

Education and Services for People with Autism Limited

ESPA Domiciliary Agency

Inspection report

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14 December 2017

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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?

Good ●

Summary of findings

Overall summary

This inspection took place on 6, 13 and 14 December 2017 and was announced. The registered provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be at the office to assist with the inspection. This was the first inspection since the service was registered at this location in January 2017.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to younger adults, people with learning disabilities or autistic spectrum disorders and people with mental health conditions. At the time of our inspection 16 people were receiving personal care from the service.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

There was a registered manager in place. 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.

Risks to people were assessed and plans put in place to reduce the chances of them occurring. Policies and procedures were in place to promote infection control. People's medicines were managed safely. Policies and procedures were in place to safeguard people from abuse. The provider and registered manager monitored staffing levels to ensure enough staff were deployed to support people safely. The provider's recruitment processes minimised the risk of unsuitable staff being employed.

Relatives told us staff had the knowledge and skills needed to support people. Staff completed mandatory training in a number of areas, and this was refreshed to ensure staff worked to current best practice. Newly recruited staff were required to complete the provider's induction programme before they could support people without supervision. Staff spoke positively about the training they received. Staff were supported with supervisions and appraisals. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this. People were supported to maintain a healthy diet and access external professionals where needed.

People were happy and relaxed with the staff supporting them. Relatives spoke positively about staff at the service, and described the support they delivered as kind and caring. People were treated with dignity and respect. Staff were knowledgeable about people's communication needs, and used this information to engage with people effectively. People were supported to maintain as much independence as possible and

to maintain and enhance their independent living skills. People were supported to access advocacy services where needed.

People received personalised support that was responsive to their support needs and preferences. Where it was part of their support package people were supported to access activities they enjoyed. Policies and procedures were in place to investigate and respond to complaints. At the time of our inspection no one was receiving end of life care but policies and procedures were in place to arrange this if needed.

Staff spoke positively about the culture and values of the service. Staff felt supported by management and had regular opportunities to contribute to the running of the service. Relatives spoke positively about the leadership of the service. The registered manager, provider and team leaders carried out a number of quality assurance audits to monitor and improve standards at the service. People's views were regularly sought and acted on. Staff were given opportunities to share best practice and discuss outcomes for people supported. The provider worked in partnership with others. The registered manager had informed CQC of significant events in a timely way by submitting the required notifications. This meant we could check that appropriate action had been taken.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

Risk to people using the service were assessed and actions taken to address them.

People's medicines were safely managed.

Recruitment systems were in place to minimise the risks of unsuitable staff being employed.

Staff had an understanding of safeguarding issues and the action they would take to ensure people were safe.

Infection control processes were in place.

Is the service effective?

Good ●

The service was effective.

Staff were supported with regular training, supervisions and appraisals.

The service was worked within the principles of the Mental Capacity Act 2005 and supported people to make decisions themselves.

People were supported to maintain a healthy diet.

People were supported to access external professionals to maintain and promote their health.

Is the service caring?

Good ●

The service was caring.

People were treated with dignity and respect by staff who knew them well.

Staff supported people in a kind and caring way.

Staff were effective in communicating with people and

supporting them to express themselves.

Procedures were in place to arrange advocates should they be needed.

Is the service responsive?

Good ●

The service was responsive.

Care was planned and delivered in a personalised and responsive way.

People were supported to engage with activities they enjoyed.

The complaints procedure was clear and applied when issues arose.

Procedures were in place to arrange end of life care should this be needed.

Is the service well-led?

Good ●

The service was well-led.

Staff spoke positively about the culture and values of the service.

Quality assurance processes were used to monitor and improve standards.

Feedback was sought from people and their relatives.

ESPA Domiciliary Agency

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 6, 13 and 14 December 2017 and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Inspection site visit activity started on 6 December 2017 and ended on 14 December 2017. It included home visits to people, with their permission. We visited the office location on 6 and 13 December 2017 to see the manager and office staff, and to review care records and policies and procedures. We reviewed further evidence on 14 December 2017, when inspection activity concluded.

The inspection team consisted of two adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are reports about changes, events or incidents the provider is legally obliged to send us within required timescales.

The provider completed a provider 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 improvements they plan to make.

