Spectrum (Devon and Cornwall Autistic Community Trust)

Tresleigh

Inspection report

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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

We inspected Tresleigh on 15 December 2015, the inspection was unannounced. The service was last inspected in January 2014, we had no concerns at that time.

Tresleigh provides care and accommodation for up to five people who have autistic spectrum disorders. At the time of the inspection four people were living at the service. There was a registered manager in post. 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 was not available on the day of the inspection visit. However we spoke with them at a later date.

During the day people were supported by sufficient numbers of staff to allow them to take part in activities in the community. When there were unexpected staff absences there were systems in place to minimise the effect of this. At times the service required two waking night members of staff to support people when they were unsettled. One waking night role was often swapped for a sleep-in member of staff. Management said it was not always necessary to have two waking nights as people's needs fluctuated.

Recruitment practices helped ensure staff working in the home were fit and appropriate to work in the care sector. Staff had received training in how to recognise and report abuse, and all were confident any concerns would be taken seriously by the manager and organisation.

People were assessed in line with the Deprivation of Liberty Safeguards (DoLS) as set out in the Mental Capacity Act 2005 (MCA). DoLS provide legal protection for vulnerable people who are, or may become deprived of their liberty. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals when appropriate. Staff demonstrated a good understanding of the main principles of the Mental Capacity Act (MCA).

The building was well maintained and decorated to a good standard. There were plenty of shared rooms to enable people to spend time together or on their own as they wanted. There was a TV lounge, a large dining area sometimes used as a games room, a well laid out and modern kitchen, a sensory room and another quiet sitting area. People had free access to all the shared areas and we observed people using different parts of the premises throughout the day.

Staff valued people's privacy and dignity. Cultural differences were recognised and respected. Spectrum had arranged additional training for staff to improve their understanding of people's cultural needs.

People's support plans included clear and detailed information about their health and social care needs.

Although care plan reviews were held regularly information was not always up-dated. Some information was repeated and the content varied. This could have caused confusion for staff leading to people not receiving support in line with their plan of care.

Roles and responsibilities were well-defined and understood by the staff team. The registered manager was supported by a deputy manager who had a clear set of responsibilities. There was a key worker system in place. Key workers are members of staff with responsibility for the care planning for a named individual.

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 entirely safe. People were supported by sufficient numbers of staff to allow them to take part in activities in the community.

Staff had received safeguarding training and were confident about reporting any concerns.

Care plans contained clear guidance for staff on how to minimise any identified risks for people.

Is the service effective?

Good

The service was effective. Staffed received comprehensive and regular training.

The service acted in accordance with the legal requirements of the Mental Capacity Act and associated Deprivation of Liberty Safeguards.

People had access to other healthcare professionals as necessary.

Is the service caring?

Good

The service was caring. Staff were kind and considerate in their interactions with people.

People's cultural differences were recognised and respected.

Staff recognised the importance of family relationships and supported people to maintain them.

Is the service responsive?

Good

The service was responsive. Care plans were detailed, however some information was out of date.

Information was recorded on a daily basis to ensure any changes in people's health was noted in a timely fashion.

People were supported to take part in a range of pursuits which

were meaningful to them and reflected their individual interests.

Is the service well-led?

Good

The service was well-led. There was a clearly defined management structure in place which was understood by the staff team.

There was a robust system of quality assurance checks to help ensure the service was safe.

The organisation was developing systems to gather the views of stakeholders.

Tresleigh

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 15 December 2015 and was unannounced. The inspection was carried out by one inspector.

Before the inspection 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 also reviewed previous inspection reports and other information we held about the home including any notifications. A notification is information about important events which the service is required to send us by law.

Due to people's health care needs we were not able to verbally communicate with people who lived at the service to find out their experience of the care and support they received. Instead we observed staff interactions with people. We spoke with the deputy manager, Spectrum's deputy head of operations, a divisional manager and four care workers. Following the inspection visit we spoke with the registered manager and contacted two relatives to hear their views of the service.

