National Autistic Society (The)

Gillitts Road

Inspection report

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Date of inspection visit: 3 August 2015
Date of publication: 16/09/2015

Ratings

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

Overall summary

This inspection took place on 3 August 2015, and was unannounced.

Gillitts Road is a residential care home for 12 adults living with autism. The home is situated in the suburbs of Wellingborough in Northamptonshire. The service comprises of two five-bedroom homes, 'Beige House' and 'Green House', and 'The Flat', a two-bedroom apartment created to promote independent living skills. At the time of our inspection 10 people were living at the home.

There was no registered manager in post. This was because the registered manager had left employment and a new manager had recently been appointed but was yet to register as the manager with the Care Quality Commission (CQC). 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.

Summary of findings

Important transfer information was not always updated as and when people's needs had changed which meant people could not be assured they would receive consistent co-ordinated care when moving between different services.

The providers monthly keyworker care review arrangements were not consistently followed, which resulted in some people not benefiting from having their individual needs regularly assessed, recorded and reviewed by their keyworker.

The staff were knowledgeable about each individual person's needs and preferences and understood their responsibilities to keep people safe and safeguard them from abuse.

Risk assessments were in place that identified specific risks to individuals. They set out how the risks were to be managed to prevent people coming to harm and took into account people's rights to take risks.

There was sufficient staff available to meet people's needs and the staff recruitment procedures ensured that staff employed at the home were appropriately skilled and suited to the roles they were to perform.

Appropriate systems were in place that ensured medicines were administered and handled safely.

People were looked after by staff that were caring, compassionate and treated them with dignity. People's consent was sought before staff provided any care or treatment. The principles of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) codes of practice where correctly followed by staff when acting on or make decisions on other people's behalf.

People's nutrition and hydration needs were met. They were supported to choose, prepare and cook their own meals and drinks and had access to snacks and drinks throughout the day and night.

People were supported to attend healthcare appointments and to receive advice and treatment from their GP and other healthcare professionals as and when needed.

The staff supported people to access the community, which reduced the risks of people becoming socially isolated. People were fully supported to pursue their preferred hobbies and interests.

There were effective systems in place for responding to complaints and people and their relatives were made aware of the complaints processes.

Quality assurance systems were in place and were used to obtain feedback, monitor service performance and manage risks.

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.

People were protected from abuse and avoidable harm by staff that understood the risks and knew how to report and deal with concerns.

There was sufficient staff available to meet people's individual needs and keep them safe.

Effective recruitment practices were followed.

People's medicines were managed safely by staff that had been appropriately trained.

Good

Is the service effective?
The service was effective.

Staff had been provided with appropriate training which equipped them with the skills and knowledge to meet people's needs.

People's consent was sought and the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were followed when people need help to make decisions.

People were provided with adequate amounts of food and drink to maintain a balanced diet.

People were supported by staff to maintain good health and to access healthcare services when required.

Good

Is the service caring?
The service was caring.

Staff supported people to develop positive and caring relationships.

Staff were knowledgeable about people's needs, preferences and personal circumstances.

People's privacy and dignity was respected and promoted.

Good

Is the service responsive?
The service was not always responsive.

Due to important information on grab sheets not always being updated as and when people's needs had changed. People could not be assured they would receive consistent co-ordinated, person-centred care when moving between, different services.

Requires improvement

Summary of findings

The providers monthly keyworker care review arrangements were not consistently being followed. This resulted in some people not benefiting from having their individual needs regularly assessed, recorded and reviewed.

The service had a complaints process and complaints were dealt with appropriately.

Is the service well-led?

Requires improvement

The service was not always well led.

There was not a registered manager in post. A new manager had been appointed but had yet to register with the Care Quality Commission (CQC).

Quality assurance management systems were used to continually monitor the quality of the service. The manager demonstrated they were aware of the areas to focus on to drive improvement and improve the quality of service.

The staff understood and worked towards the vision and values of the service.

Gillitts Road

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 was unannounced and took place on 3 August 2015. It 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 checked the information we held about this service and the service provider. We also contacted the Local Authority. No concerns had been raised and the service met the regulations we inspected against at the last inspection, which took place on 4 December 2013.