We contacted the commissioners of the relevant local authorities, the local authority safeguarding team, other professionals who worked with the service to gain their views of the care provided by ESPA Domiciliary Agency.

People who used the service were not always able to communicate verbally. We visited two people who

used the service at home with their permission. During these home visits we interacted with people and observed support being delivered. We spoke with nine relatives of people who used the service on the telephone.

We looked at three care plans, three medicine administration records (MARs) and handover sheets. We spoke with nine members of staff, including the registered manager, a development manager, two team leaders and five support workers. We looked at three staff files, which included recruitment records.

Is the service safe?

Our findings

Relatives we spoke with said the staff at the service kept people safe. One relative told staff were knowledgeable about a person's health condition and knew how to support them in emergency situations. Another relative said, "[Named person] is supported properly'."

Risks to people were assessed and plans put in place to reduce the chances of them occurring. Risk assessments were specific to people, their support needs and interests. For example, one person had risk assessments in place for the activities they were interested in so that staff knew how to safely support them during these. Risk assessments were also used as a tool to promote people's independence and positive risk taking. For example, one person who might have been able to manage their own medicines was risk assessed to see if this could be carried out safely. Assessments were regularly reviewed to ensure they reflected people's current levels of risk. Relatives told us they had been involved in carrying out and reviewing risk assessments. One relative said, "I contributed quite a lot to the risk assessments."

People were supported in their own homes. The service was not responsible for people's accommodation, but staff still considered any risks to people arising from their home. For example, in some properties the service had created emergency evacuation packs for people to use should they need to urgently leave their premises. These included clothing to keep them warm and information on their support needs that could be given to the emergency services. During our home visits we saw that staff were attentive to people's environment, and ensured that any trip hazards were cleared away as people moved around their homes.

Accidents and incidents were recorded and monitored. A team leader told us any accidents or incidents involving people would be investigated and analysed to see if any improvements could be made to people's safety. The registered manager was able to give us an example of how lessons had been learned following one incident, which led to improvements being made in how people's finances were managed where this was part of their support package.

Policies and procedures were in place to promote infection control. Staff received infection control training. During visits to people's homes we saw them putting infection control principles into practice, for example by using personal protective equipment (PPE) such as gloves and aprons and appropriately washing their hands before and after support interventions.

People's medicines were managed safely. Staff had access to a medicines policy that provided guidance on areas including medicine administration, recording and the use of 'as and when required' (PRN) medicines. Staff received medicine training, and the provider had a policy of reviewing medicine competences annually. Records showed that this was not always taking place. We spoke with the registered manager about this, who said competence reviews would be planned and begin immediately. Following our visit to the service's officer the registered manager sent us evidence to confirm this.

People's medicine support needs were set out in their care plans and medicine administration records (MARs). A MAR is a document showing the medicines a person has been prescribed and recording when they

have been administered. MARs we reviewed had been completed without gaps or anomalies. People had protocols in place for any PRN medicines they were taking. When we visited people at home we saw they were given a choice over whether they wanted their medicines by staff who explained what they were for. Where medicines were taken a clear record of this was made on people's MAR. A relative we spoke with said, "[Named person] gets [named medicines] when she needs them. They do it properly".

Policies and procedures were in place to safeguard people from abuse. Staff had access to a safeguarding policy containing guidance on the types of abuse that can occur in care settings and information on how this could be reported. The provider also safeguarding leads, with one on duty at all times, so staff had someone they could contact should they have any questions about safeguarding issues. Staff told us they were aware of this system, and that they would be confident to report any concerns they had. Records confirmed that where issues had been raised they had been investigated and dealt with in line with the provider's policy.

The provider and registered manager monitored staffing levels to ensure enough staff were deployed to support people safely. People's support needs were assessed before they started using the service, and staffing levels were determined by this for each person. A team leader told us, "It's based on service need and service design, and how many hours are provided." Records showed that people were usually supported by the same staff, which helped them to receive continuity in their care. We asked one person if they were usually supported by the same member of staff, and they said "yes", smiled and nodded.

Relatives we spoke with said there were enough staff at the service, and that people were supported by stable staffing teams. One relative said, "Yes, there's a high percentage of carers." Another relative said, "Staff haven't changed much." Staff also said there were enough staff at the service. One member of staff told us, "There is always enough staff to cover what's needed."

