Autism Care (North West) Limited

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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 caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection of this service took place across three dates; 4, 5 and 19 August 2016. The registered manager was given 24 hours' notice prior to the inspection so that we could be sure they would be available to provide us with the information we required.

We last inspected the service under the previous name of Autism Care North West on 19 and 30 October 2015. At that inspection, we found seven breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) 2014 and a breach of Regulation 18 of the Care Quality Commission (CQC) (Registration) Regulations 2009.

At the last comprehensive inspection in October 2015 under the previous name of Autism Care North West, the provider was placed into special measures by CQC.

The overall rating for this service is 'Requires improvement'. However, the service remains in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures."
Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures."
CQC is now considering the appropriate regulatory response to resolve the problems we found.

Autism Care (North West) Limited currently has seven supported tenancies in the North West, supporting individuals with learning disabilities or autistic spectrum disorder within the community. Each supported tenancy is managed on a day-to-day basis by a support team leader, who are supported by the registered

manager. 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.

We found that risk assessments were not always completed accurately. Where risks had been identified, care planning around the associated risk was not always recorded and did not always contain all the relevant information to mitigate the risk. This lack of risk management meant people were not always safe.

We found gaps in information regarding people's medicine regimes. Where a risk assessment had been completed, which stipulated a medication support plan was required this was not in place for all people. The provider was not following their own policy and procedure with regards to medications, which could have put people at risk of medication mismanagement.

We found that a high number of agency staff were being used at the service, which had a negative impact on the care and treatment people received. People were spending long periods in their homes with no activities to reflect their personal choice

Staff told us they knew how to report safeguarding concerns and felt confident in doing so. We felt reassured by the level of staff understanding regarding abuse and their confidence in reporting concerns.

We reviewed recruitment records of four staff members and found that robust recruitment procedures had been followed.

We looked at how the service gained people's consent to care and treatment in line with the Mental Capacity Act (MCA). We found that the principles of the MCA were not consistently embedded in practice. We found that people's capacity to consent to care had not always been assessed and decisions had not always been recorded.

The staff approached people in a caring, kind and friendly manner. We observed a lot of positive interactions throughout the inspection. We observed staff speaking with people who lived at the home in a respectful and dignified manner.

We found the service had improved the way it used quality assurance systems. However, some issues that we noticed during the inspection had been missed.

We have made some recommendations about following best practice guidance for medications, updating care plans and ensuring robust audits are in place to improve the quality of the service.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of person centred care, safe care and treatment, need for consent and staffing. You can see what action we told the provider to take at the back of the full version of this 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.

There were not appropriate or effective systems in place to identify the possibility of risk and to prevent harm to people who used the service.

Policies and procedures were in place to guide staff in how to safeguard people from abuse and staff had received training in this area.

We looked at people's care plans and found gaps in information regarding people's medicine regimes.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's rights were not always protected, in accordance with the Mental Capacity Act 2005.

We found the management had begun to hold regular supervision sessions and annual appraisals with staff.

We reviewed records of staff training and found staff had received a wide range of training since our last inspection.

Is the service caring?

Good

The service was caring.

We saw that staff had good skills to communicate with people on an individual basis.

We saw that staff interacted with people in a kind and caring way.

We saw staff treating people with dignity and respect.

People and their relatives were involved in care planning.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Peoples' needs were not reviewed when they had experienced a change in circumstances.

People and their relatives said they knew how to raise a complaint.

Staff understood people's individual needs and we saw that person centred care was central to their support services.

Staffing levels had a negative impact on the provisions of activities for people.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems were in place to monitor and evaluate the quality of service being provided to people who lived in the home.

We found some audits had not reflected all issues. We made a recommendation around this.

The information from risk assessments was not always used to manage the risk effectively.

Autism Care (North West) Limited

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.

The inspection team comprised of two adult social care inspectors, one of which was the lead inspector for the service.

Prior to this inspection, we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us. We received feedback from social work professionals. This helped us to gain a balanced view of what people experienced.

At the time of our inspection of this location, 25 people used the service. We spoke to two people who used the service and six relatives. This enabled us to determine if people received the care and support they needed and if any identified risks to people's health and wellbeing were appropriately managed.