Prior to this inspection we also reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law.

We spoke with two people who used the service but for many of the people using the service they had difficulty in communicating verbally and used gestures and body language to express their views. We observed how the staff communicated and interacted with people who used the service and how they supported people during individual tasks and activities.

During the inspection we spoke with the manager and area manager, one team leader, one permanent care worker and one 'bank' relief care worker.

We reviewed the care records relating to three people living at the home to determine if they were reflective of people's needs. We also reviewed staff records that contained information about recruitment, training, supervision and appraisals. We also looked at records relating to the management of the service including quality audits.

Good

Is the service safe?

Our findings

People were protected from harm and abuse by staff that had been trained appropriately and understood the importance of safeguarding people from abuse. One person said, "The staff are very good at knowing when things might get a bit out of hand, they make sure we're all safe". During the inspection people appeared relaxed and comfortable in the company of each other and staff.

The staff told us they received training on safeguarding and whistleblowing procedures. They were knowledgeable about the different types of abuse and said they would feel confident to raise any concerns about people's safety and welfare. One member of staff said, "It's really important that all staff have the right attitude and a calm disposition to work here, through getting to know people we can detect when a person is behaving in a way that could lead to them harming themselves or others and we casually aim to intervene to calm the situation down".

We saw documentation that confirmed safeguarding incidents had been reported appropriately to the local authority safeguarding team and the Care Quality Commission (CQC). For example, with incidents between people using the service, the provider had investigated the concerns and had taken appropriate action to reduce the risks of any re-occurrences.

Risk assessments were in place to promote and protect people's safety in a positive way. They included situations such as, accessing the community, managing medicines and carrying out daily living tasks. They had been developed with the person and where needed their representatives and /or other professionals had been involved. We also saw they had been subject to regular reviews. However we noted the date when the assessments were carried out was not always recorded on the forms, although the date for the next planned review was entered on them.

Accidents and incidents were recorded in line with the provider's policies and were regularly monitored to identify any trends in incidents, so that measures could be put in place to minimise the risks of repeat incidents. We also saw that body charts were used for staff to record when a person had sustained any bruising or break to their skin. For example, a person that was prescribed a medicine that had a side effect of increasing their risk of bruising had a body chart in place for staff to check for bruising, and to consider and account for what may have caused it.

There was sufficient numbers of suitable staff on duty to keep people safe and provide appropriate support to meet people's needs. The manager told us the service currently had vacancies for seven day care staff and one night care staff. They said the vacancies were currently filled by using staff from within their own 'bank' staff team, and staff from two external care agencies. They said staff recruitment was on-going and the vacancies were advertised locally and on social media sites. A senior carer confirmed they always called upon the same staff from the external care agencies, saying it was important that people were cared for by staff they knew and felt comfortable with. Throughout the inspection the staff demonstrated in their actions that they knew the people well, and people seemed relaxed in their company.

People were safeguarded against the risk of being cared for by staff that were unsuitable to work in a care home. A member of staff told us that people living at the home were involved with interviewing new staff whenever possible. We saw evidence that staff recruitment procedures included checks on previous employment and written references had been obtained from previous employers. We also saw that checks had been carried out through the government body Disclosure and Barring Service (DBS) that included Criminal Records Bureau (CRB) checks.

People's medicines were only administered by staff that had received appropriate training, which was followed up by having medicines competency assessments carried out that involved observing and assessing the competency of the staff to administer medicines to people safely. The medicines records demonstrated that the administration and disposal of medicines were appropriately managed. We also saw that the medicines were stored appropriately.

Good

Is the service effective?

Our findings

People received effective care, which was based on best practice, from staff who had the knowledge and skills needed to carry out their roles and responsibilities effectively. The staff told us when they first started working at the home they had received induction training that covered topics such as promoting people's rights, choice, dignity, responsibility and independence. They also said they had worked alongside an experienced member of staff when they first started working at the service.

Staff were provided with training that covered health and safety, infection control, behaviour and risk management and the types of autistic spectrum disorders (ASD). They told us the training was provided through face to face workshops. E-learning modules were used to update and refresh the staffs' knowledge on subjects relevant to caring for people living at the service. Staff also told us they were provided with the opportunity to obtain a recognised accredited care qualification through the Qualifications and Credit Framework (QCF). We saw records of training that demonstrated that staff training was ongoing.