The provider's recruitment processes minimised the risk of unsuitable staff being employed. Applicants for jobs were required to complete an application form setting out their employment history and explain any gaps, and provide proof of identity and written references. Interviews were carried out and Disclosure and Barring Service (DBS) checks made before staff were employed. The DBS carry out a criminal record and barring check on individuals who intend to work with children and adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and adults.

Is the service effective?

Our findings

Relatives told us staff had the knowledge and skills needed to support people. When we asked one relative about staff skills they said, "They are excellent." Another relative told us, "They have ongoing training."

Staff completed mandatory training in a number of areas, including emergency first aid, safeguarding, managing behaviours that can challenge, safer manual handling, food safety and fire awareness. Mandatory training is the training and updates the registered provider deems necessary to support people safely. Team leaders monitored people's support needs and observed staff delivering care, and if they felt additional or specialist training was needed this was arranged. Refresher training was carried out to ensure staff were working to the latest best practice. Training was planned and monitored by the provider's training department. We looked at their records and saw that staff had either completed mandatory training or that it was planned.

Newly recruited staff were required to complete the provider's induction programme before they could support people without supervision. Where staff had no or little experience in care they were required to complete the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It sets out explicitly the learning outcomes, competences and standards of care that will be expected. All newly recruited staff observed more experienced staff delivering support and completed a performance review meeting before they could support people on their own. People and their relatives were also consulted about the suitability of new staff. A relative we spoke with said, "He gets on with all the staff. He likes them. When they're a new member of staff they shadow for a week or so to learn about him and whether he wants them to be part of his team. This involves discussion with us."

Staff spoke positively about the training they received. One member of staff said, "I had a three week induction. It was intensive." When asked about the training they had received another member of staff said, "It was very good. I'd done training before but they do things we haven't covered, like epilepsy training."

The registered manager attended meetings with other professionals to learn about latest best practice in care, and shared this information with team leaders and other staff. The provider's chief executive also sent a regular newsletter to staff with updates on any changes to national guidance. This meant procedures were in place to help staff support people effectively using latest best practice.

Staff were supported with supervisions and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Records showed that meetings took place regularly and that staff were encouraged to raise any support needs they had. Staff said they found supervisions and appraisals useful and would be confident to ask for support if they felt they needed it. One member of staff told us, "I can let them know if I have an issue."

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.

We checked whether the service was working within the principles of the MCA. People's mental capacity was considered when they started using the service, and where there was a possibility that they lacked capacity meetings were held with them, their relatives and other professionals to see how they could best be supported to make decisions or have them made in their best interest. For example, following one meeting a decision was taken by the person's relatives to apply for a Court of Protection order to set out how decisions could best be made for them. Where people lacked capacity to make major decisions for themselves they were still supported to make other choices. For example, one person was assessed as being able to make decisions about "low risk" things such as what activities they would like to take part in. Their care plan contained detailed guidance for staff on how they could be supported with this. One relative told us, "We attend best interest meetings."

When we visited people at home we saw staff encouraging them to make as many choices as possible for themselves. For example, one person had a list of things they were doing that day and a member of staff encouraged and supported them to decide what order they would like to do them in. This meant the principles of the MCA were applied when staff supported people.

Some people received support with managing their food and nutrition as part of their care package. Where this was the case their dietary needs and preferences were recorded in their care records, and people were encouraged to participate as much as possible in preparing meals and choosing what they wanted. During one home visit we saw a person deciding what they wanted for their breakfast. The person went on to say that they were enjoying what they had chosen. A relative we spoke with said, "They provide something at lunchtime they write in the diary what he's had". Another relative told us, "He's happy with the food, they try to get him involved. They go out to the shop, and he helps to prepare meals."

The service worked with other professionals involved in people's care to help ensure they received effective support. Before people started using the service staff contacted other professionals involved in their care for information on how they could best be supported, and held meetings with them, the person and their relatives to draw up care plans. When care plans had been developed we saw evidence that they had been sent to other professionals to see if they had any comments. This included professionals such as General Practitioners (GPs), speech and language therapists (SALT) and consultant neurologists. Relatives we spoke with said staff worked well with other professionals involved in people's care. One relative told us that when a named person was ill their GP had sent information to all staff on how they could best be supported.

