The Kent Autistic Trust

The Kent Autistic Trust - 165 Jemmett Road

Inspection report

165 Jemmett Road
Ashford
Kent
TN23 4RH
Tel: 01634 405168
Website: www.kentautistic.com

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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?	Requires improvement

Overall summary

The unannounced inspection took place on the 12 and 14 October 2015. 165 Jemmett Road provides accommodation and support for up to six people who have a learning disability or autistic spectrum disorder. The service had last been inspected in November 2013 and had been compliant with our regulations.

There were six people living at the service at the time of our inspection. Each person had their own room on the first floor of the property. On the ground floor was a communal kitchen, lounge, dining room, office, laundry room and toilet facilities. There were also two shared bathrooms on the first floor. There was a large well maintained garden which could be accessed from most rooms on the ground floor. All people were able to access the shared facilities of the home. People could not freely leave as there was a keypad system on the main entrance/exit. People living at the service had been

Summary of findings

subject to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS). During our visit one person was away visiting their family. All other people living at the service attended day services from Monday until Friday form 10:00am until 04:00pm.

A registered manager was not in post at the time of our visit which is a requirement of the registration of the service. However, a new manager had been appointed and visited the service during the 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 and associated Regulations about how the service is run.

Staff had not received regular supervision to fulfil their role since the previous registered manager had left. Staff were having to work extra hours to keep up to date with paperwork and cover the shortfall in staff numbers while recruitment was underway.

Maintenance of the service was not always responded to in a timely way and some areas of the service had been left in need of repair. Although the provider had taken action to address these issues with the owners of the property the repairs had been unresolved.

Some documentation had not been updated recently. Internal audits that the provider had made had also identified this. However, individual care plans were personalised and detailed and written in a format to help the person understand its content.

Statutory notifications had not been submitted to the Commission without delay which is a requirement of the regulations, although processes had been put into place to improve this.

Staff understood the Mental Capacity Act 2005 and the service has taken the appropriate steps to meet the requirements of this law.

Staff were trained to recognise and report abuse. There was up to date safeguarding and whistle blowing policies and procedures to follow which were in an easy read format. Staff were able to describe the actions they would take if they suspected or saw abuse.

Risk assessment were person centre and identified how people could be supported in a way which reduced risks and considered their preferences. Risk assessments were written in a format which would help people understand their content.

Staff had suitable skills, knowledge and experience to meet the needs of people. People received a high level of support and the service adapted support levels when people's needs changed. Safe recruitment processes were followed and staff only commenced work once the required safety checks had been completed. New staff were offered a comprehensive induction package including mandatory training.

Staff received support from the organisations internal specialist team who helped with behaviours and communication. The behaviour specialist would analyse incidents and help staff implement new ways of working to help people manage their behaviours.

Robust processes were in place to ensure people received their medicines safely and in a way which suited their needs. Medicine was stored, administered, recorded and audited safely. Staff had a good understanding around the process and importance of handling medicines safely.

People were encouraged to make individual choices around their food and drink. People could have snacks and drinks when they wished. Peoples health needs were responded to promptly and referrals to outside professionals were made without delay.

People were supported by staff who showed care and compassion. People were spoken to in a way which was respectful and dignified, staff understood people's needs well. People were free to move around their home and staff responded to their wishes.

There was an up to date complaints policy in an easy read format to help people understand how to complain.

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?
The service was safe.

Staff understood how to report abuse and were given appropriate training. The service had a whistle blowing policy which staff were aware of.

Medicines were administered, stored and recorded safely.

Individual risk assessments were in place to reduce risks to people. Documents were written in a format which would help the person understand.

Robust systems were in place for recruiting suitable staff.

Good

Is the service effective?
The service was effective.

Staff had the appropriate skills and were trained to complete their roles effectively.

The provider was meeting the requirements of the Mental Capacity Act 2005.

People were promptly referred to healthcare professionals when there was a requirement to do so.

Good

Is the service caring?
The service was caring.

People were spoken to and supported in a way which demonstrated dignity, respect and kindness.

