured a safe and efficient service. For example, incidents, medicines and senior's shift checklist were in use.

The registered manager understood and met their regulatory responsibilities.