People's needs were met by staff that were effectively supported and supervised. We saw that staff team meetings took place and each member of staff also had regular scheduled one to one meetings and annual appraisals with their supervisors. The meetings were used to discuss and evaluate the staffs work performance and identify any further support and training needs. The staff said the newly appointed manager was very approachable and always willing to offer advice and support and practical help whenever they needed it.

The manager and staff were aware of their responsibilities under the Mental Capacity Act 2005 (MCA 2005) and the Deprivation of Liberty Safeguards (DoLS) code of practice. People's care plans contained assessments of their capacity to make decisions for themselves and where people lacked the capacity to make some decisions 'best interest' decisions were made on the person's behalf following the MCA and DoLS codes of practice. Staff told us they received training on promoting positive behaviour and training on the use of restraint. They said they always focussed on promoting positive behaviour and as such incidents requiring the use of restraint were seldom needed and restraint was only ever used as a last resort.

Consent to care and support was gained at all times. One person who had very limited verbal communication used gestures, body language and picture cards to express their likes and dislikes. We observed interactions between staff the person and other people living at the home. From their actions it was a fundamental part of their day to day work that people were asked their consent before the staff provided people with any care tasks. The staff told us that even if people were unable to verbally communicate their agreement, they knew them well enough to understand if they did not agree.

People were supported to eat a balanced diet that promoted healthy eating. The staff closely monitored people's food and drink intake and worked in collaboration with other health professionals. One person said the meals were 'very tasty' and told us they could choose on a day to day basis what they wanted to have for their meals. We saw that fruit and snacks were available for people in between meals.

We observed over lunchtime the atmosphere within the dining room was relaxed, the meal was unrushed. We observed the staff discreetly provided help to people who needed assistance to eat and drink in order to preserve their dignity. They ensured that each person had sufficient quantities to eat and drink and extra helpings and alternative foods were offered to people as needed.

Individual nutritional assessments were carried out and the staff discreetly monitored people's food and drink intake and reported any concerns regarding dietary changes to the person's GP and when necessary referrals had been made to dietician and speech and language services as needed.

The care records contained information that demonstrated people's physical and mental health condition was regularly assessed and monitored. The staff promptly contacted the relevant health professionals in response to concerns or sudden changes in their physical and mental health and acted on the instruction given from the health professionals.

Good

Is the service caring?

Our findings

People received care from staff that treated them with respect and dignity. One person told us they were very pleased with the care and support they received from the staff. We observed that people appeared relaxed in the company of each other and the staff. The staff treated people with dignity and respect and responded discreetly when attending to personal care.

People were given time to make decisions and staff respected the choices they made, for example, one person was going out and they were given a choice about where they wanted to go, using picture cards for the person to indicate their choice. We observed a number of positive and friendly interactions between staff and people. Our observations demonstrated that staff had positive relationships with the people they supported.

People were involved in making decisions and planning their care. We observed that staff gave people time to make their own decisions, for example, when deciding on what recreational and occupational activities to do each day. We also saw that each person had the opportunity to meet with their named keyworker on a regular basis to discuss their specific care and treatment.

Each person's had within their care plans information about their background and important events in their lives. The information went towards putting together a personal profile, to ensure that all staff knew as much as was needed about each person to ensure their care and treatment was fully tailored towards meeting their specific needs and preferences.

We also saw that communication profiles were contained within their care plans that described how each person communicated to make their needs and choices known. For example, using picture cards, gestures and body language. The staff demonstrated through their interactions with people that they knew each person communication needs very well.

People were supported to develop and maintain relationships with people that mattered to them. We observed people had developed friendships with other people living at the home and they appeared happy in each other's company.

There was good relationships between the staff team and staff knew the individual needs of people and their life histories. For example, we heard staff having discussions

with people about their hobbies and interests, people were comfortable talking to staff about events that were particular to them and the staff showed genuine interest and gave people their full attention.

Requires improvement

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Each person had their needs assessed before they came to live at the home and the assessments formed the basis of a care plan that guided staff on how to provide their care.

