Care Quality Commission

Autism Wessex

Autism Wessex-Middle Path

Inspection report

58 Middle Path,
Crewkerne TA18 8BG
Tel: 01460 72707
Website: www.autismwessex.org.uk

Date of inspection visit: 12 November 2015
Date of publication: 16/12/2015

Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on 12 November 2015 and was unannounced.

The service provides accommodation and support for up to four people with a learning disability or autistic spectrum condition. At the time of the inspection there were three people living in the home with moderate learning disabilities or autistic spectrum conditions. People were able to communicate verbally although some had more limited verbal communication skills than others. They required staff to support them when they went into the community to reduce their anxieties and to help keep them safe from harm.

The service had a 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.

The registered manager said the service ethos was "To promote people's independence and ensure they have as normal a life as possible. We want people to be happy, have new experiences and be well cared for".

The registered manager was responsible for two of the provider's care homes and spent roughly half of their time

Summary of findings

in each home. The deputy manager at Middle Path supervised the staff on a day to day basis and was very accessible and visible around the home. People, relatives and staff all commented on how approachable the deputy manager was. They said they would approach the deputy manager in the first instance. They could also go to the registered manager for help or advice when this was needed.

There were sufficient numbers of staff to meet people's needs and to help to keep them safe. One person said "Yes, staff protect me. They make me feel safe". Staff had a good understanding of each person's support needs, behaviours and preferences. One person's relative said "[Their relative] has never been better. Their keyworker is absolutely brilliant and knows them as well as I do".

Each person had a 'circle of support', including family members, staff and other professionals involved with the person's care. The 'circle of support' was involved in planning the person's care to ensure they experienced as good a quality of life as possible.

Staff told us they wanted the best for the people they supported and we observed they were understanding and considerate of their needs. They said people were encouraged to be as independent as they wanted to be because this helped improve their self-esteem.

The home was spacious and people were free to use the communal areas or return to their own rooms as they pleased. People's rooms were large and well furbished to suit each individual's tastes and interests. All areas of the home were clean and tidy and in good decorative condition.

The provider had an effective quality assurance system which ensured the service maintained good standards of care and promoted continuing improvements.

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.

There were sufficient numbers of suitably trained staff to help keep people safe and meet each person's individual needs.

People were protected from abuse and avoidable harm.

Risks were identified and managed in ways that enabled people to lead more fulfilling lives and to remain safe.

Good

Is the service effective?
The service was effective.

People received effective care and support from staff who were trained to meet their individual needs.

People were supported to live their lives in ways that enabled them to have a better quality of life.

The service acted in line with current legislation and guidance where people lacked the mental capacity to consent to aspects of their care.

Good

Is the service caring?
The service was caring.

People were supported by caring staff who were committed to promoting people's wellbeing and independence.

People were treated with understanding, dignity and respect.

People were supported to maintain their family relationships.

Good

Is the service responsive?
The service was responsive.

People and their relatives were involved in decisions about their care and support, as far as they were able to be.

People's individual needs and preferences were known and acted on.

People, relatives, staff and other professionals were able to express their views and the service responded to feedback.

Good

Is the service well-led?
The service was well led.

People were supported by a dedicated staff team and there were clear lines of responsibility and accountability.

The service had a supportive culture focused on promoting people's independence and quality of life.

The provider's quality assurance systems helped ensure a good standard of service provision.

Good

Autism Wessex-Middle Path

Detailed findings

Background to this inspection

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

This inspection took place on 12 November 2015 and was unannounced. It was carried out by one inspector. Before the inspection we reviewed the information we held about the service. This included previous inspection reports, statutory notifications (issues providers are legally required to notify us about), other enquiries and the Provider's Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. At the last inspection on 26 November 2013 the service was meeting the essential standards of quality and safety and no concerns were identified.

During the inspection we spoke with the three people who lived in the home, the registered manager, deputy manager and two other members of staff. We observed staff practices and their interactions with the people in the home. We reviewed three care plans and other records relevant to the running of the home. This included staff training records, medication records, complaints and incident files. We reviewed the responses and comments from people's relatives and the commissioning authorities from the service's annual quality monitoring questionnaire. We also telephoned a relative following the inspection to obtain their views on the service.

