Education and Services for People with Autism Limited

ESPA Agency

Inspection report

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16 May 2018

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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 was an unannounced inspection carried out over three days on 28 March, 20 April and 16 May 2018. On the first day the visit was unannounced as the provider did not know we would be visiting. On the other two days our visits were announced as we had made appointments to visit people in their homes. Five people were using the service at the time of our inspection.

This was the first rated inspection of the service since it was registered.

Education and Services for People with Autism (ESPA) Agency is registered to provide personal care to adults with an autism spectrum disorder or related condition. People are supported by staff to live individually in their own homes.

The service also provides care and support to people with an autism spectrum disorder in two supported living settings, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

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.

A registered manager was 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.

We have made a recommendation that a supported living model of care is operated, rather than a residential model as some of the organisational business was carried out from people's own homes.

Some people who used the agency had complex needs which meant they did not express their views about the service. During the time we spent with people we saw they appeared comfortable with staff. Other people told us they felt safe and staff were kind.

Staff knew the people they were supporting well. Care plans were in place detailing how people wished to be supported and people were involved in making decisions about their care. Staff had developed good relationships with people, were caring in their approach and treated people with respect. Care was provided with patience and kindness.

There were sufficient staff employed and people received a reliable and consistent service. Staff were well

supported due to regular supervision, annual appraisals and a robust induction programme, which developed their understanding of people and their routines. Staff also received a wide range of specialised training to ensure they could support people safely and carry out their roles effectively.

People were supported to access health care professionals when required. They received varied and nutritious diets with involvement from other professionals to obtain advice for any specialist needs. They were supported to receive their medicines and manage their finances safely.

Staff were aware of the whistle blowing procedure which was in place to report concerns and poor practice. There were enough staff available to provide individual care to people. Staff had a good understanding of the Mental Capacity Act 2005 and best interest decision making approaches, when people were unable to make decisions themselves.

People were involved in decisions about their care. They 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 practice. Information was made available in a format that helped people to understand if they did not read. This included a complaints procedure. People we spoke with said they knew how to complain.

People were supported to led fulfilled lives and to be part of the community. They had access to a range of activities and leisure pursuits. They had the opportunity to give their views about the service. There was consultation with staff, people and/ or family members and their views were used to improve the service. People we spoke with said they knew how to complain. The provider undertook a range of audits to check on the quality of care provided.

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.

Staffing levels were sufficient to meet people's needs safely and flexibly. Appropriate checks were carried out before they began work with people. People received suitable support to take their prescribed medicines.

People were protected from abuse as staff had received training with regard to safeguarding.

Risks were assessed and managed. Positive risk taking was encouraged as people were supported to take acceptable risks to help promote their independence.

Is the service effective?

Good

The service was effective.

People were provided with good standards of care by staff who were well trained and supported in their roles.

Systems were in place to ensure people consented to their care.

The service assisted people, where required, in meeting their health care and nutritional needs.

Staff worked together, and with other professionals to ensure people's care and support needs were met.

Is the service caring?

Good

The service was caring.

Staff were kind, caring and supportive of people and their families.

People were offered choice and staff encouraged them to be

involved in decision making whatever the level of support required.

People's rights to privacy and dignity were respected and staff were patient and interacted well with people.

Staff supported people to access an advocate required.

Is the service responsive?

Good

The service was responsive.

People received support in the way they wanted and needed because staff had detailed guidance about how to deliver people's care.

People were provided with a range of opportunities to access the local community. They were supported to follow their hobbies and interests and were introduced to new experiences.

People had information in a format they may understand to help them complain if they needed to.

Is the service well-led?

Good

The service was well-led.

A registered manager was in place who promoted the rights of people to live a fulfilled life within the community.

An ethos of involvement was encouraged amongst staff and people who used the service.

The registered manager monitored the quality of the service provided and introduced improvements to ensure that people received safe care that met their needs.

We have made a recommendation to ensure a supported living model of care is operated.

ESPA 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 was 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.

The inspection took place on 28 March 2018 and was unannounced on the first day. We visited the office location on 28 March 2018 to see the registered manager and reviewed the service's systems and records. We made announced visits on 20 April 2018 and 16 May 2018 to the two supported living schemes run by the agency to speak with people and the staff who supported them. The inspection was carried out by one adult social care inspector.

