National Autistic Society (The)

National Autistic Society - Camden Road

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
National Autistic Society – Camden Road provides accommodation, care and support for up to 12 people with learning disabilities or autistic spectrum disorder. At this inspection they were providing care for eight people.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

People's experience of using this service and what we found

Right Support:
The service did not give people care and support in a safe, clean or well-maintained environment that met their sensory needs. People's risks were not always identified or met safely. Medicines systems and processes were not always safe.

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; the policies and systems in the service supported this practice.

Right Care:
The service did not always have appropriately skilled and competent staff to meet people's needs and keep them safe. People did not always receive care that was focused on their quality of life or followed best practice.

The staff knew people well and had developed positive relationships. However, people's communication needs were not always understood or met. Some care and support records had not been updated for a long time and may not be reflective of people's current needs.

Right Culture:
The provider's quality assurance, governance systems and processes to monitor the quality and safety of the service failed to identify areas where improvements were required. This exposed people to the avoidable risk of harm and poor-quality care.

People's wishes and needs were not always at the centre of everything and were not used to develop or improve the service. People were not always supported by staff who understood best practice in relation to

the wide range of strengths, impairments or sensitivities people with a learning disability and/or autistic people may have.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 31 May 2019)

Why we inspected
The inspection was prompted in part due to concerns received about staff conduct. A decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of safe, effective and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively

Enforcement
We have identified breaches in relation to safety, staff training, person centred care, leadership and quality monitoring.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led key question sections of this full report.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

You can see what action we have asked the provider to take at the end of this full report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

National Autistic Society - Camden 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 Health and Social Care Act 2008.

Inspection team
The inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
National Autistic Society-Camden Road is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. National Autistic Society-Camden Road is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 5 staff members including the registered manager and 4 support staff. We observed staff interactions with 3 people who could not verbally communicate with us. We observed their body language during their interactions with care staff to further help us understand their experience of the care they received. We also spoke with two people's relatives.

We reviewed a range of records. This included 4 people's care records and 5 medicines administration records. A variety of records relating to the management of the service, were reviewed. We used the Quality of Life Tool which is designed to support the corroboration of all sources of evidence gathered during inspection.

Inadequate

Is the service safe?

Our findings

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

At our last inspection this key question was rated requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Preventing and controlling infection; Using medicines safely

- People were not always protected from risk. People had risks assessed, however risk assessments and support plans had not been updated for a long time. Some people's support plans to make sure they were safe had not been updated since 2017. This meant we could not be assured these plans and risk assessments were reflective of people's current needs or effective in promoting safety.
- There were a number of risks in the environment which were not being managed. These included; cleaning products were not locked away as is required for substances which are hazardous to health. The radiators in two lounge areas were not covered and extremely hot to touch. A cupboard containing electrical power supplies was not locked. A cupboard containing a boiler which was hot to touch, was not locked. This meant people were at risk of sustaining burns. There was discarded furniture and rubble in the garden area and in one of the sheds. These areas were accessible to people and caused risk of avoidable harm.
- One person had a special lock on their bedroom door which meant they could leave their room without the use of a key but a key was required by staff to enter the room. There was no risk assessment in place about how staff could quickly access this room in the event of a fire if the person did not respond to the fire alarm.
- People were not protected from infections. Not all areas of the service were clean. There was rubbish in the garden and outside areas. A fridge containing meat and cheese was found to be open and not at the correct temperature. The laundry floor was dirty. Mops heads and mop buckets were not stored in line with infection control policy and guidance.
- Staff wore personal protective equipment such as face masks but did not adhere to the required 'bare below elbows 'uniform policy for effective infection control.
- Medicines were not always managed in a safe way. A medicine error occurred which resulted in a person having a seizure. Systems and processes for the safe administration of medicines did not always ensure people had their medicine in a safe way.

Risk was not managed effectively, and people were not protected from avoidable harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had received training about managing people's medicines and had their competency assessed. Medication administration records we saw were accurate and up to date. Medicine storage areas we saw complied with safe storage regulations.

Staffing and recruitment

● Staffing numbers and skill mix of staff did not always meet people's needs. The provider experienced difficulties recruiting staff. A large number of agency staff were regularly used.

● Although agency staff knew the service because they were booked to work blocks of shifts at a time, they did not have all the skills required to safely manage people's needs and this meant people did not always have their needs met.

● People had complex needs and required staff to know and understand them well in order to meet their needs and keep them safe. Some people could not always take part in the activities they liked to do because staff could not safely support them. Some people spent a lot of time unoccupied and this had a negative effect on their well-being.

Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not always deployed. This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited in a safe way. The registered manager described recruitment procedures they followed. These included carrying out checks to ensure staff had the right skills and character to work at the service. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

● People may not always be protected from abuse. There were safeguarding investigations in progress at the time of our inspection which were not yet concluded.

● A relative told us they did not feel their family member was safe and had removed them from the service for this reason. Their family member had been found to have unexplained bruising on a number of occasions. This had not always been reported or investigated.

● There were ongoing altercations between people who used the service and people were not always protected from other people. There was evidence of some people being fearful of other people using the service.

Learning lessons when things go wrong

● A number of the environmental issues we identified at this inspection had been identified at our last inspection in 2019. These included concerns about cleanliness, food storage and people being exposed to risks of burns. The provider had not made the necessary changes to ensure people were protected from these risks.