Good

Is the service safe?

Our findings

People who lived in the home told us they felt safe and secure. One person said "Yes, staff protect me. They make me feel safe". One person's relative told us "[Their relative] is safe, no worries about that". We observed people were at ease and comfortable with the staff supporting them.

People were protected from the risk of abuse through appropriate policies, procedures and staff training. Staff knew about the different forms of abuse, how to recognise the signs of abuse and how to report any concerns. Staff told us they had never had any reason to raise concerns about any of their colleagues but they would not hesitate to report anything if they had any worries. Staff said they were confident that if any concerns were raised they would be dealt with to make sure people were protected.

The risks of abuse to people were reduced because there were effective recruitment and selection processes for new staff. This included carrying out checks to make sure new staff were safe to work with vulnerable adults. Staff were not allowed to start work until satisfactory checks and employment references had been obtained.

Care plans contained risk assessments with measures to ensure people received safe care and support. Risk assessments covered issues such as: support for people when they went into the community, participation in social and leisure activities, and environmental risks. There were risk assessments and plans for supporting people when they became anxious or distressed. All staff received training in positive behaviour support to de-escalate situations and keep people and themselves safe.

All incidents were investigated and action plans were put in place to minimise the risk of recurrence. For example, one person sometimes became anxious or distressed and could display challenging behaviours toward another person in the home. They could now access a small private living room where they could listen to music or watch their DVDs when they became anxious and wanted to be on their own. The person's anxieties and the number of incidents had significantly reduced since the private living room arrangement had been introduced.

All incident report forms were signed off by the registered manager and kept in people's support plans. The registered manager carried out a monthly review of incidents to identify any learning and report these to the provider's head office. Significant incidents were reported to the relevant statutory authorities, as required.

Staff knew what to do in emergency situations. Staff said they would call the relevant emergency services or speak with the person's GP, or other medical professionals, if they had concerns about a person's health and welfare. The provider also had a central clinical support team to support local services with more complex care needs or to assist with serious incidents.

The registered manager carried out quarterly health and safety checks and the provider arranged annual checks to ensure the physical environment in the home was safe. The provider had a comprehensive range of health and safety policies and procedures to keep people and staff safe.

There were sufficient numbers of staff to meet people's needs and to help to keep them safe. The service employed a small team of seven permanent staff who were very knowledgeable about people's preferences and behaviours. The staffing on most shifts consisted of the registered manager or deputy manager and two or three care staff depending on the planned activities. At night, there was one sleep-in member of staff on duty and a senior person on-call for advice or support. Staff told us there were always sufficient staff numbers to meet people's needs and to take people out on most days. Staff turnover and sickness rates were very low but if there was a short notice absence they could call on the provider's relief team for assistance. Relief team members of staff received the same training as the permanent staff and were familiar to the people living in the provider's homes. The service rarely needed to call on outside agency staff.

Systems were in place to ensure people received their medicines safely. All staff received medicine administration training. Medicine administration rounds were periodically observed by the managers to ensure staff practices were safe and correct. Each shift leader was responsible for checking staff had completed and signed people's medicine administration record sheets. These checks helped to ensure the correct medicines were administered to the right people at the right time.

Good

Is the service effective?

Our findings

Feedback from people's relatives and from outside professionals showed the service was effective in meeting people's needs. One person's relative said "[Their relative] has never been better. Their keyworker is absolutely brilliant and knows them as well as I do". A social work professional commented "They provide person centred support and understand people's needs and wishes".

Staff were knowledgeable about each person's needs and preferences and provided care and support in line with people's agreed plans of care. Staff told us they received very good training which enabled them to provide effective care and support. This included generic training such as: safeguarding, first aid, infection control and administration of medicines. Service specific training was also provided in autism awareness, positive behavioural support and epilepsy. Staff were also supported with continuing training and development, including vocational qualifications in health and social care. Over 75% of the staff had vocational qualifications.