Is the service caring?

Our findings

When we visited people at home we saw that they were happy and relaxed with the staff supporting them. When we asked one person about staff they said, "They're good." We asked another person if they liked the staff supporting them and they said, "Yes."

Relatives spoke positively about staff at the service, and described the support they delivered as kind and caring. One relative told us, "Absolutely lovely (staff). They are very patient getting her in and out of the car. They are really sweet and are amazing with her. She has a solid bond with all of them, it's amazing to watch." Another relative said, "The staff are lovely, they include her in everything." A third relative told us, "They are amazingly on the ball, really good." A fourth relative said, "They are all excellent."

People were treated with dignity and respect. During our visits to people at home we saw staff speaking with people in friendly but polite ways, and ensuring that support was delivered privately. Relative we spoke with said staff always promoted people's dignity when delivering support. One relative we spoke with said, "They respect and protect his dignity." Another relative told us, "They treat him with respect and he is happy."

Staff were knowledgeable about people's communication needs, and used this information to engage with people effectively. During home visits we saw that staff recognised people's individual cues and gestures and could interpret what the person was trying to say. A relative we spoke with said, "I think they understand him. Lots of phases he uses, he expects a set response. He has happy and unhappy phases. They know them all."

People were supported to maintain as much independence as possible and to maintain and enhance their independent living skills. People's care plans contained personal goals of things they would like to achieve and evidence of how they were working towards this. During our home visits we saw that one person was encouraged to do as much of their usual morning routine as possible for themselves. Relatives we spoke with said staff always promoted people's independence. One relative said staff had encouraged a named person to be as mobile as possible, by supporting them at their own pace and walking with them. The relative said, "They spent a long time getting him to walk independently". Another relative told us, "Promoting independence is very difficult. They do what they can. She understands a little bit. They are really good." A third relative said, "They are helping him with skills keeping the flat clean and tidy." Staff we spoke with understood the importance of promoting choice and independence to ensure people with learning disabilities and autism using the service could live as ordinary a life as any citizen.

During our visits to people at home we saw numerous examples of kind and caring support being given. Staff clearly knew the people they were supporting very well, which meant that could have professional but personalised and friendly interactions with them. One person told us how they were getting prepared for Christmas by going into town to do some shopping later in the day. Staff then helped the person to tell us what they did to prepare for Christmas and how they liked to decorate their room. Staff used appropriate touch and gestures to communicate with people, and we saw one person laughing and joking with staff about their plans for the day.

Nobody was using an advocate at the time of our inspection. Advocates help to ensure that people's views and preferences are heard. The team leaders told us how people would be supported to access advocacy services should they be needed. We found the service had listened to family members as natural advocates for people to learn about people who used the service. Relatives had been actively involved in the service to ensure people received the appropriate care and treatment.

Is the service responsive?

Our findings

People received personalised support that was responsive to their support needs and preferences. During our home visits we saw that support was planned and delivered based on what people wanted to do. Relatives we spoke with said the service was responsive to people's needs. We asked one relative if people received the care they wanted. They said, "Yes, very much so. Any suggestions or changes are actioned, they are very open. Whatever we suggest they try." Another relative said, "We are very involved. It's very much a fifty, fifty relationship."

People's support needs were assessed in a number of areas before they started using the service, including personal care, communication, medication and mental health. Where a support need was identified a care plan was drawn up based on the person's needs and how they wished to be supported. People, relatives and other professionals were involved in designing care plans to help ensure they responded to the person's needs. Care plans we reviewed were detailed, personalised and written from the perspective of the person they belonged to. For example, one person's care plan contained a detailed section on 'how autism affects me.' This contained guidance to staff on how autism specifically impacted on them and how staff could support them with this. Another person's communication plan contained detailed guidance on how staff could support the person to be understood, which in turn would help the person to feel involved and empowered in their care.

Care plans also contained a 'personal statement' that included lots of information about the person's life history, family and other relationships, things that were important to them and their likes and dislikes. This helped staff reading the care plan to gain a picture of the person as a whole and not just one focused on their support needs.