We looked at detailed care records for two individuals, staff training records, staff rotas, three staff files and other records relating to the running of the service.

Good

Is the service safe?

Our findings

People living at Tresleigh had limited verbal communication and were unable to tell us about their experience of living at the service. We did spend some time meeting with people and observed the care and support being provided to them. People spent time with staff and the positive interactions we observed indicated they felt safe and comfortable in their home. We saw people relaxing in their rooms and smiling and engaging with staff. Feedback from relatives included; "They've made sure he's safe. We've never felt worried about him," and "Generally speaking they're probably the happiest they've ever been."

When we arrived at the service at 9:30 we were told by staff they were short staffed as one person had phoned in sick at short notice. The minimum staffing levels were five care workers during the day and only four were on duty. People were still in bed and one member of staff was just completing administering medicines. They told us they prioritised tasks and had not had time yet to support people to get up. Shortly after our arrival a fifth member of staff arrived to make up the numbers. At approximately 10:30 a sixth member of staff arrived, this meant people who required 2:1 support in the community were able to attend planned activities. This demonstrated systems were in place to help ensure people had the support they needed. Staff told us they were usually fully staffed during the day. We looked at rotas for the previous month and saw the minimum staffing levels had been consistently met during the day.

During the night-time the staff team was made up of three care workers. One person required constant monitoring and two others had periods of unsettled nights when they sometimes needed support. The staffing level at night was organised according to people's needs at the time. Sometimes there were two waking night workers and one sleep-in and sometimes two sleep-in and one waking night staff. This was in accordance with the support commissioned by each person's Local Authority. Staff expressed concern that anyone working a sleep-in who had a disturbed night might also be on shift the following day. This could mean they were too tired to work safely and effectively. We discussed this with the deputy manager and deputy head of operations. They told us staff were able to access the on-call system if they felt too tired to work in these circumstances. The deputy manager said they would try and arrange for cover for anyone in that position within the staff team. It was agreed that arrangements for these kinds of situations would be discussed with staff to remind them of the actions they could take to minimise any risks. There were three vacancies in the staff team, one of which was for a waking night worker. These vacancies were due to be filled in the next few weeks following an induction of new staff. The deputy head of operations told us people's needs fluctuated and sometimes it was not necessary to have two waking nights on shift.

Recruitment processes were robust; all appropriate pre-employment checks were completed before new employees began work. For example Disclosure and Barring checks were completed and references were followed up. This meant people were protected from the risk of being supported by staff who did not have the appropriate skills or knowledge.

People were protected from the risk of abuse because staff had received training to help them identify possible signs of abuse and knew what action they should take. The registered and deputy manager had taken additional safeguarding training aimed at managers and provided by the local authority. Staff told us

if they had any concerns they would report them to the registered manager and were confident they would be followed up appropriately. They were aware of the management hierarchy and how they would escalate concerns if necessary. Staff told us safeguarding issues were discussed at staff meetings to help ensure they were up to date with the latest advice and information. Flyers and posters in the office displayed details of the local authority safeguarding teams and the action to take when abuse was suspected.

Care plans contained detailed information to guide staff as to the actions to take to help minimise any identified risks to people. The information was contained within the relevant section of the plan. For example one person enjoyed using a jacuzzi. Due to their health care needs this activity contained some risks. These had been thoroughly investigated and weighed against the benefits of taking part in the activity for the person. There was clear guidance for staff on how to minimise the risks and actions to take in the event of an incident. This showed people were supported to take informed risks in order to take part in meaningful occupation which would benefit their well-being.

People's medicines were stored securely in a locked cabinet. Medicines that required stricter controls by law were stored appropriately. The amount of medicines held in stock tallied with the amount recorded on medicine administration records (MAR). MARs were completed consistently and in line with current guidance. Not all creams, ointments and liquid medicines had been dated on opening. This meant staff might not be aware when the medicines could become ineffective or at risk of contamination. We discussed this with the deputy manager who told us they would remind staff of the need to do this. All staff were trained to administer medicines including emergency rescue medicines. Information was available for staff about people who required, as needed (PRN) medicines. The information set out under what circumstances this medicine should be administered and the protocols to be followed including getting approval from an on-call manager. These safeguards helped ensure staff took a consistent approach when deciding whether to administer PRN.