A new member of staff told us they were "really impressed" with the training provided. They received a comprehensive induction programme, which included completion of a detailed workbook over the first 12 months of their employment. They had also attended an in-depth training course in autism awareness and strategies. After the initial induction training programme, they shadowed experienced members of staff for two weeks to get to know people's individual support needs. New staff received formal one to one supervisions sessions every four weeks during their probationary period. The competency, knowledge and skills of new staff were assessed over a 12 month probationary period to ensure they knew how to care for people effectively.

Established staff received six weekly supervision sessions and had annual performance and development appraisal meetings with the registered manager. The registered manager said the provider had recently introduced reflective practice video sessions. With the consent of the member of staff and the person they were supporting, the staff member's practice was videoed for a short period of time. This was then played back to the member of staff who reflected on good practice and it encouraged self-evaluation. For example, one member of staff learned from their video session they were not allowing the person they supported sufficient time to process and respond to what they were saying.

Staff were trained to communicate effectively in ways people could understand. This included use of pictures and symbols to aid understanding. We observed daily activity boards with symbols and easy to read phrases in people's rooms. Care plans also included information in easy to read formats. Although communication aids were available, the people who currently lived in the home understood verbal communications and could express their choices clearly through speech.

Staff said everyone pulled together as a supportive and dedicated team to ensure people received effective care and support. They said people's individual care and support needs were discussed regularly at shift hand-overs, staff supervision sessions and monthly team meetings. This ensured people continued to receive appropriate and effective care.

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 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 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. When people lacked the mental capacity to make certain decisions, the service followed a best interest decision making process. Staff received training and had an understanding of the requirements of the MCA and the DoLS.

The service had made DoLS applications for the three people who lived in the home. This was because certain restrictions were needed to help keep people safe from harm. This showed the service was ready to follow the requirements in the DoLS. We observed related risk

Good

Is the service effective?

assessments and best interest decisions in people's care plans. The service regularly reviewed the restrictive practices with a view to reducing the number and impact of any restrictions on people's freedom, rights and choices.

People had sufficient to eat and drink and were encouraged by staff to have a balanced diet. There was a rolling four weekly menu which people reviewed at their weekly house meetings. Alternative meals were provided if people did not want to have the set menu choices. Staff were knowledgeable about people's dietary needs and preferences. For example, one person was on a high calorie diet to help them gain weight and another person was being encouraged to eat more healthily in order to lose excess weight. Another person was a vegetarian and their meals were planned accordingly. We observed there were baskets of fresh fruit in the kitchen/dining area and people made themselves drinks whenever they pleased. The home had been awarded the top five star food hygiene rating from the local authority environmental health department.

People were supported to maintain good health and wellbeing. Each person had an annual health check and medicine review. We were told the local GP and local dentist were very supportive and experienced in treating people who had a learning disability. More specialist advice was sought as required, including from the mental health NHS trust's clinical support team and the provider's own central clinical support team. Care plans contained records of hospital and other health care appointments. Care records showed people had access to a wide range of health and social care professionals.

Good

Is the service caring?

Our findings

People and their relatives thought the service was caring and committed to meeting people's individual needs. People appeared to get on really well with the staff supporting them. We heard a lot of friendly banter between the staff and the people they supported. One person said "Everyone's very nice". A relative told us "I can't fault anything. The staff do the best they can".

Each person had a designated key worker with particular responsibility for ensuring the person's needs and preferences were known and respected. We found staff were very knowledgeable about each of the people they supported, regardless of whether they were the person's keyworker or not. All of the interactions we observed between people and staff were relaxed, friendly and supportive.

Staff told us they wanted the best for the people they supported and we observed they were understanding and considerate of their needs. Staff took pride in the progress people had made since moving to the home. They said people were encouraged to be as independent as they wanted to be because this helped improve their self-esteem. Staff prompted and supported people to develop daily living skills such as cooking, laundry and cleaning. One person said "I love food and make my own meals. Sometimes my keyworker takes me to a restaurant. They also help me to tidy my room. Sometimes they say it needs a woman's touch". Staff told us how much more independent the person had become since moving to the home.