We observed how staff interacted with people who use the service and viewed seven people's care records. We spoke to seven care workers, the registered manager, and a member of the senior management team.

We also looked at a wide range of records. These included; the personnel records of four staff members, a variety of policies and procedures, training records, medicines records and quality monitoring systems.

Inadequate

Is the service safe?

Our findings

People we spoke with told us: "Yes I feel my son is safe in this service". And: "The safety of the residents seems an integral part of the care provided". However, a relative told us: "No we do not feel our son is safe".

When we last inspected the service in October 2015, we found concerns with regard to people being protected against avoidable harm and abuse, how risks to people were managed, the safe management of medicines and safeguarding of vulnerable people. Following the inspection, we took action to ensure the provider made improvements to the service.

We have closely monitored improvements at the home through contact with the provider and the local authority. We undertook this inspection to check what improvements had been made.

When we last inspected the service, we found that risk assessments were not always up to date. Where risks had been identified, care planning around the associated risk was not always recorded and did not always contain all the relevant information to mitigate the risk. This lack of risk management meant people were not always safe.

During this inspection, we looked at seven care files overall. We looked in detail at written plans of care and associated documentation for four people who used the service. We found that not all risk assessments had been completed accurately. An example of this was for a person who was at risk of choking when eating and drinking. The risk screen tool directed the reader to an eating and drinking plan, which was not in situ. The staff were not aware of the plan and had not seen one. The support plan stated that the person had a guide for staff to follow if the person was to choke, this documentation could not be located at the time of inspection.

Another example we found was where someone was putting others at risk due to their behaviour. There was no documentation in place to guide or inform staff of how to manage this, in order to protect the individual, others and staff members.

We found that a risk assessment for a person who was diagnosed as having diabetes was missing. Support documentation stated; 'I have limited foods with high sugar content'. There were no plans in place to guide staff around what the person could and could not eat or the recommended quantities of food intake. This put the person at possible risk, as there was a lack of clear guidelines for staff around how this person's diabetes was managed.

The risk management issues identified amounted to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected the service in October 2015, we found medicines were not managed safely. We looked at people's care plans at this inspection and again found gaps in information regarding people's medicine regimes. Where a risk assessment had been completed, which stipulated a medication support plan was

required this was not in place for all those people. The provider was not following their own policy and procedure with regards to medications, which could have put people at risk of medication mismanagement.

We recommend that the provider follows best practice guidelines for medication.

Staff told us they had all completed the appropriate training in medicines management and the staff files and training documentation supported this.

We looked at staffing levels and found concerns with regard to the number of staff deployed throughout the service. We asked staff if they felt there were sufficient numbers of staff to provide care and support for people who lived within the service. At the time of our inspection, everyone we spoke with raised concerns about staffing levels. The service had been relying heavily on agency staff due to a high turnover of staff leading up to our inspection. Staff members and professionals informed us that the instability of the staff teams was having a negative impact on the people who used the service. One person who used the service told us: "All the different staff make me very anxious".

This amounted to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked how staff had been recruited during our last visit in October 2015 and found that this was not always safe. During this inspection, we saw records, which showed the provider had undertaken checks to ensure staff had the required knowledge and skills, and were of good character before they were employed at the service. The checks included written references from previous employers, a check with the Disclosure and Barring Service (DBS), formerly the Criminal Records Bureau (CRB) and interviews with staff, a record of which was kept in their personnel files. These checks helped to keep people safe by ensuring only suitable candidates were employed to deliver care to people who lived at the who used the service.

During our last inspection staff and relatives informed us that people who used the service contributed to staff expenses, but we found no documentation to support this, which left people open to possible financial abuse. We looked at a random selection of financial records during this inspection and found that clear financial transactions were appropriately recorded. People's monies were checked at each handover and regular audits were conducted. This helped to ensure that people were safeguarded from financial abuse.

When we last inspected the service, we found the provider had not ensured plans were in place to protect people in case of an emergency, such as a fire or flood. During this inspection we reviewed Personal Emergency Evacuation Plans (PEEPs) for each person who used the service. We found PEEPs had been reviewed and were reflective of people's current needs. We saw PEEPs were now implemented; this helped to make sure people could be evacuated safely in an emergency.