Before the inspection, the provider had 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 reviewed the PIR and other information we held about the service prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We contacted local authority commissioners.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

As part of the inspection we spoke with three people who were supported by ESPA, two team leaders, seven support workers, a personnel staff member from the office and the registered manager. We reviewed a range of records about people's care and checked to see how the schemes were managed. We looked at care plans for four people, the recruitment, training and induction records for four staff, staffing rosters, three medicines records, staff meeting minutes, meeting minutes for people who used the service and the quality assurance audits that were completed.

Good

Is the service safe?

Our findings

Due to some people's complex communication needs they did not communicate verbally with us. They looked calm and relaxed as they were supported by staff. Other people told us were safe. One person commented, "I feel safe here. My Mum feels I'm safe here. She can go to sleep at night knowing I'm being well-looked after." Another person said, "I'm well-looked after here and staff help me." A third person told us, "I like living here, I do feel safe."

Staff had a good understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the registered manager. They were aware of the provider's whistle blowing procedure and knew how to report any worries they had. They told us they currently had no concerns and would have no problem raising concerns if they had any in the future. They told us, and records confirmed they had completed safeguarding training. One staff member commented, "I'd report any concerns straight away to the senior staff."

The provider had a system in place to log and investigate safeguarding concerns. We viewed the log and found concerns had been logged appropriately. Safeguarding alerts had been raised by the service with the relevant local authority and investigated and resolved to ensure people were protected.

The registered manager and staff team understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities or independent investigations were carried out. Where incidents had been investigated and resolved internally information had been shared with other agencies for example, the local authority and the Care Quality Commission.

There were sufficient numbers of staff available to keep people safe. Staffing levels were determined by the number of people using the service and their needs. Staffing levels could be adjusted according to the needs of people using the service and we saw that the number of staff supporting a person could be increased or decreased as required after negotiation with commissioners of the service. Staff worked on a one-to-one or two-to-one basis with some people they supported during the day. Overnight staffing levels at the houses varied between one and two members of staff who slept on the premises. As the service supported people to relax within their new environment, learn new skills and to become more independent in activities of daily living a person might over time require less staff support.

People and staff had access to emergency contact numbers if they needed advice or help from management when the office was not open.

Robust procedures were followed to safeguard against financial abuse. People had appointed representatives or relatives who supported them in managing or having oversight of their finances. Risk assessments were completed around finances and support plans were agreed with the person and/or their representative. Each person who had money held for safekeeping had a ledger to record their transactions. Receipts were obtained for all purchases. Regular checks of the records and cash balances were carried out

by management.

Assessments were undertaken to assess any risks to the person using the service and to the staff supporting them. These included environmental risks and any risks due to the health and support needs of the person such as moving and assisting, epilepsy and distressed behaviour. These assessments were also part of the person's care plan and there was a clear link between care plans and risk assessments. They both included clear instructions for staff to follow to reduce the chance of harm occurring. At the same time, they gave guidance for staff to support people to take risks to help increase their independence. Our discussions with staff confirmed that guidance had been followed.

Measures were in place to reduce the spread of infection. Staff received training about infection control and regular infection control audits were carried out in each household. Staff checks included good hand hygiene and use of protective equipment such as aprons and disposable gloves and correct disposal of waste products.

Positive behaviour support plans were in place for people who displayed distressed behaviour and they were regularly updated to ensure they provided accurate information. The care plans contained detailed information to show staff what might trigger the distressed behaviour and what staff could do to support the person. They provided guidance for staff to give consistent support to people and help them recognise triggers and help de-escalate situations if people became distressed and challenging. One staff member told us, "I've done positive behaviour training."

A personal emergency evacuation plan (PEEP) giving guidance if the house needed to be evacuated in an emergency was available for each person. They took into account people's mobility and moving and assisting needs. PEEPs were reviewed monthly to ensure they were up to date.

Staff were aware of the reporting process for any accidents or incidents that occurred. These were reported directly to the team leader of the house so that appropriate action could be taken. The team leader told us all incidents were audited to check action was taken as required to help protect people. They told us learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. The provider's information return, (PIR) stated, "The Behaviour Nurse Specialist is sent monthly figures by team leaders on incidents. " They will offer guidance to the staff team, support completion of behaviour plans, attend multi-disciplinary meetings and deliver training following significant incidents."

People received their medicines in a safe way. All medicines were appropriately stored and secured. Medicines records were accurate and supported the safe administration of medicines. Suitable checks and support were in place to ensure the safety of people who managed their own medicines. One person commented, "I keep my own medicines and take them morning and night." Care plans were in place that detailed the guidance required from staff to help people safely manage and be responsible for their own medicines. This also included guidance if self-medicating arrangements were suspended for any person. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs. These are medicines that require extra checks and special storage arrangements because of their potential for misuse. Staff were trained in handling medicines and a process had been put in place to make sure each worker's competency was assessed. One staff member commented, "We have six monthly checks for medicines competency." Staff told us they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines.