The provider was implementing a new system for monitoring people's progress against personal objectives for improving their quality of life. The system was called goal attainment scaling (GAS). The goals were agreed with the person following discussions with staff and people's family or other representatives. Progress on achievement was then monitored using a five point scale to determine whether the goal was about right, too easy or too challenging for the person to achieve. For example, one person had a GAS for hanging out their washing. The attainment scales went from refusing to hang out their washing, to doing so without any staff support or prompting.

Staff provided examples of how people had developed since moving to Middle Path. People had become much more independent and could now carry out many of their own daily living tasks. People's anxieties had also significantly reduced and they were generally much calmer. For example, we heard how one person had overcome an intense fear of dogs through pet therapy. By setting a series of achievable goals the person had progressed from simply touching the lead of a member of staff's pet dog to now taking the dog out for walks as one of their weekly activities.

Staff respected people's privacy and dignity. Staff ensured doors were closed and curtains or blinds drawn when personal care was in progress. Staff spoke very respectfully about the people they supported and were careful not to make any comments of a personal or confidential nature when other people were present.

People were supported to maintain relationships with their families and friends. Each person had an agreed 'circle of support', including family members and others who were involved with the person's care. With people's agreement, the 'circle of support' was involved in reviews and conversations about relevant aspects of the person's care to ensure the person experienced as good a quality of life as possible.

Relatives told us they could visit or call the home as often as they wished, without any undue restrictions. Staff also supported people to visit their families when this was agreeable to all concerned. The registered manager said "As people's relatives are getting older, we try to support them as much as possible too".

Care plans included information about people's end of life preferences and any spiritual or religious beliefs. This ensured that staff were aware of people's wishes and preferences and respected their choices during their final days and following death. The provider had a policy on what actions were needed in the event of the death of a person who lived in the home.

Good

Is the service responsive?

Our findings

People's needs and preferences were understood by staff and the staff acted on people's choices. For example, people engaged in a range of different activities both within and outside of the home. One person said "I'm encouraged to go for walks and swimming and I love going bowling, but I don't have to go out if I don't want to". A relative said "All [their relative's] needs are being met. They are given opportunities to lead a fulfilling life with activities in and out of the home".

People were supported by staff to spend time in the local community on most days of the week. People told us they were too anxious to go out on their own and felt safer with staff to support them. One relative said "Most days [their relative] is doing something. I often see them around town or going to the gym". People participated in a range of group and individual activities to suit their interests. Activities included attending a local college, fitness and leisure activities, holidays and trips out. We observed communication boards in people's rooms detailing their daily routines and activities in easy to read and symbol format to assist with their understanding. People were free to refuse or choose different activities if they wished, although generally they preferred to keep to a structured routine.

To encourage greater social interaction, the provider organised various activities and events across several of their homes, such as a recent bonfire night party. This enabled people from different homes to meet and socialise. Activity weeks and group holidays were also organised by the provider. In addition to group activities, each person had a rostered 'keyworker day' once every fortnight. On the 'keyworker day' the person received one to one support from their keyworker to visit a place of interest to them or participate in whatever activity they wished.

Each person had a comprehensive care and support plan based on their assessed needs. These provided clear guidance for staff on how to support people's individual needs. Each person's keyworker reviewed their care plan on a monthly basis. They were responsible for updating the person's support guidelines and for ensuring these were appropriate to their current needs. People were consulted about their preferred choice of keyworker and staff members of the same gender were available to assist people with personal care, if this was their preference.

The registered manager checked the care plans regularly to ensure they remained person centred and focussed on each individual's health and welfare needs. A more formal annual review took place each year involving the person, a close family member, and the person's commissioning authority's representative.

The home was spacious and people were free to use the communal areas or to return to their own rooms as they pleased. Each person had a large, well-appointed bedroom personalised to suit their own tastes and interests. One person lived in a self-contained annexe to the main house. People chose their preferred colour schemes and each room contained personal belongings to make them more homely, such as: TV and sound systems, model cars, lighting systems and a fish tank.

