Salisbury Autistic Care Limited

Holt Road

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

We inspected Holt Road on 22 December 2014. This was an unannounced inspection. Holt Road provides accommodation, personal care and support for five people with autistic spectrum disorders, learning disabilities and complex needs. The people who use the service require one to one or two to one support from staff due to the assessed risks to themselves and others due to exhibiting behaviours that challenged the service. There were five people living at the home when we visited.

At our last inspection in November 2013 the service was meeting the regulations we inspected. There was not a registered manager at the time of our inspection. 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 last registered manager left in November 2013. Two

Summary of findings

further managers were appointed but both left before they were registered. At the time of our inspection the provider's area manager was acting as manager of the service pending appointment of a permanent manager.

People were not protected against risks to their safety in the premises. There were poor arrangements for the management of medicines that put people at risk of harm. There were no measures to address the risks from open flames on the cooker or the handling sharp knives. The area manager had started to manage the home a few days before the inspection. Records about the management of the service were not available during the inspection. The area manager was not able to show how they monitored the quality of care provided. Staff told us that they knew how to support each person effectively and to address any behaviour that challenged the service with positive reinforcement. However, there were no records to show that staff had regular supervision of their work and the training records were not available. We have made a recommendation about this.

We observed some examples of staff interacting with people in a positive way, but we also observed other examples of negative interactions that did not support people to manage their behaviour. For example, we observed a member of staff using abrupt language and another example of staff not telling the person what they were doing. We found that there could be developments in providing space for privacy within the home and we have made recommendations about these matters.

The service did not respond to people's individual needs effectively. Care plans contained information on people's needs, but were not detailed. In particular, care plans did not address each person's individual preferences for activities in the service and in the community. The activity records that we saw showed that similar activities took place for people on a daily basis, and many of the activities involved a drive or a shopping trip. A staff member told us, "People go out in the minibus and then split up and do other activities when we are out." However, these individual activities were not recorded. We have made a recommendation about supporting people with autistic spectrum disorder to take part in their choice of activities.

The provider did not fully follow the Code of Practice of the Mental Capacity Act 2005 (MCA). People did not have assessments of their mental capacity to make decisions for themselves, and for others to make decisions in their best interests if required. CQC is required by law to monitor the operation of the MCA Deprivation of Liberty Safeguards (DOLS) for care homes, and to report on what we find. Where there is a deprivation of a person's liberty DOLS requires the provider of the care home to submit an application to a 'Supervisory Body' for authority to do so. Risk assessments showed that people were at risk outside the home if unaccompanied. However, only one person at the home was subject to a DoLS. We have made a recommendation about following the MCA Code of Practice.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and corresponding regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These relate to medicines management, risk assessments and records. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Aspects of the service were not safe. Systems for the management of medicines did not ensure that people using the service received prescribed medicines safely.

Measures were not in place to manage risks to the safety of people using the service.

There were enough staff to meet people's needs. Staff were aware of their responsibility and the procedures for reporting any concerns about people's safety and welfare.

Requires Improvement

Is the service effective?

Aspects of the service were not effective. Records were not available to demonstrate staff had received a range of training and supervision.

The provider was not following in full the Mental Capacity Act 2005 Code of Practice.

People using the service were supported to maintain good health and have access to healthcare services and support when required.

Requires Improvement

Is the service caring?

Aspects of the service were not caring. Some staff did not always respond positively to people to support them to manage their behaviour.

Staff understood how each person communicated and supported them to make decisions about their daily lives.

Requires Improvement

Is the service responsive?

Aspects of the service were not responsive. People were not supported to take part in their choice of individual activities.

Care plans provided guidance for staff to manage behaviours and care plans contained relevant information about people's communication needs.

Requires Improvement

Is the service well-led?

Aspects of the service were not well-led. There was no registered manager and records relating to staff and the management of the service were not available. There were objectives for an effective service for people with Autistic Spectrum Disorder.

Requires Improvement

Holt Road

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 22 December 2014 and was unannounced. The inspection team consisted of two inspectors and a specialist advisor. The specialist advisor for this was a consultant psychiatrist and specialist in challenging behaviour management.