The provider had robust recruitment processes which included completed application forms, interviews and

reference checks. The provider also checked with the disclosure and barring service (DBS) whether applicants had a criminal record or were barred from working with people who required some support. This was to ensure only suitable staff were recruited.

Good

Is the service effective?

Our findings

Staff had opportunities for training to understand people's care and support needs. One staff member commented, "Training is brilliant." Another staff member told us, "There are loads of training opportunities." Other staff comments included, "We do well with training" and "I'm going to be doing autism for professionals training."

Staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff for a number of days. A staff member commented, "I did an induction at headquarters for two weeks. I then shadowed a staff member." This ensured they had the basic knowledge needed to begin work. They said initial training consisted of a mixture of face-to-face and practical training." A team leader told us new staff studied for the Care Certificate in health and social care as part of their induction training. The Care Certificate is a standardised training approach in health and social care.

The staff training matrix showed staff were kept up-to-date with safe working practices. The registered manager and staff told us there was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. Staff completed training that helped them to understand people's needs and this included a range of courses such as epilepsy awareness, autism, communication, positive behaviour training and equality and diversity.

All staff received supervision and appraisal throughout the year to support their personal development. Managers received training to help develop their skills managing people and other aspects of management. Staff told us they received regular supervision from the management team, to discuss their work performance and training needs. They said they were well supported to carry out their caring role. One staff member commented, "I'm well supported." Another person told us, "I receive supervision every six to eight weeks." Staff said they could approach the registered manager and other managers in the service at any time to discuss any issues. One staff member said, "The team leader is very approachable." Staff also said they received an annual appraisal to review their work performance.

Staff told us there was good communication and that they worked well together in providing people's care. One staff member commented, ""We have verbal and written handovers when we come on duty." Another staff member told us, "We work well as a team." A new staff member said, "The staff team are very helpful and they were welcoming."

People's needs were assessed before they started to use the agency. This ensured that staff could meet their needs. A staff member at one of the households described a long process that took place to check that people wanted to live at the houses and that they were compatible with people who already lived there. The induction included visits and was carried out at the pace of the person.

Records showed pre-admission information had been provided by relatives and people who were to use the service. Assessments were carried out to identify people's support needs and they included information

about their medical conditions, dietary requirements and their daily lives.

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.

The registered manager and staff were aware of the deprivation of liberty safeguards and they knew the processes to follow if they considered a person's normal freedoms and rights were being significantly restricted. Within the Independent Supported Living (ISL) houses some people required constant support to keep them safe. The registered manager was aware the deprivation of liberty process was not applicable within the supported living environment as people were tenants in their own house therefore the local authority was involved as part of the Court of Protection process. The Court of Protection will consider an application from a person's relative, if one is available, to make them a court appointed deputy to be responsible for decisions with regard to the person's care and welfare and finances where the person does not have mental capacity.

The agency worked within the principles of the Mental Capacity Act and trained staff to understand the implications for their practice. Records showed that the least restrictive interventions were applied where people lacked mental capacity. Consent was obtained from people in relation to different aspects of their care, with clear records confirming how the person had demonstrated their understanding.

Mental capacity assessments had been carried out, leading to decisions if required, being made in people's best interests. For people who did not have the capacity to make these decisions, their family members and health and social care professionals involved in their care made decisions for them in their 'best interests'. A team leader told us they worked with the local authority to ensure appropriate capacity assessments were carried out where there were concerns regarding a person's ability to make a decision.

People lived in their own homes which were adapted to meet their needs. Staff worked with people to ensure their homes were maintained according to their personal preferences.

People had food and drink to meet their needs. People's care records included nutrition care plans and these identified requirements such as the need for a weight reducing or modified diet. People required different levels of support. One person was following a sensory diet to encourage them to eat. Some people received support from staff to help them plan their weekly menu. They would then be supported by staff to help prepare or make a meal and drinks. One person told us, "I can do some cooking. I do shopping and staff support me." Another person said, "I buy what I want to cook and cook my own meals." Some people had specialist needs regarding how they received their nutrition and staff received guidance and support to ensure these needs were met.