People were encouraged to make their own decisions and receive support in a way which they preferred.

Staff had good understanding and knowledge of the people living there and encouraged people to improve their skills to improve their lives.

Good

Is the service responsive?
The service was responsive.

Care plans were person centred and incorporated pictures and an easy read format to help people understand its content.

People were encouraged to participate in the activities they liked. People had access to a full timetable of activity.

There was a clearly documented complaints policy which detailed what people should expect if they made a complaint.

Good

Is the service well-led?
The service was not always well led

Requires improvement

Summary of findings

A registered manager was not employed at the time of inspection although measures had been taken to provide support to staff when they required this.

Action of shortfalls identified were not always followed up and areas of improvement in the service had not always been acted on in a timely way. Some documentation had not been updated or reviewed recently.

The views of others were sought to improve the service and staff had regular meetings to discuss the needs of people living there.

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Detailed findings

Background to this inspection

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

The inspection took place on the 12 and 14 October 2015 and was unannounced. The inspection was conducted by one inspector.

A Provider Information Return (PIR) had not been requested prior to our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We gathered this information during the inspection. Before our inspection we reviewed the information we held about the service, including previous inspection reports and notifications. A notification is information about important events which the service is required to tell us about by law. The registered provider was asked to send us some further information after the inspection, which they did in a timely manner.

We viewed all areas of the service. We observed communication between the people who used the service and the staff but were unable to receive verbal feedback from people because of their limited communication skills. During our inspection we spoke to two team leaders, one senior support worker, three individual support workers, the service quality compliance manager, the new manager, and the area operations manager. We spoke with two relatives and two care professionals after the inspection. We looked at management records including three people's support plans, risk assessments, daily records of care and support, staff recruitment files, training records, maintenance records and quality assurance information.

Good

Is the service safe?

Our findings

People were not able to express their views clearly due to limited communication skills, but people felt secure with staff supporting them and were able to go where they liked and carried out their preferences. People looked at ease in the presence of staff and were happy to engage in their own way with them.

Staff were given sufficient training in recognising and reporting abuse and knew how to refer to outside agencies if they had any concerns. One staff told us, "I know how to report abuse. I would tell CQC or the care managers. I have no problem reporting". Another staff said, "I could report to CQC or the police. I completed my training in February 2015 and understand the whistle blowing policy". The whistle blowing policy had been re-issued in 2015 and was available in hard copy or through the organisations website. There was an easy read up to date safeguarding protocol and flow chart located in the hallway to help staff report abuse.

People received a high level of staff support. Throughout the day and evening four people were supported one to one by staff and two people were allocated one staff member between two. At night there were two sleep in staff available and one wake night staff. All people attended day services from Monday to Friday between the hours of 10:00am until 04:00pm. Staff were allocated specific hours with each individual and would rotate with other staff after a period of time which meant staff supported each other to manage behaviours which may be challenging or stressful to deal with. The staff team consisted of two team leaders, two senior support workers, five individual support workers and one wake night support worker. There were some staff vacancies and staff were working extra shifts to cover the shortfall; agency staff from preferred agencies were used when shifts could not be covered internally. Out of hours numbers were available in the office detailing what senior person would be on call for each week. Staff were able to use this call out system should they require any support or advice.

Safe recruitment procedures were being followed. Disclosure and Barring Service checks had been made; these checks identified if prospective staff had a criminal record or were barred from working with adults. References had been obtained and photographs were available on the files that we looked at. Employment gaps had been explored and recorded appropriately. All staff had commenced work after the relevant checks had been made.

Risk assessments were centred on the needs of the individual. They included clear descriptions about the risk to individuals, how risk could be reduced and offered appropriate guidance for staff to follow. Risk assessments included areas such as travelling in vehicles, spending time alone, being supported in the community and vulnerability. The risk assessments included important things to remember when supporting the person, other things to consider and the effects this could have on the person. A shift planner was used to allocate specific tasks to staff to mitigate risk. For example staff were assigned to specific people throughout daytime and evening hours to assist them with fire evacuation. Staff were also assigned to duties such as medicine, cleanliness of home and petty cash. This meant staff were clear in their allocated tasks each shift and people received support to minimise risks to their safety. Allocation of tasks in this way also helped eliminate mistakes and helped prevent important tasks being forgotten.