Before we visited the home we checked the information we held about the service, including notifications of significant events that the provider had sent to us.

People who used the service were not able to communicate with us verbally. We observed care and support in communal areas of the premises. We spoke with four support workers and the provider's area manager. We looked at five people's care records and a range of records about people's care and how the home was managed.

Requires Improvement

Is the service safe?

Our findings

Medicines were not administered safely. Medicines were provided to the service in individual monitored dosage (MDS) blister packs. We checked the medicines and medicines administration records (MARs) in the home. Some medicines were not available in the home. The area manager told us that staff had taken the medicines with them to administer as required while people were on a day trip out of the home. However this was not recorded and the evidence therefore showed that prescribed medicines were not available. MARs were in the home, which meant that any medicines administered while people were out were not recorded at the time they were given in accordance with recommended procedures.

Staff told us that they had received training in managing and administering medicines safely. However one member of staff was not aware of the PRN medicines to be used if a person required them.

Medicines that were not provided in MDS blister packs were stored in the medicines cupboard in plastic baskets for each person. We noted that one person had medicines prescribed to be taken when required (PRN), but there were no supplies of these medicines in the home. Staff told us that they did not take PRN medicines out with them. This meant that these medicines were not available if needed, either in the home or when people went out. The medicines storage baskets were untidy, and we found loose medicines and loose prescription forms in two baskets. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The area manager told us that no controlled drugs (CDs) were currently prescribed for people using the service. However, the area manager was not able to locate the keys to open the medicines cupboard for CDs, which meant that we were unable to check whether storage and recording was available for CDs if they should be required.

We saw individual risk assessments that were specific to each person's needs, for example for personal care activities, social activities, road safety and use of public transport. These included details of the action staff should take to minimise these risks and keep people safe.

We saw that risk management plans were in place for each identified risk and contained detailed information for staff on how to manage activities that included what to do if the person's behaviour changed during the activity. General risk assessments for the service were also in place, including the use of the vehicle and use of physical interventions.

However, we noted some aspects of the service presented a risk for people using the service but measures were not in place to address these and reduce the risks of harm. For example, sharp knives were in an unlocked drawer in the kitchen, which people using the service had access to. We observed a second example where people using the service were picking objects up in the kitchen near the gas cooker while eggs were boiling on an open flame. The area manager told us that neither of these observed risks presented a risk to the people concerned, but there were no risk assessments in place to address them. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received safeguarding adults training. The area manager informed us that updates to training in safeguarding, managing behaviours that challenged the service and physical intervention was being arranged. Staff were aware of their responsibility and the procedures for reporting any concerns about people's safety and welfare.

The area manager told us that the manager and three staff had left the service during the previous month. They said that the staffing levels provided one support worker for two people using the service, and that additional staff were scheduled when required, for example to provide one to one support when people went out. We found that the staff on duty during the inspection were sufficient to meet the needs of people who required additional one to one support. We noted from support plans that two people were each assessed to have fourteen hours a day of one to one support. Three support workers were in the home when we arrived to support five people, and three arrived later to support people for a trip out.

Requires Improvement

Is the service effective?

Our findings

We spoke with staff for a short period at the start of the inspection before they took the people using the service out for a planned community activity. Staff told us that they followed the provider's objective of seeing the world "through the eyes of people with Autistic Spectrum Disorder", and we observed some examples of staff interacting with people in a positive way. However, the area manager was not able to show us evidence of staff supervision and therefore confirm that staff were provided with regular support and guidance with providing care for people using the service.

The last staff meeting minutes available were from September 2014. The provider told us that a behavioural specialist had been employed to provide training and support on autistic spectrum disorder, behaviour management and physical interventions. However, this person had recently left and staff had not had up to date training on these aspects of the service. The area manager was not able to provide a training schedule or records of training that staff had completed because the team leader had a paperless system and she was not available at the inspection to show us. The provider informed us that 85% of staff working at the time of the inspection had received all mandatory training. We have made a recommendation about having staff supervision and training records available when needed

We recommend that records relating to staff including staff supervision and training records are kept securely and can be located promptly when required.