The care records were sufficiently detailed, however we noted that several documents contained within people's care files did not contain the person's full name and in some instances the name was not entered onto the forms at all. .We also noted there was nowhere on the forms that specifically asked for the person's name to be entered; this created a risk that records could go astray if they were taken out of the files.

We brought this to the attention of the manager and they raised it directly with the provider's head office. The manager said they had listened to the feedback and would amend the forms going forwards.

We also saw that each person's care file contained a form called a 'grab sheet', which provided a summary of the person's medical history, their prescribed medicines along with other important information about them. The staff told us the grab sheet was used to handover important information in the event of an emergency admission into hospital. However we noted a medicine to treat anxiety was listed on one person's grab sheet, which the person was no longer prescribed. We also noted that no date was entered onto the form to indicate when it had been put in place. In the event of the person being admitted to hospital having incorrect information could have resulted in the person not receiving the right care and treatment when transferring from one service to another.

Each person had a member of staff assigned as a 'keyworker' who held the responsibility for holding monthly care reviews with people and /or their representatives. We saw that records of the reviews were available. However one person did not have any records available to demonstrate their care needs had been reviewed by their keyworker since June 2014. Although other care reviews had taken place involving other health care professionals during 2015. We brought the absence of the keyworker care reviews for the person to the attention of the manager, who assured us it would be followed up with the person's individual keyworker.

People were supported to engage in occupational and recreational activities. The care records contained information detailing people's interests and hobbies and they were encouraged to record in their care profiles what their likes and dislikes, hobbies and interests were. This was so that activities could be arranged that suited individual preferences.

People were supported to use and maintain links with the wider community, for example, on the day of the inspection people were supported by staff to engage in activities of their choosing, for example one person visited a local railway station, another person had gone into town shopping and another had been swimming.

People were encouraged and supported to work towards achieving personal goals and aspirations, for example, to achieve greater independence, some people did their own laundry, cleaned their rooms and prepared their own snacks and light meals, the level of support needed was reflected within their care plans. A member of staff said, "We understand that some people need more time than others to build on their independence, we gauge when the time is right for the them to take on more responsibility, it's very rewarding when you see people becoming more independent".

The service routinely listened to and learned from people's experiences, concerns and complaints.

We saw that resident meetings took place and during which people were asked if they had any concerns or complaints. The staff told us people also had the opportunity to raise any concerns they had in private and they supported people to make a complaint if they wished.

We looked at the records of complaints that indicated that formal complaints had been appropriately responded to in line with the providers own complaints procedure.

On the day of our inspection we sat in on the handover between the morning and afternoon staff. The information shared between the staff demonstrated that the daily needs of each person living at the home were reviewed on a daily basis and important information was effectively communicated between staff.

Requires improvement

Is the service well-led?

Our findings

The registered manager had left employment at the beginning of the year and a new manager had recently taken up post in July 2015. The home had been under interim management arrangements for a number of months. The staff told us they thought that the moral within the home had become better since the appointment of the new permanent manager. All the staff commented that they were pleased that a permanent manager had been appointed at the service.

Although there were a high number of permanent staff vacancies there was also an experienced and knowledgeable staff team, including bank staff that had worked at the home for a number of years. Discussions with the staff and observations of care practice demonstrated that they knew the provider's values and philosophy of caring for people living at the home. They told us this was explained to them during their initial induction training and promoted throughout their day to day activities. We saw the vision and values of the service were posted on notice boards within the home to act as visual reminders. We found there was a positive culture at the home where people living at the home were involved in decisions about their care as much as their capabilities would allow.

We also saw that the service worked in partnership with other organisations to make sure they were following current best practice in providing a high quality service. For example, new staff were supported to work towards achieving the National Care Certificate award.

Systems were in place for people living at the home and their relatives to provide feedback on the quality of the service. This was achieved through regular resident meetings and annual satisfaction surveys.

Quality assurance systems were in place to monitor people's care and treatment. Regular management audits took place that covered for example, care records checks, medicines management systems and routine checks to the building and equipment. In addition regular provider quality reviews were carried out to oversee the management of the home by a senior manager from within the organisation.