All equipment and safety certification of the building had been checked within the required time and certificated for approval. One staff said, "Every day a manager is on call so we document and report any accidents and incidents to them". There were contingency plans in place for events such as flood, fire, local emergencies and adverse weather conditions. This demonstrated that the service was prepared for such situations which could pose a risk to peoples safely and wellbeing. During the inspection a contractor visited to test the water temperatures of the communal areas of the home.

There were safe processes for storing, administering and returning medicines. Seniors and team leaders were in charge of ordering and checking medicines. New medicines delivered to the service were logged and medicines leaving the service with people when they went out were counted and logged out. Daily temperatures of the medicine storage were recorded to meet required standards of safety. Medicines which were prescribed for occasional use (PRN) had clear guidelines to help staff understand at what point these occasional medicines should be administered. Guidelines included the signs and symptoms the person may display if unable to verbally express they needed

Good

Is the service safe?

them. People had individual assessments around how they liked their medicines to be administered. We observed one person receiving their prescribed medicine; the staff member communicated with the person throughout in a caring manner and said “Well done” and completed the task in a safe way. Medicines were audited every week by team leaders who also ordered the new cycle of medicine.

Good

Is the service effective?

Our findings

Staff understood the requirements of the Mental Capacity Act (MCA) 2005. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people were assessed as not having the capacity to make a decision, a best interest decision was made involving people who knew the person well and other professionals, where relevant. One staff said, "Mental capacity is about the best interests of people. People shouldn't be restricted and should be free to live how they like". Three people had been granted urgent authorisation for specific restrictions to their freedom. Three other applications had been made by the previous registered manager for urgent authorisations which were being processed by the local authority.

The provider is expected to notify the Commission of certain events which include the Deprivation of Liberty Safeguards (DoLS) in a timely manner. DoLS provide legal protection for those people who are, or may become, deprived of their liberty. The safeguards ensure that the deprivation of peoples liberty is made lawful and in a person's best interests. Two people had been subject to DoLS authorisations but the Commission had not been notified until seven months after the date of the authorisation being granted. However, the service quality compliance manager introduced a tool called, "Algorithm for reporting statutory notifications to CQC" and additional monthly audits to support the service to meet this requirement.

Staff were given appropriate induction and training. This included completing one week at the main office where mandatory training was delivered. New staff would then continue their induction in the service, shadowing other staff. The length of time would depend on individual competencies which would be checked by team leaders and other managers if the manager was unavailable. One staff said, "Training is very good. We can ask for training". Casual care workers or agency staff would be given an induction checklist to complete when they came to work at the service. Staff completed mandatory training as well as additional training in specific areas such as epilepsy, managing challenging behaviour, loss and bereavement, nutrition awareness, intensive interaction and sensory overload. One staff said, "We do a mixture of e-learning and face to face training. Trainers will sometimes come here in between the split shift gap. Sometimes we go to college or a training provider".

A large proportion of people's time was spent at a day centre which was also part of the same organisation. There were good levels of communication between the staff at day centre and the staff at the service. Each person had a detailed handover called personal daily planner which would go with them when they attended the day centre and be completed on their return. This was well documented and detailed. Included was important information such as medicine taken or required, if the person had been feeling unwell or has a current health issue. One staff told us, "We don't want to miss anything like appointments, a copy will be sent with the person to the day centre. We also do verbal handovers".

There were good processes for staff to follow to help people manage their behaviours. Everyone living at the service had their own positive behaviour plan. Staff were pro-active in identifying and responding to behaviour which may challenge others by the use of hourly behaviour records. The service was further supported from the provider's internal specialist advisors which included two behaviour support staff and a communication specialist. The behaviour support and communication specialist would attend the monthly meetings and support staff to update and devise new ways to help people to manage their behaviours and improve their communication skills. The behaviour team would also oversee the analysis of individuals behaviour incidents to identify trends so further interventions could be introduced to reduce triggers and incidents. They would help the staff look at better ways to support people. A staff member told us, "We can ask the behavioural support team to help us. They offer us training and more guidance and they come to our meetings. We are lucky to have the behaviour support team".