A range of checks were carried out on a regular basis to help ensure the safety of the properties and equipment was maintained. These checks included fire alarm, water temperature and electrical appliance checks. A gas safety certificate was available to show all appliances were checked on a periodic basis by an external contractor. This helped to ensure people were kept safe and free from harm.

At the last inspection, we found that the service did not collate and analyse accidents and incidents effectively. The information was not used to ensure that preventative measures were put into place. We reviewed the accident and incident information during this inspection and found that improvements had been made. A manager had signed off accident forms that we viewed and clear information had been

recorded to demonstrate that lessons had been learnt from any accidents and incidents.

We looked at how people were protected from bullying, harassment, avoidable harm and abuse. We found that the service followed safeguarding reporting systems as outlined in its policies and procedures.

Staff told us they knew how to report safeguarding concerns and felt confident in doing so. We felt reassured by the level of staff understanding regarding abuse and their confidence in reporting concerns.

Requires Improvement

Is the service effective?

Our findings

When we last inspected the service in October 2015, we found people did not receive effective care, which was centred on best practice, from staff that had the knowledge and skills to carry out their roles and responsibilities. We found multiple examples of where the standard of care had fallen significantly short of meeting people's needs. The service was unable to evidence staff training and staff had not received suitable support by way of supervision and appraisal. We also found valid consent was not always sought before people received care. During this inspection, we checked to see what improvements had been made.

At our last inspection, we found the service did not always gain valid consent to care, in line with national guidelines and legislation. We checked whether the service was working within the principles of the Mental Capacity Act 2005.

The 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 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 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.

We looked at how the service gained people's consent to care and treatment in line with the MCA. We found that the principles of the MCA were not consistently embedded in practice. We found that people's capacity to consent to care had not always been assessed and decisions had not always been recorded. We saw documentation for one person that stated they did not have capacity to consent to take their medication; but there was no MCA documentation to support this decision. However, we did see evidence that some decisions had been assessed, recorded and documented, but these were not always signed and dated.

The registered manager and staff told us that they had received training around the MCA; however they did not demonstrate a satisfactory level of understanding of the MCA. They lacked awareness of how to complete the appropriate assessments and whose responsibility this was. One person's medication file contained information that the GP had been contacted to complete the MCA paperwork.

This failure to follow the code of practice amounted to a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our last inspection, we found staff were not being supported by way of regular and effective supervision and appraisals. At this inspection, we spoke with staff and management about what improvements had been made in this area. We found the management had begun to hold regular supervision sessions and annual appraisals with staff. These helped to ensure staff had the right level of training and support for the role they were employed to carry out and gave staff the opportunity to discuss performance, development and any concerns. The registered manager told us they planned to hold

supervision sessions with staff on a regular basis, whether as individuals or in a group, to cascade important information and best practice guidance. Although not all staff had received regular supervision and appraisal, we could see improvements had been made in this area.

We reviewed records of staff training and found staff had received a wide range of training since our last inspection. Topics that had been covered included safeguarding adults, the MCA, DoLS, medication and food safety. Newly recruited staff were supported through a comprehensive induction. This helped to fully prepare them for the role they would undertake.

One staff member told us: "The induction was in depth and really helped set me up for the role".

The provider explained following our last inspection the company trainer had carried out a training needs analysis and delivered training and refresher courses to the majority of staff. Staff we spoke with told us they felt they now had sufficient training to carry out their roles. Staff confirmed they had completed all mandatory training.

During our last inspection, we found that although people could access external healthcare professionals, communication between the home and professionals was not always good and professional guidance was not always followed to ensure the health, safety and welfare of people who used the service. We saw some improvements had been made in this area. Peoples appointments were recorded in their care plans and we could see that guidance was being documented.

We looked at how people were supported to eat and drink, in order maintain good health and we found that where concerns about people's abilities to eat and drink were identified, referrals had not always been made to external professionals for support and guidance. Where guidance had been sought, this was not always incorporated clearly into people's written plans of care.
Staff were seen to offer people choices of food and drinks. We looked at weekly menus and found that people who lived at the service were able to contribute to menu planning. Care plan documentation included peoples likes and dislikes.

Good

Is the service caring?