People were supported by staff to have their healthcare needs met. Records showed people had access to a range of healthcare professionals. For example, in people's care records there was evidence of input from GPs, opticians, dentists, speech and language therapists, behavioural team, nurses and other personnel. Written guidance was available for staff with regard to people's support requirements. One person told us, "I would tell staff if I was ill and they'd make a doctor's appointment for me." For another person we saw written information was available that stated, '[Name] needs support to make appointments and plan what they will say prior to attending. They have capacity to make decisions about medicals and treatment."

Good

Is the service caring?

Our findings

Not all people we visited could comment verbally about the support they received from staff. We saw they appeared comfortable and relaxed with staff. During the inspection there was a relaxed and pleasant atmosphere in the houses. People moved around freely and got on with their daily lives and interests, with staff support where required. Staff interacted well with people. One person told us, "ESPA is the best place I have ever been. The staff know me so well." Another person commented, "I'm happy here." A third person said, "Staff are so kind, they're very caring."

Staff were not rushed in their interactions with people. They spent time chatting with people individually and supporting them to engage. Where people required support, it was provided promptly and discreetly by staff with people's privacy and dignity being maintained.

The registered manager promoted amongst staff an ethos of involvement and empowerment to keep people involved in their daily lives and daily decision making. Staff were respectful of people's opinions and choices. People told us they were able to decide for example when to get up and go to bed, what to eat, what to wear and what they might like to do. The registered manager told us and we observed that people could choose which staff they wanted to support them. People were also actively encouraged and supported to maintain and build relationships with their friends and family. People were able to visit their relatives and friends regularly and were also supported to use the telephone to keep in touch. Staff at the agency responded well to people's wishes and helped them to fulfil their aspirations. The registered manager told us they had supported and made arrangements for a person who had expressed an interest in beginning a friendship with someone. They had been supported and boundaries had been established to enable the friendship to flourish and the person at the house enjoy the benefits of the friendship.

People who may need support with decision making were encouraged to make choices about their day-to-day lives and staff used pictures and signs for some people to help them make choices and express their views. Communication methods such as Picture Exchange Communication System (PECS), Makaton and other bespoke methods of communication were also used. Some people had applications programmed onto their individual I-pads to help make choices and express their views and communicate. For example, one care record stated, 'I will often ask for a cookie with my communication aid.' Information was available in this format to help the person make choices with regard to activities, outings, day plans and food. Care plans included details about peoples' choices. One care plan recorded, 'I may need support to ask what I want as I tend to go with the flow rather than be assertive and say what I actually want.'

Guidance was available in people's support plans which documented how people communicated. For example, one care plan stated, '[Name] has good basic communication skills and can ask for clarity from familiar others. Has difficulty expressing feelings and emotions.' Another recorded,' [Name] will demonstrate physically when they are upset.' Staff told us they observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain.

People told us they were involved and they said they were listened to. They were involved in regular

individual meetings to discuss their care and support needs which also included discussion about their plans for the future and their aspirations. One person commented, "Meetings happen and it's your choice if you attend." Some houses held monthly meetings to discuss the running of the household and asked people for any suggestions or areas for improvement.

Staff respected people's privacy and dignity and provided people with support and personal care in the privacy of their own room. People were able to choose their clothing and staff assisted people, where necessary, to make sure that clothing promoted people's dignity.

Staff asked people's permission before carrying out any tasks and explained what they were doing as they supported them. This guidance was also available in people's support plans which documented how people liked and needed their support from staff. For example, a support plan for personal hygiene stated, 'Bath time is a pleasurable experience for me so please don't rush me.'

Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well. Detailed records were also available for new staff who were not familiar with people and the information gave them some insight into people's interests and likes and dislikes. Examples included, 'I like many things especially military antiques and animals. I own a horse', '[Name] doesn't like Christmas' and 'I having stories read to me.'

Staff informally advocated on behalf of people they supported where necessary, bringing to the attention of the registered manager or senior staff any issues or concerns where an advocate may be needed. Advocates can represent the views of people who are not able to express their wishes, or have no family involvement.

Good

Is the service responsive?

Our findings

People were supported to access the community and try out new activities as well as continue with previous interests. People all went out and spent time in the community. One person told us, "I have a horse which I look after at the stables." Another person commented, "I love drums and I enjoy music." Records showed people were supported with a range of activities and these included golf, swimming, hydrotherapy, cycling, go-karting, shopping, horse riding and trips to the country and coast and meals out. One person attended college. People also followed their own interests indoors such as computing, listening to music and relaxing in their bedroom with sensory equipment. One person said, "We have a social evening on Saturday and people have a take-away meal." People had gardens and outdoor space and we observed some people enjoyed being outside in the fresh air relaxing on their garden furniture.