People were encouraged to help plan the weekly menu. Each person would choose a meal for a day of the week from an assortment of pictures to help them understand the options. Where people wanted to choose a different option this was catered for. One staff said, "We know what people like to eat, we vary the menus. We show pictures to people and some will pick what they want". Every Saturday people could order a takeaway, there were an array of takeaway menus available. One person had recently had

Good

Is the service effective?

fish and chips, two people had chosen Chinese food and one person had ordered a curry. We observed people accessing the kitchen and being given drinks and receiving snacks.

People had health plans which were in an easy read format with pictures to help the person understand its content. Health plans included areas such as "When I am ill" which described how the person may act if they were unwell or in pain and could not verbalise this. An example of this was when a person had lost weight shortly after moving into the service. The service looked at this in more detail to identify if the person was in need of further medical intervention. Weight was monitored monthly for all people and referrals made to the dietician if necessary. When people had specific health issues such as epilepsy clear protocols were in place to be followed and staff were able to describe the correct action they should take in these situations to maintain the person's safety.

Good

Is the service caring?

Our findings

We observed people being approached by staff in a friendly caring manner maintaining their dignity. People chose where they wanted to be, some people were relaxing in the lounge watching television, others chose to be in their bedrooms and some were doing puzzles in the dining area. There was a relaxed feel to the service and staff were focused on the people. A relative told us, "The staff are so good, they are wonderful. They are responsive to needs, I can't fault them". Because people had a high level of support, staff said they tried to be mindful that the person should have their own space when they indicated they desired this. One staff said, "(Person) is supported on a one to one basis. We try not to follow them around; we stay close and try to give more freedom". Each person had a lock to their bedroom door to ensure that their privacy and dignity was maintained. Staff said that some people liked to go into other people's rooms and remove personal items if doors were left open.

Although people were unable to tell us directly of their experiences we were able to observe that staff demonstrated the right attitudes of care and compassion and placed people at the centre of the care they provided. The staff we spoke to clearly demonstrated they had a good knowledge of peoples individual needs and could describe what they liked, disliked and how they preferred to be supported.

Staff were proud about the progress that people had made while living at the service. For example one person had lacked confidence when making choices. They would only point to a selection of squash they wished to drink. Now they would go to the kitchen cupboard and physically choose the squash they desired themselves. Another example was when a person had moved into the service they would not undress themselves. This person could now do this independently having been supported by staff over time to develop this skill. We observed one staff member engage with one person who was non-verbal by gently touching them on the shoulder and smiling. The staff said, "(Person) knows their routines very well. At day centre they do communication sessions".

Clear information was presented to people in a format that was suitable to their needs and staff communicated in a way which was individual to that person's preference. Some people used Makaton signs, others preferred to used pictures and objects of familiarity to help them communicate and some used Picture Exchange System (PECS). PECS is an alternative way of communicating with people with autism spectrum disorder or for people who have various communicative, cognitive and physical impairments. One person could understand a different language as well as English so staff would try to incorporate basic words in both.

People were encouraged to make their own decisions and express their views. We observed people being encouraged to engage in their surroundings. We observed that support was person led, people were freely moving around the home and staff responded to their wishes. A relative said, "We have meetings once or twice a year and they listen to what I say. I can't fault them, they are wonderful." Staff had a clear understanding of people's individual behaviours. Staff described the person's journey since living at the service and how they had grown in confidence and improved their skills.

One staff described how a person chose to spend a lot of time engaging in isolated activities. This person over time started to engage with others more and try different activities. The staff said they started off small, so the person would not feel overloaded or walk away from the activity. It was clear that staff wanted the best outcomes for people and cared about their welfare. One staff said, "We live our jobs, you couldn't do this job if you didn't love it". The service tried to involve people in making their own decisions. One staff told us, "(Person) has diary time once a week; we help them plan their week using PECs. It helps them understand their choices".