Our findings

When we last inspected the service in October 2015, we found caring relationships between people who lived at the houses and staff members. During this inspection, we observed staff interacted well with those who used the service. These observations were very positive. It was apparent that the staff teams shared genuine, warm relationships with those who used the service.

We received some positive comments about the staff and about the care that people received. People told us: "The staff are friendly and caring towards the residents and encourage them to keep their home clean and tidy, encouraging them to cook independently". "The staff are very committed to supporting my son and we work together to support him in achieving his goals in life". And: "I am confident in the quality of care my son receives".

We saw evidence that people who used the service and their relatives were involved in their care plans. One relative told us: "We have been involved in our son's care planning": "We are invited to meetings to review the care provided". And: "Yes I feel involved in the care and I work with the staff and others to complete the paperwork".

Information about Autism Care North West could be produced in a variety of different formats, if needed. For example, in large print, Braille or on CD for those with varying degrees of sight loss and in alternative languages for those whose first language was not English. This provided everyone with equal opportunities, by enabling them to have access to the same information, despite their nationality, age or disability.

Much attention had been paid within people's care plans to their individual wishes and the things that mattered to them. One person's care plan stated: "I want to be supported by someone who likes walking and doesn't talk a lot". Another read: "I like going to garden centres". We established that people's wishes and preferences were respected.

There was a good level of detail about people's individual methods of communication and how people might express themselves non-verbally. This helped staff to support people to express their views, to make decisions and enabled everyone to have the same opportunities as each other, irrespective of any disability.

There was reference in care files to advocacy services and information was available for people. An advocate is an independent person, who would act on behalf of someone who used the service, to help them make decisions, which were in their best interests.

Requires Improvement

Is the service responsive?

Our findings

We spoke with people about the activities that were available; people told us that staffing levels had a negative impact on the provisions of activities for people. One professional told us: "The service is delivering core care hours and one to one hours are not fulfilled." A staff member told us: "We don't have the staff to fulfil one to one in the community so people are missing out". One relative told us: "They don't have many staff that drive, one thing that is important to my daughter is to go out in a car, but this seldom happens, occasionally she will go in a taxi or for a walk, but it is not the same". People were spending long periods in their homes with no activities to reflect their personal choice.
This amounted to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our last inspection in October 2015, we found people did not receive personalised care that was responsive to their needs. People or those close to them, where appropriate, were not routinely involved in making decisions about their care. People told us and we saw care documentation, which showed people's individual preferences were not explored and taken into account in the way care was delivered to them. There was no evidence available to show people were involved in regularly reviews of their care and treatment.

During this inspection, we checked to see what improvements had been made.

The care plans we saw were, in general well written, person centred documents. They were based on the needs and personal goals of each individual. They incorporated a section entitled, 'What is important to me?' Examples of this included, learning to cook, going shopping and accessing the community.

The plans of care clearly focused on peoples' routines, goals and the progress people made towards their goals was constantly evaluated. We saw some good examples of very well detailed behaviour support and communication planning. This was done in a very positive manner and focused on the needs and strengths of the particular individuals. There was some pictorial information provided in people's care plans to assist them in accessing the information more easily.

We looked at assessments of people's needs and care planning documentation. We found assessments, overall, were now being completed accurately and were being reviewed regularly, in line with changes in people's circumstances, for example, following a fall or medical treatment. However, we did find an example where the person's condition had deteriorated and their care documents had not been updated. A referral had been made to the GP and the regular staff were aware of the person's needs.

Similarly, written plans of care were reviewed regularly and changed when necessary, in accordance with people's needs. There was evidence in people's care plans to show, and people we spoke with confirmed they were involved in reviewing the care that was delivered to them. This showed the service had made some improvements with regard to responding to people's needs by way of assessment, planning and delivery of care, which met identified needs in line with peoples' preferences.

When we last inspected, we found referrals to external healthcare professionals were not followed up in a timely manner, or were not made at all. During this inspection, we reviewed records, which showed such referrals were being made as appropriate. One professional told us: "The staff worked well with our service, they took advice followed all intervention, management and risk plans, in order to ensure the service was fully meeting the needs of the individual". However, guidance and advice from professionals was not always being used to inform care planning.