The registered manager was responsible for two of the provider's care homes and spent roughly half of their time in each home. The deputy manager at Middle Path managed the home when the registered manager was not present. The deputy manager supervised staff on a day to day basis and was very accessible and visible around the home. People, relatives and staff all commented on how approachable the deputy manager was. One person who lived in the home said "If I had any problems I would talk to [deputy manager's name] and she would sort it out".

The provider had an appropriate policy and procedure for managing complaints about the service. This included agreed timescales for responding to people's concerns. Records showed the service had not received any formal written complaints in the last 12 months.

Prior to our inspection, the relative of a former resident had complained about various issues to the Care Quality Commission. We were told they had verbally raised these concerns with the service. We discussed these issues in detail with the registered manager and the deputy manager. The issues appeared to revolve around some complex relationships. There were clearly communication difficulties between this relative and the staff team. We were satisfied with the explanations given and it was unlikely that similar difficulties would arise in the future.

Good

Is the service well-led?

Our findings

The home was managed by a person who was registered with the Care Quality Commission as the registered manager for the service. The registered manager was responsible for the running of two of the provider's care homes and spent roughly half of their time in each home. The deputy manager at Middle Path managed the home when the registered manager was not present. There was a clear staffing structure in place with clear lines of reporting and accountability. Staff told us everyone pulled together as a team to ensure people were well cared for.

The deputy manager supervised the staff on a day to day basis and was very accessible and visible around the home. People, relatives and staff all commented on how approachable the deputy manager was. Staff said the deputy manager was "on the floor for a lot of the shifts" and staff went to her first. The deputy manager was on shift for half of their working hours and was the line manager to all support staff in the service's management structure. Similarly, people who lived in the home said they would speak with their keyworker or the deputy manager if they had any concerns or other issues.

Staff said the registered manager was a strong "straight talking" character but was also supportive and they could go to her for help or advice if needed. However, we were told some staff were hesitant about approaching the registered manager because of this "stern approach". The 2015 staff survey results showed the majority of staff either agreed or strongly agreed that the service was well led. A relative said "On the whole, they manage things very well. I can pop in whenever I like. I've never had any problems with the manager, she is always very sympathetic".

The registered manager said the service ethos was "To promote people's independence and ensure they have as normal a life as possible. We want people to be happy, have new experiences and be well cared for". Staff were given training to promote these service aims. This included a comprehensive induction for new staff and continuing training and development for established staff. It was reinforced at monthly staff meetings, shift handovers and one to one staff supervision sessions. The approach was also supported by the provider's policies, procedures and operational practices.

The provider operated a quality assurance system to ensure they continued to meet people's needs effectively. The registered manager and deputy manager carried out a programme of weekly, monthly and quarterly audits and safety checks. This included monthly observations of individual staff practices. The provider's director of services visited the home every four to six weeks and carried out checks of key aspects of the service. Staff said the director regularly attended their staff meetings and was very approachable and easy to talk to.

People's relatives and other professionals involved with people's care were encouraged to give their views on the service. They were able to contact the management and staff on a day to day basis and through more formal annual review meetings. Annual satisfaction questionnaires were also circulated to relatives, staff and external professionals to gain feedback on all aspects of the service. The most recent survey results showed relatives and external professionals agreed, and in most cases strongly agreed, that the service provided good care and support and that management and staff were approachable.

The provider participated in forums for exchanging information and ideas and fostering best practice. These included internal provider 'practice forums', multi-agency meetings, training events, conferences and seminars. They also accessed online resources and training materials from service related organisations, such as the British Institute for Learning Disabilities.

The provider employed a central clinical support team to support local services with more complex care issues. They provided comprehensive staff training in autistic spectrum disorder strategies and gave advice on supporting people with complex needs and behaviours. The service fostered good links with local health and social care professionals. Specialist support and advice was sought from external professionals when needed. This helped to ensure people's mental and physical health needs were appropriately met.

People were supported to engage in the local community to the extent they were able to. Staff supported people to go out most days of the week. The registered manager said people in the home were known by name to the neighbours and in many of the local shops. To promote awareness in the local community the registered manager had performed a parachute jump to raise money through local sponsorship. Other local fundraising events were being planned.