Good

Is the service effective?

Our findings

People were supported by skilled staff with a good understanding of their needs. Staff talked about people knowledgeably and demonstrated a depth of understanding about people's specific support needs and backgrounds. People had allocated key workers who worked closely with them to help ensure they received consistent care and support. Although there had been some changes to the staff team a small group of staff had worked in the service for a number of years and knew people well. A relative told us; There's a strong core of staff who know [person's name] well."

New staff were required to undertake an induction process consisting of a mix of training and shadowing and observing more experienced staff. The induction process had recently been updated to include the new Care Certificate. This is a national qualification designed to give those working in the care sector a broad knowledge of good working practices.

Training identified as necessary for the service was updated regularly. Staff also had training specific to people's needs such as autism awareness. Staff told us they were happy with the amount of training they received and believed it equipped them to do their jobs effectively. One commented; "It's good quality and quite thorough."

Staff told us they felt well supported by the registered manager and received regular supervision. This gave them an opportunity to discuss any changes in people's needs and exchange ideas and suggestions on how best to support people. Staff were able to ask for additional supervision at any time.

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, and whether any conditions on authorisations to deprive a person of their liberty were being met. Everyone living at Tresleigh was either subject to a DoLS authorisation or an application had been made to that effect. The applications and other related records showed the correct procedures had been followed. Mental capacity assessments and best interest meetings had taken place and were recorded as required. One person was subject to continual supervision due to their health needs. Staff explained how they worked to try and minimise the effect of this by being as unobtrusive as possible. The restrictions in place were reviewed regularly by the manager and external professionals.

Staff had received training in the Mental Capacity Act (2005) and associated Deprivation of Liberty Safeguards (DoLS). These areas were covered during the induction process and updated with regular on-line

training. Staff also discussed the associated issues during supervision sessions. Staff made sure people consented before providing personal care and support. A community nurse had visited the service the day before the inspection visit to carry out well health checks for people. One person had refused to have their ears checked and staff had respected and supported their decision.

People ate varied and healthy diets. People were supported to be involved in meal preparation and menu planning for the week. A large file containing photographs and pictures of meals was available in the kitchen. This was used to support people to make meaningful choices about what they ate. We saw one person using the shared kitchen to make themselves a hot drink with unobtrusive support from a member of staff. Care plans recorded people's preferences and dislikes.

People were supported to access other health care professionals as necessary, for example GP's, opticians and dentists. Care records showed that where necessary, additional support was put in place to allow people to access these services. For example staff used social stories to support one person when visiting the GP. These are short descriptions of a particular situation, event or activity, which include specific information about what to expect in that situation and why. In addition people were able to meet with more specialised healthcare professionals according to their needs such as speech and language therapists. Care documentation contained information about past appointments and any action taken as a result. Where it had been identified as necessary, regular health screenings were undertaken. Easy read information in respect of various medical screenings was available in people's care plans. Records showed specialist liaison nurses had visited the service to discuss people's access to screening services.

The building was well maintained and decorated. One person had a self-contained flatlet and the others all had en-suite bedrooms. There were various sitting areas which meant people were able to choose to socialise with each other or have time alone. One shared room was being developed as a sensory room with input from one person. Another room, next to the kitchen, was sometimes used as a games room or an area where people could take part in meal preparation. There was a garden adjacent to the building. This was well kept and had several benches to allow people to enjoy it. Staff told us people often used the garden during the summer months.

Good

Is the service caring?

Our findings

We observed staff interacting with people and the care and support they provided. People were treated kindly and respectfully by the staff team. We observed people smiling and engaging with staff. One relative told us; "There are some carers there that can do anything with [person's name] because he trusts them." Staff talked about people affectionately and demonstrated pride in their achievements. Comments included; "[name] is so much more relaxed now."