We recommend that the provider ensures any changes in need are recorded in a timely manner and in a way that is clear and concise. In addition, that care planning involves professionals involved in peoples care to ensure best practice.

Everyone we spoke with said they would know how to make a complaint in the belief it would be addressed. One relative told us: "Any issues I have I am happy to discuss with the team and feel that I am listened to by them".

A system for recording and managing complaints and informal concerns was in place. We saw evidence of complaints and information was available to demonstrate how those complaints had been reviewed, investigated and responded to.

Requires Improvement

Is the service well-led?

Our findings

During our last inspection in October 2015, we found shortfalls in service provision, which meant people and their relatives, were not actively engaged in developing the service. Systems designed to assess and monitor the quality of service provision were not being operated effectively. The management and leadership at the service was poor. The service was not meeting the requirements of their registration, as statutory notifications were not being submitted to CQC.

Following our inspection, we took action to make sure improvements were made. We monitored the improvements closely through contact with the provider and the local authority.

We carried out this inspection to check what improvements had been made.

Since our last inspection, there had been many changes within the service. The Lifeways group had acquired the service and continued to make changes at both operational and service delivery level. The service had a new manager, who had registered with CQC and there had been a number of other managerial changes. The service now had a senior service manager and a service manager who supported the registered manager. The service had a quality team, who monitored quality assurance for the provider group. This resulted in people receiving a much better standard of care.

However, people we spoke with were confused by the recent changes and did not feel these had been well communicated. People told us: "There is lack of visible management, they seem to come on board and then leave": "We have had minimal correspondence from Lifeways about the takeover of Autism Care UK". And: "One thing that has been lacking is a management structure above the team leader but I am assured that this will be addressed as part of the new management structure within Lifeways".

We found the service had improved the way it used quality assurance systems. We discussed with the registered manager how they monitored quality and reviewed a number of audits that had been completed recently.

Evidence was available to demonstrate that the quality management team conducted an audit every twelve months within each property, following which relevant action plans were developed in relation to any shortfalls identified. Each service manager completed a monthly workbook, which was a checklist that looked at how a variety of areas were being managed, such as safeguarding concerns, health and safety incidents, accidents and complaints. These were submitted to Head Office every month.

We found that where issues had been highlighted through audits and checks, action was taken to improve the service. However, some issues that we noticed during our inspection had been missed. We discussed this with the management team. The checks were completed by house team leaders and passed to service managers and then relayed to the registered manager via completed workbooks. Therefore, the audits relied on the information being correctly recorded at house team leader level.

We recommend that quality assurance is improved in line with best practice to ensure that any risks or shortfalls in care are identified in order to drive up improvement for all people who use the service.

We saw an action plan entitled, 'Driving up Quality', which was devised using the latest CQC report, internal audit results, satisfaction surveys and monthly reports. In addition, meetings took place with the organisations quality manager on a three monthly basis.

One service manager advised that weekly managers meetings took place, during which managers had the opportunity to discuss service developments and review any adverse incidents, such as accidents. This helped to ensure learning could be cascaded throughout the teams.

We saw evidence that staff meetings had taken place and that best practice was being discussed within them. Other topics included lessons learned, staff feedback on handovers and documenting peoples choices.

A service users' guide and a wide range of policies and procedures were in place at the agency office, which were current and covered areas, such as dignity and respect, health and safety, moving and handling, infection control, the Mental Capacity Act and safeguarding adults and children.

It was noted that although significant improvements had been made, the service would benefit from the stability of a management and staff team. We will check this during our next planned comprehensive inspection.

Since our inspection the registered manager has informed us of progress he has made as a result of our feedback and recommendations made, which is considered to be good practice.

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
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not have systems in place with a view to achieving service users' preferences and ensuring their needs are met with regards to activities Regulation 9 (3) (b)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not have suitable arrangements in place to ensure that the treatment of service users was provided with the consent of the relevant person in accordance with the Mental Capacity Act 2005. Regulation 11(1) (2) (3)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have suitable risk management arrangements in place to make sure that care and treatment was provided in a safe way for service users. Regulation 12 (2) (a) (b)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing

The provider did not ensure sufficient numbers of staff were deployed to meet peoples care and treatment needs

Regulation 18 (1)