Carlton Nursing Homes Ltd

Carlton Autistic Care Centre

Inspection report

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19 September 2018

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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

This inspection took place on 13 and 19 September 2018.

Carlton Autistic Care Centre 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.

Carlton Autistic Care Centre provides care and support for up to 18 people with autism and learning disabilities in four separate houses. Each house has their own communal facilities. There were 16 people living at the home at the time of our inspection. 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.

There was a registered manager in place. 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.

At the last inspection, the service was rated good. At this inspection we found the rating remained good and the service met all relevant fundamental standards.

Staff understood how to keep people safe and were aware of the process to follow if they had any concerns. Risks had been assessed and recorded to ensure people were protected from harm without overly restricting people's freedom. Detailed positive risk assessments were in place to enable people to gain new skills in a safe and measured way.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff received ongoing support from the management team through a programme of regular supervisions and appraisals and they had been trained to ensure they had the knowledge and skills to care for people. The management team and training department kept abreast of new and innovative practices to support people with autism and ensured they sourced training to develop staff.

Positive relationships between staff and people living at the home were evident. People were happy and those that could verbalise their views confirmed this. People's independence was promoted well by staff who understood how to maximise their independence. The registered provider actively supported people to move to more independent environments once they had achieved their desired goals and were prepared for the move.

There was clear evidence of person-centred care. People were involved in activities based upon their established routines and preferences. Care records contained information on how to support people and were very detailed. Reviews of people's care needs took place at a regular interval or when their needs changed.

The registered manager was visible in the service and staff told us the management team regularly attended the service seeking their feedback and looking for ways to make the service better. Communication was open, honest and transparent and staff did not hide from sharing their views with us, giving us an honest appraisal of the service.

Systems and processes for ensuring the quality of the service were securely and effectively in place. New systems ensured the service continued to improve against nationally recognised evidence-based standards of care for people living with autism/learning disability.

Further information is in the detailed findings below

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? This domain remains Good	**Good**
Is the service effective? This domain remains Good	**Good**
Is the service caring? This domain remains Good	**Good**
Is the service responsive? This domain remains Good	**Good**
Is the service well-led? This domain remains Good	**Good**

Carlton Autistic Care Centre

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 13 and 19 September 2018 and was unannounced. On the first day there were two adult social care inspectors and on the second day one adult social care inspector.

We reviewed information we had received from the provider such as statutory notifications. We also contacted Healthwatch to see if they had received any information about the provider. We contacted the local authority commissioning and monitoring team, the fire service, the infection control teams and reviewed all the safeguarding information regarding the service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with the registered manager, the governance lead, the quality and compliance lead, the deputy manager and two support staff. We also spoke with four people using the service and two relatives. We took the opportunity to speak with a visiting professional during the inspection to gain their view on how the service was operating. We observed the medicines round and checked the Medication Administration records for seven people living at the home.

Good

Is the service safe?

Our findings

This domain remained good.

One relative we spoke with told us their relation was safe. They said, "Yes, I do think they are safe here. It is predictable, sustained care. Any change in routine has an impact. There are consistent staff who know [person] well. "

The service had developed and trained their staff to understand and use appropriate policies and procedures. They understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents. One member of staff was able to clearly describe a situation where they had witnessed abuse and what actions they had taken which along with the subsequent investigation, helped to improve safety of people at the home. Staff knew the whistle blowing process and were confident any concerns would be acted upon.

Systems were in place to identify and reduce the risks to people living in the home. People's care plans included detailed and informative risk assessments. These documents were individualised and provided staff with a clear description of any risks and guidance on the support people needed to manage these. We reviewed one person's care plan which detailed a graded positive approach to risk enabling the person to regain lost abilities whilst remaining protected from harm. Staff were aware of the risk some of the people they supported might face in the community from people who might not understand their behaviours, and consideration had been given to various scenarios to ensure people were protected from harm.

We looked at the staff rotas to check staffing levels were appropriate. People had designated 1:1 time funded either by the local authority or the clinical commissioning group. During these times staff would spend time with the individual either at the home or out in the community. Our review of information confirmed staffing levels were appropriate to meet the needs of the people living at the home and during our inspection there were sufficient staff to provide a safe service.