Support plans were developed from people's assessments that detailed how their needs were to be met. For example, plans were in place with regard to nutrition, personal care, mobility and communication needs. Support plans provided instructions to staff to help people learn new skills and become more independent in aspects of daily living whatever their need. For example, for one person who needed encouragement to eat their food and support plan stated, 'I am much happier when my food is not touching, to help with this I use a special plate.' For another person, 'I can put my top on if staff present it the right way.'

People were supported to learn new skills and become more independent. They were encouraged to be involved in household tasks such as cleaning and laundry. One person told us, "I do my own shopping." Another person said, "I clean my room with staff support." People were involved in preparing meals with the support and supervision of staff. Support plans provided instructions to staff to help people learn the skills and become more independent in aspects of daily living whatever their need. They provided a description of the steps staff should take to meet the person's needs.

Staff recorded each person's daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated regularly. This was necessary to make sure staff had information that was accurate so people could be supported in the way they wanted and needed.

People had a copy of the complaints procedure which was written in a way to help them understand if they did not read. People were asked at their household meeting and care reviews if they had any complaints. One person commented, "I'd talk to staff if I was worried." A record of complaints was maintained and we saw people were asked at their house meeting and care reviews if they had any complaints that the few received had been investigated and resolved.

Good

Is the service well-led?

Our findings

A registered manager was in place. They had registered with the predecessor regulator before the Care Quality Commission. The registered manager understood their role and responsibilities to ensure notifiable incidents such as safeguarding and serious injuries were reported to the appropriate authorities and independent investigations were carried out.

We noted that a model of care similar to a residential model was operating rather than true independent supported living. Although people were tenants in their own houses, and should have the right to do what they wanted with their houses, the organisation was operating their business from each household. Houses were equipped with an office and staff meetings, professional meetings and staff training took place within people's houses in their sitting room. This meant tenants did not have privacy and their house, which they paid for was also used for the running of the business. We discussed this with the registered manager and team leaders, one of them stated it was too far for staff to travel to head office. Another told us, they would seek people's permission. However, we considered this was an organisational issue.

A large amount of records, not just records to ensure staff had guidance to meet people's needs, were kept at households which should have been kept at the head office. The only records we could access at head office were staff personnel files. We had to access copies of records for the inspection from people's own homes. A copy of people's care records was not available at the main office but rather the only copy was available at the person's house.

We recommend the service considers adopting the supported living model of care rather than a residential model of care to respect tenant's rights and their homes.

People told us they were involved and they said they were listened to. Individual and group meetings took place with people to discuss activities, menus and to involve people in the running of the service. One person who was involved in the selection process for new staff told us, "I'm on the interview panel for new staff."

Staff told us and meeting minutes showed staff meetings took place. Meetings kept staff updated with any changes and allowed them to discuss any issues. Staff told us meeting minutes were made available for staff who were unable to attend meetings.

The registered manager and team leaders assisted us with the inspection. The management team were able to highlight their priorities for the future of the service and were open to working with us in a co-operative and transparent way.

The registered manager promoted amongst staff an ethos of involvement and empowerment to keep people who used the service involved in their daily lives and daily decision making. Staff when they started to work at the service were made aware of the rights of people with learning disabilities and their right to live an "ordinary life."

People were supported as they wished to have strong links with their local community including access to local shops and activities.

The culture promoted person-centred care Each individual received their care according to their own personal preferences. Information was available in alternative forms other than the written word if people who used the service did not read. There was evidence from observation and talking to staff that people were encouraged to retain control in their life and be involved in daily decision making.

The atmosphere in the houses was open and friendly. Staff and people said they felt well-supported. They were positive about the registered manager and management team. Staff told us the registered manager was approachable, accessible and visible within the service, working alongside staff and providing a positive role model. They said they could speak to them, or would speak to a member of senior staff if they had any issues or concerns. One staff member commented, "The registered manager is fantastic."

Auditing and governance processes took place to check the quality of care provided and to keep people safe. A quality assurance programme included daily, weekly, monthly and quarterly audits. All audits showed the action that had been taken as a result of previous audits. They included finances, health and safety, infection control, care provision, safeguarding, complaints and accidents and incidents. Feedback was sought from people and relatives through surveys. Feedback from staff was sought in the same way. All people and staff spoken with told us they were listened to and could make suggestions about the running of the agency.