CareQuality Commission

Include 'In' Autism community interest company

Include 'In' Autism

Inspection report

Plains Farm Youth and Community Centre
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04 December 2020
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09 December 2020
12 January 2021
19 January 2021

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Include in Autism is a domiciliary care agency providing personal care to people living in the community with a diagnosis of autism. They also provide personal care to children and young people in an unregistered children's home they operated. The service was responsible for supporting two adults and eight children with personal care. During the COVID-19 pandemic a number of care packages had been suspended.

People's experience of using this service and what we found
The service failed to maintain accurate, complete and contemporaneous records and have effective systems to assess, monitor and improve the quality and safety of the service. Safe recruitment guidance was not always followed.

Risks relating to not wearing face masks had not been managed safely. People did not receive care and support from suitably skilled and experienced staff. Some staff had not received training around people's specific needs or working with children.

Robust systems were not in place to ensure learning occurred when things went wrong. The provider had failed to adhere to legal requirements in relation to the operation of services and registered locations.

Experience of the service for relatives with children or adult family members was different. Whilst children were supported by a consistent staff team this was not achieved for adults. Communication with some relatives was poor which created anxieties for families.

Relatives and staff were asked to provide feedback about the service. However, the provider had not considered gathering feedback from children.

Feedback from relatives was mixed, children's relatives spoke positively about the caring nature of staff and the responsiveness of the service. Whilst adult relatives' comments were negative and outlined failings by the provider, which had a negative impact on their family members.

Care plans for the adults using the service were person centred and provided staff with clear information on how to support people in line with their preferences. Children's care plans were not available in a format for them to understand. The provider had no systems to support the children's rights.

The provider had systems in place to ensure people were protected from abuse and harm. People's individual and environmental risks were identified and mitigated against. The provider had a plan in place to ensure people would continue to receive support in the event of an emergency.

The manager had developed good working relationships between staff, and external professionals to ensure people received appropriate care and support.

During the Covid-19 pandemic with restrictions on accessing external facilities, staff utilised their facilities, enabling people to have access to other surroundings than their home or open areas such as parks. This allowed continued support for people to develop their independence.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
A comprehensive inspection took place in December 2019. At the time the service was not fully operational. We did not have enough information about the experiences of enough people using the service to accurately award a rating for each of the five key questions and therefore could not provide an overall rating for the service.

Why we inspected
This was a planned inspection based on our inspection programme.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to assessment of risk in preventing, detecting and controlling the spread of infections, recruitment, training and governance. We have issued warning notices in respect of a breaches in regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and in Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Care Quality Commission

Include 'In' Autism

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The manager had started the process of becoming registered with the Care Quality Commission. This means that along with the provider, they will become legally responsible for how the service is run, and for the quality and safety of the care provided.

Notice of inspection
We announced the inspection on the 4 December 2020. Inspection activity started on 9 December 2020 and ended on 19 January 2021. We visited the office location on 12 January 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with four relatives of people who used the service about their experience of the care provided. We

looked at records relating to the management of the service. These included accident and incidents, safeguarding, recruitment and quality assurance records. We looked at four people's care and support files. We spoke with five members of staff, the manager, the regional operations manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We asked six staff to answer some questions about the service via email which four staff completed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was not rated as the service was not fully operational. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
• Risks to people had not always been suitably assessed and mitigated. Generic risk assessments indicated that people being supported could not tolerate staff wearing a face mask. Staff had not assessed individual needs or explored alternative solutions such as clear face masks or working with people to reduce their anxieties. This meant people were not protected as much as possible from the risk of COVID-19.
• Risks to staff during the COVID-19 pandemic had not been fully recognised. Individual risk assessments for staff who were not wearing face masks were not completed. The provider failed to protect staff who were at greater risk due to health conditions or those staff from a black, Asian or minority ethnic background.

We found no evidence that people had been harmed. However, the provider failed to have robust systems to assess the risk of infections. This placed people at risk of harm. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider had contingency plans in place to ensure people received continued care and in the event of an emergency.