The provider did not fully follow the Code of Practice of the Mental Capacity Act 2005 (MCA) to make sure that people who did not have the mental capacity to make decisions for themselves had their legal rights protected. Care plans referred to people's inability to understand information about, for example, medicines or monies, but we did not see any assessments of capacity, or evidence that best interests meetings had taken place for most people. One person had a Court of Protection appointee and support from a parent in managing their money, and we saw evidence that meetings had taken place in relation to this.

CQC is required by law to monitor the operation of the MCA Deprivation of Liberty Safeguards (DOLS) for care homes, and to report on what we find. Where there is a deprivation of a person's liberty DOLS requires the provider of the care home to submit an application to a 'Supervisory Body' for authority to do so. Risk assessments showed that people were at risk outside the home if unaccompanied. However, only one person at the home was subject to a DoLS. The area manager told us that they were aware of the 2014 Supreme Court judgements which widened the scope of the legislation, but the home had not yet made any application for other people living there.

People were supported to have sufficient amounts to eat and drink and maintain a balanced diet. People chose their menus at the weekly house meetings. Staff supported people to make their choices using pictorial aids. The area manager told us that one of the people using the service was supported to meet his cultural needs by purchasing halal meat for him.

We saw that information for staff about managing health needs was in place. For example guidance in relation to supporting a person with epilepsy included a description of the type of seizure they experienced, how to support the person, and when and how to administer emergency medication or call emergency services if required. We saw evidence that links with a range of health professionals were maintained.

We recommend that the service seek advice and guidance from a reputable source about the application of the MCA Code of Practice and DOLS to residential care services.

Requires Improvement

Is the service caring?

Our findings

We observed people using the service and their interactions with staff for an hour during the morning. People using the service did not communicate verbally, and we observed that staff used signs, body language and pictures from the Picture Exchange Communication System (PECS) to communicate and to understand people's responses and needs.

We observed that three people did not experience a caring attitude from staff. Three members of staff did not show that they understood how to communicate with specific people. One person indicated to staff that they wanted to turn the TV on by pulling them towards the TV. The staff were unable to tune the TV to a programme that the person liked, but they did not attempt to explain this to the person. We also observed staff encouraging another person to put on their coat to get ready to go out. Staff used abrupt language, for example, "You will be left behind if you don't get dressed." This was contrary to the service's guidance for the use of positive encouragement. When one person picked up some dry leaves in the garden, staff physically pulled them towards the dustbin to throw the leaves away. They did not explain what they were doing or give the person time and positive reinforcement for their actions.

We recommend that the provider seeks advice and guidance from a reputable source for staff when caring for people so as to maximise choice and balance safety.

The physical environment of the premises included one communal kitchen/dining room and a small seating area with a television. There was a separate lounge which could provide a quiet area. Staff told us that people did not choose to go to this room, but may be moved there if another person was "acting out" in the dining room. The garden contained an outbuilding described as the sensory room, but the area manager told us that this was not in use due to structural damage. The garden was an open grass area with a large trampoline. There may be scope for developing the facilities so as to provide additional space for people's privacy and we have given a recommendation about that.

Care files contained information about each person's communication needs and preferences. We saw that a communication passport was in place for one person, and included information about words in their first language that staff should use to communicate with them. We observed staff communicating appropriately with one person and giving them choice about what they wanted to do. The person indicated that they wanted to go to bed and went to their room. A staff member used a communication book with PECS symbols to ask the person what they wanted to do, and later to ask them to get up in order to get ready to go out. The staff member ensured that the person was able to choose the shoes and coat that they wanted to wear and then supported them to dress. The staff member responded to the person with positive sentences and appreciation. The person indicated that they would like to go out on the bus rather than in the care with other people, and staff supported them with this decision.

There was a weekly house meeting for people to discuss what their menu choices and activities for the coming week. The minutes of the meetings showed how each person communicated their preferences. For example, "[Named person] used their index finger to point to their choice of menu". "[Named person used PECS to choose where to go for their holiday."