Care plans were regularly reviewed to ensure they reflected people's current support needs and preferences. Relatives told us they and people were involved in care plan reviews, and that communication with staff was good. One relative said, "At the reviews we discuss everything, any concerns, what's going on. We are up to date." Another relative said, "ESPA understand him and his Autism, how it affects him. We keep in touch once a week. We see the team leader in reviews every three to four months. We discuss things on a regular basis." Another relative told us how the family we kept involved in a person's care, saying, "[Another relative] gets involved in [named person's] care. They ask her views and would make changes. [Named person] was not eating properly. [Relative] recognised this and they (staff) have picked up on this. They are proactive."

Some people received support to access activities as part of their care package. Where this was the case their preferences were recorded in their care plans and relatives said they were supported to access activities they enjoyed. One relative told us how a person had enjoyed an activity but then lost the confidence to take part in it. They said staff worked for months to encourage the person resume the activity, which they were now doing and enjoying.

Policies and procedures were in place to investigate and respond to complaints. The provider had a complaints policy that set out how issues could be raised and how they would be investigated. The policy

was given to people and their relatives when people started using the service, and was available in an easy read format. Relatives told us they knew how to raise complaints to the service. One relative said, "If I had to complain I'd go to the managers."

At the time of our inspection no one was receiving end of life care. The registered manager and team leaders told us how this would be arranged should it be needed.

Is the service well-led?

Our findings

Staff spoke positively about the culture and values of the service. One member of staff told us, "It's a good company to work for." Another member of staff said, "I call this a quality of life service, because that's what we provide to the people we support." A third member of staff told us, "They (the provider) put the people first." Staff demonstrated an understanding of their role and responsibilities and were able to tell us what these were.

Staff felt supported by management and had regular opportunities to contribute to the running of the service. One member of staff said the registered manager and team leaders, "Listen to you." Another member of staff said, "We get support from them." There was a 24 hour on call service which enabled staff to contact a senior person if needed, with clear criteria for when this should be used. This meant procedures were in place for staff to access support and guidance if needed.

Relatives also spoke positively about the leadership of the service. One relative said, "The managers are approachable. I think it's well run." Another relative told us, "It's the way it is run, everything is professional. The bungalow is well managed, and staff well managed, the whole package." A third relative said, "The service is fantastic and the manager is extremely good. She has a really good rapport with my [named person]." One person we visited at home told us they liked to visit the service's office to see staff.

The registered manager, provider and team leaders carried out a number of quality assurance audits to monitor and improve standards at the service. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. Senior management carried out quarterly quality assurance checks which identified areas of good practice and any required improvements. These audits included visits to users of the service to gather the views of people supported. Actions required were fed back to senior staff to enable them to address with the team or specific members of staff as required. Additional audits were completed by team leaders on a monthly and weekly basis. These included audits of care plans, finances, staffing and medication. Records confirmed that any issues identified in audits were addressed.

People's views were regularly collected through annual surveys and quality monitoring visits, and the feedback was used to make improvements to the service. The provider reviewed and evaluated the information it received and used it to inform how it planned care and support. We looked at the results of these surveys and visits and overall noted a positive response from people and their relatives. Information received was analysed, areas for improvements were identified and included in the provider's strategic plan. Relatives we spoke with said they and people were asked for their feedback on how the service was run. One relative told us, "They often send out surveys, it's (the service) very efficient and caring with it." Another relative said, "We get a survey to fill in once a year."

The service gave staff, people using the service and relatives regular updates about the provider, changes in policies and procedures and health and social care legislation through newsletters, meetings and memos.

Relatives spoke positively about communication with the service. One relative told us, "Excellent communication."

Staff were given opportunities to share best practice and discuss outcomes for people supported. Senior staff held regular meetings with support staff to give updates and gather feedback and suggestions to improve service provision.

The provider worked in partnership with others. This meant that the service worked in partnership with other stakeholders to ensure that people received the best possible care. The registered manager and team leaders worked closely with other agencies to promote positive outcomes for people. They regularly sought advice from health and social care professionals to ensure people's needs were met. The registered manager worked with key organisations as well as professionals employed by the provider to support care provision, and develop the service to provide good quality care within the community.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. The registered manager had informed CQC of significant events in a timely way by submitting the required notifications. This meant we could check that appropriate action had been taken.