Autonomy Healthcare Limited

Autonomy: Victoria & Elizabeth

Inspection report

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17 March 2021

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service:
Autonomy: Victoria and Elizabeth 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.

The service accommodates up to nine people across two adapted buildings, the buildings contain spacious apartments. At the time of our inspection there were nine people using the service. The service specialises in the care of people diagnosed with learning disabilities, autistic spectrum disorders, and mental health needs.

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

The service was able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. We saw that people had choice and control and independence to make decisions about their lives. Care was person centred and staff encouraged people to live confident, inclusive and empowered lives.

People's experience of using this service:
People received safe care, from staff that had received training and knew how to meet people's needs. People were kept safe from potential abuse, and any concerns were reported to the local safeguarding team to investigate. Staff were safely recruited and there were enough staff to meet people's needs. People's medicines were managed safely and given as prescribed. People were protected from the spread of infection during the COVID-19 pandemic.

There was a positive culture to provide good outcomes for people. Staff spoke highly of the management in place. Robust systems were in place to monitor the quality of the service and there was a focus on continuous development to improve quality outcomes for people. The Local Authority safeguarding team had identified that improved quality of incident reporting was needed, we could see clear action had been taken to improve this.

Rating at last inspection:
The last report for Autonomy: Victoria & Elizabeth was published on 21 November 2020 and the service was rated good.

Why we inspected:
The inspection was prompted following information received about the service and concerns raised by commissioners and the safeguarding team. This was focused on incident management and the quality of incident referral documentation.

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 coronavirus and other infection outbreaks effectively.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our reinspection programme. If we receive any concerning information we may inspect sooner.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

Is the service well-led?

Good

The service was well-led.

Autonomy: Victoria & Elizabeth

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part due to anonymous information of concern received by CQC and concerns from commissioners from a local authority. Concerns related to the management of the service and the management of incidents at the service. The inspection team found the service was currently providing good quality care.

Inspection team:
The inspection was carried out by two inspectors and a mental health specialist advisor.

Service and service type:
Autonomy: Victoria and Elizabeth 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The inspection site visit activity took place on 17 March 2021 and was unannounced.

What we did:

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority commissioners responsible for monitoring the service. We used all of this information to plan our inspection. The provider had not been sent a provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. We gave the provider the opportunity to share this information during the inspection visit.

During the inspection
We did not speak to anyone using the service. We spoke with the nominated individual, the registered manager, and five staff. We gathered information from the local safeguarding team and spoke to a police officer who has previously worked with the service. We looked at care and support records for six people. We reviewed recruitment files for two staff. A variety of records relating to the management of the service, including medicines, training records and policies and procedures were reviewed.

After the inspection:
We asked the registered person to provide us with a variety of additional information. We used all this information to help form our judgements detailed within this report.

Good

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse
- Staff were trained in how to recognise potential signs of abuse. Staff were confident that any concerns raised to the management team would be acted on effectively.
- Staff had recognised potential abuse and reported concerns to the relevant authorities to investigate
- Peoples care plans explained their needs, and how these needs could make them vulnerable to abuse. This allowed staff to be aware of potential risks and put measures in place to reduce them where possible.

Assessing risk, safety monitoring and management
- Staff worked hard to get to know people's complex needs and risks. People's mental health needs could put them at risk. Staff knew individual risks and supported them effectively to promote good outcomes.
- To keep people safe, staff sometimes needed to restrain people. Staff had been trained on how to do this in a safe way. Records showed that restraint was used as a last resort and there was clear guidance to follow.

Staffing and recruitment
- There were sufficient staff to support people at the service. These staff had received suitable training to meet people's needs.
- Some people were supported on a one to one basis. If these people required a change of staff, this was available.
- Staff had been recruited safely, to ensure they were of good character and safe to work with people.

Using medicines safely
- Medicines were given to people as prescribed.
- Where people had 'as needed' medicines, there was clear guidance for staff to follow.
- Medicines were stored safely.

Preventing and controlling infection
- We were assured that the provider was preventing visitors from catching and spreading infections, including COVID-19
- We observed staff using personal protective equipment effectively and in line with government guidance.
- The service was laid out and managed to promote good hygiene.

Learning lessons when things go wrong
- The service support's people with complex mental health and/or learning disability needs. When

behavioural incidents occurred, these incidents were recorded. The local authority told the CQC that sometimes the quality of these incident forms could be improved. The registered manager agreed with this and we saw evidence that processes were in place to improve incident recording.

● There were a large amount of behavioural incidents that occurred at the service. This was reflective of the complex service user group. The service employed a psychologist to review incident forms for trends. This provided a comprehensive insight into how to better manage the behaviour in future.

● The service attended multi-agency meetings with other professionals, including police, mental health services and social care professionals. This multi-agency approach allowed a better review of people's care and how to improve people's outcomes.

Good

Is the service well-led?

Our findings

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

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff described clear examples of how they supported people at the service in a person-centred way. Documentation at the service supported this.
- Due to people's complex needs, they could behave in a way that challenged staff. Staff had clear guidance on how to manage this in the least restrictive way. Staff had a clear understanding of triggers and how to respond to escalations. Where necessary for safety, staff were trained in how to restrain people. This was used as a last resort and restraint incidents were reviewed carefully by the management team to ensure it was necessary and proportionate.

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

- There is a legal requirement to notify the CQC of incidents that occur at the service. Since the last inspection, these notifications had not always been received in a timely way. The quality of the notifications was also poorer. The registered manager recognised this, they advised there was a new administrative staff team and they were already working to improve the quality of these notifications sent to the CQC.
- The registered manager was open about what improvements needed to be made at the service. Documentation showed that action was being taken to continuously improve the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There was a registered manager in the service. They understood their role and regulatory requirements.
- Staff spoke highly of the management team and the ethos of team working. A staff member said, "I really like the managers, they are interested in the residents and I can go to them anytime with an issue."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The last inspection occurred five months ago. There had been no formal consultation of people and relatives at the service since then. However, people had been involved with reviewing their care plans. This was done in a person-centred way.
- Staff were involved in regular team meetings and supervisions with the management team. This gave them an opportunity to feedback about the service.

Continuous learning and improving care; Working in partnership with others

● The service supported people with complex needs. The nationally imposed lockdown had impacted on these people's wellbeing. This had also had an impact on the amount of incidents at the service. The registered manager was working hard to review the incidents occurring to ensure people's needs were effectively met.

● The registered manager advised that the service attended multi agency meetings to review people's care needs and outcomes. Due to COVID-19, the frequency of these meetings and accessibility of external stakeholders had been impacted. This in turn, had impacted incident management.

● The service employed a registered psychologist to work with people at the service. Advice from the psychologist was followed to provider better outcomes for people.