We recommend that the service seek advice and guidance from a reputable source about providing areas for privacy in the premises.

Requires Improvement

Is the service responsive?

Our findings

There were some positive aspects to the care planning arrangements. For example, care plans showed people's choice of cultural and spiritual activities. One person's care file contained information for staff about how to support them to attend their place of worship. We also saw guidance for staff on supporting a person with their cultural and spiritual needs. Staff told us that care plans provided them with information on communicating with people. We saw that behaviour action plans were in place for each person. These were detailed in their descriptions of people's behaviours that may be challenging, including potential causes and triggers, and contained clear information for staff about how to be proactive in reducing the impact of these. The plans provided guidance for staff around how to manage behaviours.

However, we found that care plans did not contain sufficient information for staff to respond to people's individual support needs effectively. Although care files held a detailed assessment for each person that had taken place prior to their move to the home the care plans only contained some of this detail. For example, one person was said to have "very complex needs" and needed one to one support for help them "function daily," but there was no further description of what these needs were. One care plan specified that the person should be supported to do, "more activities to stop being bored," but did not contain any information about how this objective was to be achieved. Another plan identified the person's need as, "To learn to eat food in a timely manner," but the goal contained within this plan was, "To conquer fear/phobia of flying."

Activities were not planned to respond to each person's individual wishes and preferences. Each person had a weekly activity plan, but all the plans that we saw showed that generally the same daily activities were planned for people who lived at the home, with some variation for two people who attended college courses during the week. The activity records that we saw showed that similar activities took place for people on a daily basis, and many of the activities involved a drive or a shopping trip. The staff communication notes for the previous week included "All bowling after shopping and lunch", "All swimming", and "Long drive out." A staff member told us, "People go out in the minibus and then split up and do other activities when we are out." However, these individual activities were not recorded. The activity plans did not show whether any group or individual activities were in place for people during the evenings, either at home or in the community. Individual activities were arranged by staff but we did not see records stating how people's preferences were taken into account. For example, the activity record for one person stated that they were supported to attend a football match. However there was no information on the person's request for this, or of their interest in football.

The area manager was not able to provide the complaints policy for the service although information about this was provided after the inspection. We were aware that there had been a complaint sent originally to the local authority but the provider told us that it had not been passed on to them at the time of our inspection.

We recommend that the service consider current guidance on supporting people with autistic spectrum disorder to choose and to take part in their chosen individual activities.

Requires Improvement

Is the service well-led?

Our findings

There was a lack of effective management and leadership at the service. There was no registered manager at the time of our inspection. The last registered manager left in November 2013. The next manager left in June 2014 before they were registered. A new manager was appointed but did not apply for registration and left in December 2014. When we inspected the area manager was acting as interim manager of the service. She had taken over interim management a few days before the inspection. We found that the area manager was not in daily contact with the staff and showed during the inspection that they were not aware of the procedures staff followed, for example for administration of medicines and for effective behaviour management. The area manager told us that the previous manager had implemented some processes that the provider was not aware of. Following the inspection the provider informed us that a new manager had been appointed to start work in January 2015.

Records about the management of the service were not available during the inspection at the service. They were kept at Head Office which was nearby. The area manager was not able to show how they monitored the quality of care provided. They were not able to provide staff files and records of training and supervision when we asked for them. There were no records of complaints about the service. Records and personal information about people using the service were not filed in an ordered manner. For example, care files contained behavioural recording charts but these did not record specific behaviours consistently. We saw an incident form for one person that related to a behaviour that was not recorded in their behaviour charts. There was no evidence to show how people's behavioural records were monitored and used.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had objectives for an effective service for people with Autistic Spectrum Disorder, and some measures were in place to achieve this, for example the knowledge of existing staff. Staff told us they were aware of the provider's objectives and worked to them.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. Regulation 12 (1) (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have adequate systems in place to protect people against risks to their safety in the premises. Regulation 17 (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not maintain securely records necessary in relation to persons employed and the management of the regulated activity. Regulation 17 (2) (d)