We observed the medicines round in the largest of the houses. Medicines were stored and administered safely, and medicine competency checks had been undertaken by the deputy manager to ensure staff were competent in their administration practices. We found when people required PRN medicines (When required) there were no protocols in place to guide staff. Those staff we spoke with were able to describe in detail how and when these were to be taken, but as there were no records we raised our concerns with the registered manager. They told us these had accidently been archived. They were all in place on our second day of inspection.
Regular safety checks took place throughout the home, to help ensure premises were safe. The home had their own health and safety officer who had responsibility for ensuring all checks were in place and these were audited. They also ensured the home had access to the most recent medicines devices alerts and where relevant ensured any recommendations were implemented such as precautions against the risk of fire when using emollient creams. External contractors were used for some checks and the landlord retained responsibility for these. Fire safety measures were in place, and people had personal emergency evacuation

plans. Staff received fire safety training and undertook regular fire evacuation drills including people at the service. We found areas of one house needed redecoration. There was a programme of refurbishment in place.

Staff files showed safe recruitment practices had been followed including obtaining references and ensuring Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. We looked at the records for one person who had been promoted to a team leader and could see from the information, they had also been selected through a rigorous recruitment process. A person who lived at the home told us they had been involved in a recent interview to recruit a member of care staff. They said, "I just asked questions about morals and values."

We looked to see how accidents and incidents were recorded and reviewed. The governance lead explained to us how learning had been shared amongst staff through the organisation which clearly evidenced they had effective systems in place to learn and improve practice.

The home did not employ cleaning staff and care staff undertook domestic tasks amongst their caring duties. The four different houses were found to be very different in terms of cleanliness from extremely clean in three of the homes, but the fourth home was found to require cleaning in some areas. This was pointed out to the registered manager who actioned this. The home had attained a high rating following infection control audits.

Good

Is the service effective?

Our findings

This domain remained good.

During our inspection one person was baking as part of their activity. They proudly told us, "I've made chocolate cake. All of us are going to eat it." Care staff made meals for people, and each person was able to choose what they wanted to eat. One person told us their favourite meal was shepherd's pie and which staff were the better cooks. Another person said, "I do a meal plan. You get £30 to do your shopping. I do my shopping on line."

The Mental Capacity Act 2005 (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 make decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). 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 and we found the service was meeting this requirement. Staff understood the principles of the Act and how to support people who might lack capacity to make large decisions to be involved in some of the decisions in their everyday lives. They maintained a spreadsheet which indicated when DoLS had been applied, authorised, and the renewal date.

We found decision specific mental capacity assessments were in place. For example, one person's care plan recorded they were unable to make complex decisions about their health, care and financial decisions. An Independent Mental Capacity Advocate had been involved to ensure when important decisions were to be made, there was an independent person acting on their behalf. For smaller day to day decisions, care staff supported the person to make choices, and the following information was recorded, "My support staff will make decisions on my behalf."

We found staff received ongoing support from the management team through a programme of regular supervision and appraisals. Staff received six supervision sessions each year. Most staff had received a recent supervision and sessions were delegated depending on the grade of staff. The governance lead shared with us their intention to make supervision sessions more reflective and had provided guidance to staff. They said, "I want supervision to be meaningful. Not just a tick box." We could see improvements had been made in supervision records to demonstrate they were used to develop staff. The registered provider employed a training officer who was responsible for organising and delivering some of the training. They showed us their online training matrix which showed training was up to date in essential subjects such as safeguarding, MCA, positive behavioural support and health and safety. All training was provided face to face. Specialist training had been sourced to meet the needs of people at the home such as in trauma informed care. The aim of this was to develop staff skills to work with people affected by trauma and to

provide a safe, nurturing and secure environment.

People's dietary needs were recorded in their care plan. One person's file we looked at referenced they required a special diet. We crossed referenced this with information about what they had eaten whilst they were on holiday, and through discussions with staff which confirmed, what was happening in practice matched the information in their care file. We noted one person had lost a significant amount of weight, but this was through a planned weight loss programmed with demonstrated the service was working with people to ensure their physical wellbeing in addition to supporting their mental well-being.

Good

Is the service caring?

Our findings

This domain remained good.

People who could verbalise how they felt, told us staff were kind and caring. One person said, "My core team are very caring. They protect my privacy." Another said, "Staff are nice."

There was a strong, visible person-centred culture at the home. Positive caring relationships were developed through staff understanding people's needs and their personalities. Where possible people and the staff who cared for them were matched so they shared the same interests and hobbies.

We could see people were happy and engaged, cared for by staff who understood how to communicate with them, knowing their gestures when these were used instead of words. Communication needs were recorded in detail in people's care plans to guide staff on the best way to engage with people. This included information on how the person might express they were in pain.

People's human right to be treated with respect was clearly understood by staff, who protected their privacy and cared for them respectfully. Staff told us how they ensured people's privacy was protected by ensuring they knocked on their bedroom door and kept information confidential. The staff team included people from a diverse cultural background and equally the service was able to meet the needs of people from differing faith backgrounds, providing culturally sensitive food options.