Good

Is the service responsive?

Our findings

People were supported to maintain relationships with their families. A relative told us, "(Person) comes home about every five weeks and the staff will pick (Person) up. This has been a big help and a relief as sometimes their behaviour can be difficult to manage". Another relative said, "They bring (Person) home to visit me once a month, they tell me things and keep me informed". Each person had their own document titled "Residential opportunities and life skills" which was located on the notice board in the dining area. Three people changed their activities daily and three people had a set routine throughout the week. This was assessed and implemented according to the preferences of the person. People were supported to follow their own personal spiritual wishes, for example one person liked to attend church every Sunday.

Transition and admission into the service was conducted in a way which was timely and supportive to the person's personal needs. A person who had been admitted to the service had a transition period of nine weeks to help them adapt to their new home. This allowed staff to build up a relationship with the person in their existing residence and learn how this person would wish to be supported in their new environment.

People received high levels of support and person centred care from staff. Care files were detailed and personalised offering information outlining the specific needs of the person. The plans also described how staff should communicate with the person using additional aids such as pictures or Makaton signs. Documentation in the care files clearly described how people should be supported in a consistent way and in a way that they preferred. For example one person preferred that staff should engage with them with playful banter. Their plan described that staff should say, "Here you go mate" or "Brush your teeth mate" when encouraging them to brush their teeth. Included were specific guidance on how to support people with their personal care, how staff can recognise how a person feels through their body language, and their short/long term goals with photographs of accomplishments.

The service planned outings and activities to meet the needs of people. There was an array of social activities that people could participate in which included horse riding, swimming, pub visit, theme parks, park, beach and town visits, bicycle rides, trampolining, sensory sessions, arts and crafts, golf, and volunteering at a local conservation group. On Thursdays people would usually attend a disco at a different day centre which is run by another provider supported by their usual staff from the service. Some people had computers and game consoles in their bedrooms, other people enjoyed listening to music. When people attended day centre they were either transported in the mini bus or by taxi according to their risk assessments and preferences. Staff at day service would complete the handover information so when the person returned home staff would be well informed of their day. There would be a verbal handover when people were dropped off. Handover also detailed information such as activities, a description of the personal care the person received, and information for the night staff to be aware of. The Service Quality Compliance Manager said she was currently piloting a new handover system to cut down on the time spent reading and signing documentation so staff were able to focus more of their attention on the person rather than the paperwork.

There was an up to date complaints policy in place which detailed the procedure clearly with time scales for actions and expected response times included. An easy read format was available for people living at the service. This was in the form of a leaflet called "I want to tell you how I feel". One staff said, "People have limited verbal and communication skills. The speech and language therapist works with one person, and another person is able to read. We know when (person) is upset by something. They have their own way of complaining". A relative said, "If I had concerns or complaints I would speak to staff but I am happy with the service and cannot speak highly enough of them". No complaints had been received or recorded at the time of inspection.

Requires improvement

Is the service well-led?

Our findings

At the time of the inspection a registered manager was not in post which is a condition of the services registration. This post had been vacant since June 2015. The service had taken steps to appoint a new manager whilst the previous manager worked their notice. The previous registered manager although de-registered in June 2015 stayed on to manage the service part time until the 31 July 2015. A new manager had been appointed and would be starting the role the week following the inspection. To support the service throughout the time the managers position was vacant, the area operations manager was available for staff to contact and would drop into the service to offer support. Staff were able to contact them at any time if required.

The new manager visited the service during the inspection and said, "The staff have coped well while there has been no registered manager. If a registered manager was here they would be able to evidence the good work the staff are doing here better. The staff are tired, so their ability to do things a manager would do like follow ups and auditing is lacking in places". One staff said, "Having a proper staff team will improve things here. Morale is low as staff need a manager and full staff team with support". Another staff said "I feel okay as I have the team leader here to give me support. We should be fully staffed soon". Both team leaders were present during the inspection and demonstrated good knowledge of people living in the service and what their expected roles were. It was clear that they were a relied on source of support for the rest of the staff team.