Care plans contained positive information about people and information about their personalities and social needs. For example, "[Person's name] is a girly girl." Staff told us how they supported this person to take part in activities they enjoyed and helped ensure their social needs were met. One commented; "She's very much her own person."

Care plans contained detailed information about people's communication styles. For example; "[Person's name] uses verbal single words and, occasionally if encouraged, short sentences." There was information regarding what might indicate when someone was distressed and how to support them and avoid any triggers. Communication tools had been developed and adapted to support people. For example social stories had been created, and symbol strips were used to help inform people of planned activities. Staff were able to describe to us how people communicated. For example one member of staff showed us the signs one person used to say 'cereal' and 'please'. These were signs they had developed themselves rather than standard universal signs.

People were supported in a way which meant their privacy and dignity was protected. During the inspection we went to meet with one person who indicated they wanted to be alone. Staff respected their decision. It was important for one person that they be supported by staff of the same gender as themselves. The rotas showed this was done consistently in order to protect the person's dignity. A relative commented; "In terms of respect and dignity, they [staff], absolutely respect it."

Staff supported people to be independent in their day to day lives. Care plans outlined the support people needed to take part in daily household chores. Staff worked with people to set personal goals to increase their living skills. One person had identified a wish to become more independent in the community. Staff were working with them to start using trains to get around with staff support. They told us they were starting with very short, one stop journeys. Once the person had become more relaxed about doing this they would slowly increase the length of the journey. There was a specific journey they were working towards achieving which would result in the person travelling to see family by train.

Staff recognised the importance of family relationships and supported people to maintain them. The manager or deputy manager spoke with families on a weekly basis to help ensure they were kept up to date with any developments or changes in routines.

Care plans included personal histories and information about people's backgrounds. This meant staff were able to gain an understanding of past events which may have contributed to who people were today.

Management acknowledged the importance of recognising people's cultural inheritance and supporting them to maintain family traditions. For example one person had a specific religious background. A member of Spectrum's management team, who had the same belief system, had supported the person to take part in some of the associated routines. In addition they had provided training to the staff team to help them understand the religion and its impact on the person's life. The deputy manager told us they were going to arrange for this training to be refreshed in the near future.

Good

Is the service responsive?

Our findings

People's care plans were detailed and informative, outlining their background, preferences, communication and support needs. Where certain routines were important to people these were broken down and clearly described, so staff were able to support people to complete the routine in the way they wanted. Copies of routines were kept where staff could access them easily and when necessary. For example one person had a very structured morning routine. A bullet point list to inform staff of how to support the person with this was pinned to the back of their bathroom door. This was positioned in a way that meant the person's privacy was protected.

Parts of the care plan were in easy read format to help facilitate people's understanding of them. For example one page profiles used photographs and limited text to outline what was important to and for people. A relative told us they always attended care plan reviews and their family member was also encouraged to take part. Posters on the office wall showed people had been involved in identifying and planning goals for the future.

Not all the information in care plans was fully up to date. One stated the person's fluid intake should be recorded on fluid charts. However staff told us this was no longer happening. When we discussed this with the deputy manager they were unsure as to whether the monitoring charts were still in place or not. On checking the daily records they established it was not. Another care plan contained handwritten notes and crossings out. This could be confusing to follow. Some information was repeated but the depth of the information varied. For example we saw guidance for supporting someone to apply prescribed creams was recorded in two places. In one it simply advised staff to place the cream in the persons hand and they would apply it themselves. In a different section the guidance went on to describe the support staff could give if the person was reluctant to apply the cream, ie, counting to 10 and giving positive praise. This information could easily be overlooked if staff looked at the previous section first. This could lead to staff taking over the task too soon and not fully supporting the person's autonomy. The deputy manager told us they were planning to update care plans in the near future.