Staffing and recruitment
• The provider did not follow safe recruitment procedures. Recruitment documentation was not always fully completed, and references were not always gathered from the last employer.
• Confirmation of the appropriate level of DBS check was not always recorded. At times the records indicated people commenced employment prior to completing application forms and the necessary checks. The provider had just identified the need for structured audits in December 2020.

We found no evidence that people had been harmed however, safe recruitment processes were not always followed. This placed people at risk of harm. This is a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff rotas were not always accurate. Rotas did not always reflect which staff member worked on the reported days. For example, one staff member was shown at two locations on the same day and another staff member was shown as working 12 days prior to their start date.

We found no evidence that people had been harmed. However, the provider failed to maintain accurate, and complete records. This is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People were not always supported by a regular staff team. The service had a high turnover of staff. One adult was supported by nine different staff members over a twelve-day period. Their relative told us this had a negative impact on their family member. The children supported had a familiar staff team.

Learning lessons when things go wrong

• Robust systems were not in place to ensure learning occurred when things went wrong. Accidents and incidents were recorded and reviewed. However, outcomes and lessons learnt were not always recorded.

We found no evidence that people had been harmed however, the provider failed to ensure measures were in place to enable staff to evaluate and improve their practice. This placed people at risk of harm. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection.

• Staff had completed basic infection prevention and control. Spot checks were conducted to ensure staff remained at the appropriate level. Some staff we spoke with were not confident in how to safely put on and take off personal protective equipment. The manager informed us staff would receive additional training.

Using medicines safely

• The manager informed us that no-one currently received support with their medication. However, one care plan outlined support with an 'as required' medication. The registered manager stated this was incorrect and the care plan would be changed to reflect the current situation.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was not rated as the service was not fully operational. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
• People did not receive care and support from suitably skilled and experienced staff. Some staff had not received training around people's specific needs. Relatives comments were mixed. One relative said, "They are brilliant, they understand [Family member]." Another relative told us, "Staff lack the knowledge how to support [family member]."
• No specific training regarding the care and support of children was in place.
• Training was not up to date. Accurate training records were not always maintained. The manager told us the provider had recently changed over to a new eLearning package and the matter was being addressed.

We found no evidence that people had been harmed. However, systems were not robust enough to demonstrate staff had received appropriate training to support people safely. This placed people at risk of harm. This is a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff were supported by the management team. Staff told us they felt fully supported by the manager. Supervisions and appraisals were planned and monitored.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Assessments took place prior to people receiving a service. Information gathered was used to create people's care and support plans. Relatives were fully involved in discussions about their family member's care.

Ensuring consent to care and treatment in line with law and guidance
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. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

• Care plans detailed how best to support people with choices and decision-making.

Supporting people to eat and drink enough to maintain a balanced diet
• People were supported in line with their preferences.
• Care plans included guidance for staff to follow.

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support
• Staff worked in partnership with healthcare professionals to ensure people received care and support.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was not rated as the service was not fully operational. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
• Some relatives told us they were always involved in discussions about their family member's care and support. One relative told us they worked with the staff to make decisions about the level of care and support needed. However, another relative expressed dissatisfaction and said staff did not listen to their requests.
• The provider did not have systems in place to gather the views of children, without the support of an adult either their relative or staff member.

We found no evidence that people had been harmed however, the provider failed to seek and act on feedback from children about how the services was to be provided. This placed people at risk of harm. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity
• Feedback from relatives with children or adults receiving support was remarkably different. Relatives with children spoke positively about the support and care received. Whilst relatives with an adult family member told us how the failings of the provider had a negative impact on their family members.
• Some relatives told us staff were kind and caring. One relative said, "I have nothing but praise, they are quick to support [family member] when needed."