Maintenance of the property was not always adequately responded to in a timely way meaning some areas of the home were left in a poor cosmetic condition which was not satisfactory for the people living there. One staff member said, "Maintenance is very quick when small but larger repairs take longer. We have maintenance requests; we don't always log small things". For example in the hallway there was water damage to both a wall and ceiling caused by two separate leaks. The cupboard next to this wall smelt strongly of damp. Although the leak causing this problem had been resolved the cosmetics of the hallway were left in a bad state and had been so since January 2015. The leak from the upstairs bathroom had caused water damage to the ceiling. On both days of the inspection we found that the toilet upstairs was leaking although we had been informed that the maintenance person had been in to repair this the day before which had been unsuccessful. The provider had been in contact with the owners of the property to request that these issues were resolved which had been ongoing since January 2015 and unresolved. The shower tubing around the rubber hose of the shower attachment in one bathroom was broken; staff said this shower was unusable. This had not been recorded in the maintenance records but was apparent it had been in this condition for some time.

A staff member said, "There is a lack in certain areas a registered manager would do like auditing. They can oversee, check and get things done quicker". Maintenance records were being logged on the whole, however there had been some inconsistency since the registered manager had left and follow up information on the action taken was not always available. One staff said, "Since the manager left the pressure has been put on. Seniors and team leaders have had to stay later after their shifts have ended to catch up with the paperwork."

Staff did not always receive the support necessary for them to carry out their roles. Since the departure of the previous registered manager staff had not received regular formal supervision time since March and April 2015. This was verified by one staff member who said they had not received a supervision since March 2015. The area operations manager said that they had completed supervisions with some staff but we saw no evidence to verify this. The lack of a manager in day to day charge meant staff were not receiving consistent support. One staff commented, "I think a registered manager is beneficial for general knowledge and support on a day to day basis".

A system of quality assurance checks was in place and implemented and quarterly audits of infection control, fire safety, and food safety were conducted. While the registered manager's position had been vacant the service quality compliance manager had been overseeing some of the internal auditing including the quarterly audit of the service. This included areas such as health and safety, complaints, training plans, and the support documentation for people. The service quality compliance manager said that they had noticed in their audits that some documentation has not been updated recently which will be rectified when the new manager starts. We found this to be the case for example when reviewing the training records many of the staff names listed were no longer

Requires improvement

Is the service well-led?

working at the service and some of the current staff members were not on the lists. This was pointed out to the service quality manager who said that this list had not been updated yet which would be a job for the new manager although training had happened and other computer records verified this. Another example was a health action plan which had last been updated in 2013. Internal audits had picked up areas which were identified in this inspection as missing such as formal supervision for staff but action was lacking to improve.

Policies and procedures were available which staff had easy access to; these had been updated in July 2015. People's records were kept securely and computerised data was password protected to ensure access by only authorised people. Staff recruitment records were held at the main office and were securely transported when brought to the service for inspection.

The service sought to seek the views of others and made improvements from their findings. Staff had been encouraged to complete surveys in April 2015 which the organisation analysed and produced action plans from. Recruiting effectively, supporting staff manage behaviours which may challenge, promoting engagement and reviewing staff work/home life balance were areas that the organisation had identified as needing to improve. One staff said, "The team leaders are very good, they are assets. When the new manager gets here things will improve, she is very much a hands on manager". Areas that were fed back as being good were staffs understanding of the ethos, aims and objectives of the service, dedication of the workforce, and most staff are happy doing a job which makes a difference. The service sent questionnaires to individuals outside of the organisation but the rate of response was low.

There were good systems in place for sharing information and responded to the needs of the people living there. Information regarding people was fed back in the general staff meetings. Information which was of concern would then be taken back to the area managers meetings for discussion. If further support was necessary this could then be raised at the strategic managers meetings. Each person received a monthly service meeting; key workers were responsible for producing a report about the person to share with other team members. Team leaders also had their own regular meetings.