Daily logs were completed throughout the day for each individual. These recorded any changes in people's needs as well as information regarding appointments, activities and people's emotional well-being. In addition there was a communication book to record more general information which needed to be shared amongst the team. There were also communication books in place for each individual. This meant confidential information was protected. Verbal handovers took place between shifts when the day shift started work. This meant staff were up to date with any changes or developments.

Learning logs were used to capture information about the success of specific activities. They noted the activity undertaken, what had gone well and what had not worked. This meant staff were able to develop successful strategies and share good working practise among the whole team.

People were supported to take part in a range of pursuits which were meaningful to them and reflected their individual interests. These included swimming, using the local health centre and socialising. One person

made was supported to visit Spectrum's head office and carry out some administrative tasks such as photocopying. Their relative told us they were; "Really pleased" with the arrangement. The registered manager said they were encouraging the person to be involved in similar tasks within the service. Another relative told us; "They find plenty to occupy [person's name] which can be difficult." One room was sometimes used as a games room and this contained a pool table and air hockey table. Activity rotas also included time for activities that were important to the individual although they may not be generally recognised as meaningful. For example one person liked to spend time 'snipping' or cutting up paper and this was incorporated into their daily routine. This showed the service recognised and respected individual's needs.

There was a satisfactory complaints procedure in place which gave the details of relevant contacts and outlined the time scale within which people should have their complaint responded to. No complaints had been received. Relatives told us they would be confident to raise any concerns they had with the registered manager.

Good

Is the service well-led?

Our findings

The registered manager was also registered manager for another Spectrum service and shared their time between the two. They spent 10 hours a week at each service supporting people and were included on the rota. In addition they had 20 hours protected administration time. This meant they were able to organise their time to cover all aspects of their managerial role as well as maintaining a day to day understanding of people's needs. Staff told us they were well supported by the registered manager. Relatives said they considered Tresleigh to be a well-managed service.

Roles and responsibilities were well-defined and understood by the staff team. The registered manager was supported by a deputy manager who had a clear set of responsibilities. There was a key worker system in place. Key workers are members of staff with responsibility for the care planning for a named individual. Two people had two assigned key workers and the deputy manager told us they were planning to identify second key workers for the other people living at Tresleigh. Shift leaders had allocated areas of responsibility including medicine audits, vehicle checks and environmental checks such as fire safety and water checks.

Relatives told us a representative from the service contacted them weekly to update them on their family members well-being. They confirmed they were kept informed of any medical appointments or reviews. Quality assurance surveys were circulated to families annually. One had recently been sent out but only one response had been returned at the time of the inspection. The response had been wholly positive.

A new template for recording supervisions and appraisals had recently been developed by Spectrum and was being introduced at Tresleigh. The deputy head of operations told us the new format was less prescriptive and should afford the staff member greater ownership and control over the supervision process. This demonstrated the organisation was working to improve working practises.

Information was used to aid learning and drive improvement across the service. Learning logs and incident sheets were consistently completed. Incident sheets were analysed on a monthly basis in order to highlight any trends or patterns. A relative commented; "They document everything and learn from it."

Regular staff meetings were held to provide an opportunity for open discussion. Any organisational changes were communicated via newsletters and internal emails. In order to try and improve links between care staff and the higher organisation Spectrum had recently re launched a Works Council to allow representatives from all levels to have a voice within the organisation. A recent consultation with staff regarding changes to the pay structure had taken place. Following feedback from staff a decision had been deferred to allow for further discussion and consultation. Staff told us they had a; "Really good team morale."

A questionnaire had been developed for all stakeholders including staff. This was being trialled in two services. An open day was planned for February 2016 to allow staff an opportunity to discuss any concerns or ideas they had for individual services and organisational practices.

Quarterly audits based on the Care Quality Commissions key lines of enquiry (KLOE) were carried out by the provider. Any highlighted issues or areas requiring improvement would result in an action plan with a clearly defined time frame. The registered manager had responsibility for producing a monthly report.