Respecting and promoting people's privacy, dignity and independence
• Relatives told us staff treated their family members with dignity and respect. One relative said, "The staff are lovely, they understand [family member], they are clued in on them."
• Some people were supported by an unfamiliar staff team. Some staff had limited knowledge about the people they supported.
• Some people were promoted to be independent. One relative told us how staff had supported their family member to develop new skills. Another relative told us staff had ceased all activities. The manager explained this was due to the COVID -19 restrictions and staff were working with the family to resolve the matter.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was not rated as the service was not fully operational. This key question has been rated requires improvement. This meant people's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.
• Children's care plans were not available in a format for them to understand. The provider had no systems in place to support the children's rights.
• Care plans were not regularly reviewed. This failure had been identified by the regional operations manager as an action to be addressed.
• Care plans were personalised and contained a good level of detail outlining people's routines and preferences.
• Information from external healthcare professionals was adopted into care plans ensuring staff had up to date accurate information

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• People's communication needs were assessed as part of their assessment. Information was not readily available in a format people could understand. The manager told us that if people requested a different format, it would be made available.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• During the COVID-19 pandemic with restrictions on accessing external facilities, the provider suspended a number of care packages. Where possible staff utilised their facilities, enabling people to have access to other surroundings and supported people to develop their independence.

Improving care quality in response to complaints or concerns
• The service had a complaints system in place. Relatives were confident complaints would be dealt with appropriately.

End of life care and support
• At the time of the inspection there was no-one receiving end of life care.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was not rated as the service was not fully operational. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
• Quality monitoring systems were not effective. Shortfalls had not always been identified and resolved. For example, risks relating to staff not wearing face masks had not been managed safely, training was not up to date, and safe recruitment guidance was not always followed.
• The provider did not ensure staff always maintained accurate and complete records. The manager was unable to provide us with a clear account of the actual number of people who were in receipt of personal care and rotas were not accurate.
• Communication with relatives about their family member's care and support was not always clear. Important conversations regarding people's care and support were not always recorded which led to confusion for people and relatives, which impacted negatively on the quality of care they received.
• The provider had not always submitted the required statutory notifications to CQC following significant events at the service. The provider was operating from an address not registered with CQC and had not informed us of this change or taken steps to ensure their registration information was correct. The provider was operating from an address not registered with CQC and had not informed us of this change or taken steps to ensure their registration information was correct. We established the provider was operating an unregistered children's home but had not applied to be registered with OFSTED prior to supporting children.
• Changes in the management team throughout the year had a negative impact on the running of the service. Quality monitoring was not completed. A newly appointed regional operations manager had started to introduce a series of quality assurance tools in November 2020. Due to the very short time in use, we could not see their effectiveness.

We found no evidence that people had been harmed. However, the provider failed to maintain accurate, complete and contemporaneous records and have effective systems to assess, monitor and improve the quality and safety of the service. This is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• The management team were passionate about providing good care, ensuring people were empowered to be independent and to be individuals.
• The manager had recently returned to the service and had applied to become registered with the

commission.
• There was a positive staff culture. Staff expressed how they enjoyed working at the service.
• The manager had regular contact with the staff team. During the COVID-19 pandemic, team meetings had continued online.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The manager and the provider were aware of their responsibilities under the duty of candour. There had been no incidents which required them to act on this duty.

Working in partnership with others
• Staff worked in partnership with external health and social care professionals who were involved in people's care to ensure people received any additional support they needed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The service did not follow safe recruitment procedures. The service failed to gather information in regard to the matters outlined in Schedule 4, Part 2 of the regulations. 19(1)(a)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service failed to maintain systems to demonstrate staff had received appropriate training to support people safely. 18(2)(a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service failed to have robust systems to assess the risk of infections. 12(2)(h)

The enforcement action we took:

Issued a warning notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service failed to maintain accurate, complete and contemporaneous records and have effective systems to assess, monitor and improve the quality and safety of the service. 17(2)(a), (2)(b).

The enforcement action we took:

Issued a warning notice.