People were encouraged to be as independent as possible. For example, the service provided a different intensity of care in the different houses providing for people to move on, when they gained further independence. The goal for some people was to move to the registered provider's supported living service. Arrangements were in place for their care staff to initially move with them to ensure a smooth as possible transition. Where people had very little independence staff encouraged them to do what they could during any activity and we saw prompts for staff were contained in their care plan to maximise engagement.

The home used advocacy services for those people who did not have family to independently advocate on their behalf or for more important decisions. An independent mental capacity advocate (IMCA). IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. We were evidence of an IMCA involvement for person living at the home when a decision needed to be made for the purchase of furniture for their bedroom.

Good

Is the service responsive?

Our findings

This domain remained good.

Detailed assessments were undertaken prior to people coming to live at the service. Each person had a multi-disciplinary assessment to ensure the service was able to meet the needs of the person but also to ensure they could match people with those already living at the service to ensure compatibility. We saw evidence people were introduced gradually into the service where possible to ensure a smooth transition to living at the home. We saw this approach worked and one person told us they had benefitted from meeting staff who would care for them prior to moving. They said what attracted them to this service was the openness of staff. They said staff told them, "We are not perfect, but we are proud of what we do." They were very happy living at the home and confirmed staff were responsive to their needs, offered them choice and provided care in line with their preferences.

We looked at four people's care records in detail. We found care plans were extremely detailed and contained all the information required to guide staff. There were separate sections to guide staff around a person's personal care needs, eating and drinking, mobility, elimination, skin integrity, general health, medication, communication, mental health, capacity and consent, social activities, finances, safety and sleeping. Care plan reviews were frequent, and any changes recorded.

People were supported to take part in a range of activities and their relatives confirmed this. For each activity there was a support plan which guided the staff on the risks, the opportunities, and the positive outcome to be achieved. There was a sensory room in one of the houses with walls made from blackboard material, so people could write on the walls if they chose to do so.

The provider was meeting the Accessible Information Standard which requires them to ask, record, flag and share information about people's communication needs. We saw documents which would accompany people to hospital such as Hospital Passports. Information was provided to people in easy read formats to ensure they could access information. They had compiled easy read information to promote healthier lives such as one about understanding constipation, recognising the importance of raising awareness in this area.

We spoke with the management team on how they were using technology to support people at the service. Some people used the internet to shop, or to keep in touch with people and staff were aware of the importance of ensuring people were protected from online bullying or hate crime.

Although not supporting people at the end of their life during our inspection, there were plans in place to support people. Staff also recognised people at their service were at risk of developing dementia later in life and they explained training in dementia was now offered.

The registered provider had a complaints policy in place which we reviewed as part of our inspection. Information was available in each building and in accessible formats on how people could complain.

Good

Is the service well-led?

Our findings

This domain remained good.

The manager had been registered with CQC since 2011 and had been the manager at the service for 13 years. 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 registered manager was very visible in the service and knew people living there very well. They had a great rapport with people using the service and we could see this relationship had been built up due to their understanding of people's support requirements. Staff told us how much they enjoyed their roles. They told us they were able to influence change. One member of staff said each unit was different and a good idea for one unit didn't always work in the others, "We'll try and use it if it's better. One size doesn't fit all." This showed, they were open to ideas for improvements.

We saw evidence the registered provider was recognising the importance of ensuring people's protected characteristics were recorded and they had included this on their quality audits. Staff knowledge was raised at management meetings by using knowledge quizzes and managers using this information to inform their teams.

The registered provider had oversight of the service through a management team who had specific areas of responsibility. One area was around governance and we were shown the home's improvement plan. This evidenced they were auditing all areas of service provision to drive up the quality of the service they provided. It also showed they were using evidence based best practice to benchmark their service to ensure they continuously improved. Audits were undertaken regularly at the service and the management team showed us how they were changing these to be more specific to the location and to mirror the CQC key lines of enquiry

We saw evidence the registered provider worked in partnerships with other key organisations to ensure people's needs were met. One professional we spoke with during our inspection said, of the service, "Very cooperative and helpful. People are happy. Relatives are happy. Staff are motivated. People have good lives."

Organisationally, we saw evidence the registered provider ensured local partnerships were developed to benefit people at the service. Staff constantly sourced community activities to benefit people at the service, such as Creative Minds (a charity which develops community partnerships and delivers projects to promote community engagement and people's quality of life). People were involved with the local community and the management team told us how supporting the local community was, attending events held at the service but also feeding back to management if they had any concerns.

The registered provider had a range of policies and procedures which they were updating. Those that had been updated were detailed and provided guidance for staff to follow to ensure their practice reflected current best practice A few still referenced CQC outcomes rather than the fundamental standards, but the governance lead advised us these changes would be made to all policies and to ensure they reflected what was happening in practice.