Visiting in care homes

● There were no visiting restrictions. the provider followed government guidance for safe visiting in care homes.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff support: induction, training, skills and experience; Adapting service, design, decoration to meet people's needs

- Care and support was not always delivered in line with best practice guidance and standards. People had their needs assessed. However, peoples support, and positive behaviour plans had not been updated for a long time. This meant they may not be reflective of peoples' current and changing needs.
- People did not always follow their schedules and routines. These structured routines were designed to support people's wellbeing and promote a good quality of life. One person did not attend to their personal care, they also became frustrated and distressed and harmed themselves. Another person was not taking part in the activities they enjoyed during our inspection, they spent time in bed during the day because staff were unable to engage them.
- While staff monitored people to keep them safe and where applicable, to protect other people, they did not always engage people or communicate with them in the most effective way. People's communication needs were not always met because many staff did not have training including communication training and supporting people with learning disabilities or autism. We did not observe staff using visual or pictorial aids to support effective communication during any of our visits.
- People's aspirations and goals had not been reviewed for a long time, some people did not attend all of the activities they liked because there were not enough staff with the right experience to support them.
- The delivery of care and support did not always comply with National Institute for Clinical Excellence (NICE) guidance for Autism spectrum disorder in adults: diagnosis and management and Learning disabilities and behaviour that challenges. Residential care environments should include activities which are structured and purposeful and designed to promote integration with the local community.
- The premises were institutional in appearance and did not comply with NICE guidance. While refurbishment of most bathrooms, kitchens and some bedrooms had taken place, many of the corridors and communal areas had fluorescent lighting which is known to be a trigger of distressed behaviour for some people with autism. Some of the flooring was old and institutional in appearance. Lounges contained equipment used by staff such as computers and white boards, this meant these lounge areas were not as comfortable or homely as they should be.

People did not always receive person centred care. This was a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

● One person was visibly underweight. They had not been weighed and no other method for monitoring their weight was used. Staff were instructed to record the amounts of food and fluids consumed. Records we saw were only partially completed and it was not clear if they had enough to eat each day. This meant the person was at risk of malnutrition and this was not being monitored or managed.
● Meals we observed did not appear to be appetizing to the person. They were given large meals containing foods they may not enjoy. A note on the persons care record stated they preferred food not to be mixed together on the plate, yet they were served with mixed vegetables and meat all together on the plate. At our second inspection day they were given large servings of meat, vegetables and potatoes. A staff member said, "[Person] doesn't like big dinners, they like little snacks throughout the day." This meant the meal wasn't suitable for the person and not presented in a way that was appealing to them.
● There was no evidence of meals provided being based on people's individual likes and preferences.

The provider did not have a food and drink strategy that addressed the nutritional needs of people using the service. This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Meeting nutritional and hydration needs.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People did not always receive prompt access to healthcare services. One person had a seizure and sustained significant bruising. No medical attention was sought in response to this.
● Records showed people had been supported to access healthcare professionals such as dentists and opticians. However, a communication passport developed by a speech and language therapist was not always being followed.
● Staff worked with other professionals such as the local authority.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.
In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
● Appropriate DoLS authorisations were in place where these were required. Staff assessed people's capacity to make decisions and supported people in the least restrictive way.

Requires Improvement

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There were failings relating to the leadership and governance of the service. Quality assurance systems and processes either failed to identify concerns, or had identified them but failed to address them. In particular this was in relation to the environment, infection control, staffing and meeting nutritional needs.
- The provider's systems for managing risks and quality performance had failed to identify risks of harm caused by uncovered radiators and unlocked boiler cupboards and unrestricted access to hazardous substances and data protection breaches. This put people at risk of significant harm. The registered manager had been raising their concerns about the environment for a number of years. While some refurbishment of bathrooms and some people's bedrooms had taken place, there were many areas of the building which remained unsafe and or did not meet the needs of people using the service.
- People did not always receive personalised care because support plans had not been reviewed for a long time and may not be reflective of people's current needs, preferences and wishes. Some people had complex needs and required positive behaviour support to keep them safe and to promote the best quality of life. The provider had specialist teams to support positive behaviour plans. Although the process of assessment had begun in the summer of 2022, people's positive behaviour plans had not been developed.
- A large proportion of staff were employed by an agency and although they knew people well, they had not received all the training they required to meet people's needs. This meant that at times, a person was not able to access activities outside of the service because staff on duty had not received the required training to support them. Staff did not have all the training they required to support effective communication.
- People were not routinely asked for feedback or involved in developing or reviewing their care and support so that care and support could be continually evaluated and improved.
- We received negative feedback from one person's relatives about the care and support not always meeting their family members needs and about their frustration having to constantly raise the same issues.
- Staff told us the registered manager was approachable and accessible. However, some staff were frustrated because ongoing issues in the environment had still not been addressed and did not feel people always got the care and support they required to keep them safe or to promote good outcomes for quality of life.

Quality assurance systems and processes failed to effectively monitor the quality and safety of the service. This placed people at significant risk of harm. This was a breach of regulation 17 of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

● At our last inspection in 2019 we identified issues which remained at this inspection. For example, our last inspection found that cleaning schedules were variable and people were not protected from risks because of a refrigerator was found to above safe temperature limits and hot water tanks were accessible to people. This showed the provider had not used this learning to improve care.

Working in partnership with others

● The provider usually worked with other professionals to ensure people received joined up care. However, on one occasion, medical attention was not sought following an incident when a person sustained injuries. Staff did not always follow a person's communication passport which had been developed by a speech and language therapist.

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 registered manager gave us an example of how they had been open and apologised when something had gone wrong.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive person centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs One person did not have their nutrition and hydration needs met.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk of harm because risks were not always identified or managed.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance leadership and governance was not always effective.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff skill mix and experience did not always meet people's needs.

The enforcement action we took:

We served a warning notice.