Swanton Care & Community (Autism North) Limited

Park Lodge

Inspection report

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Ratings

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

Overall summary

Park Lodge provides care and support for up to eight people who have autistic spectrum conditions. At the time of the inspection there were six people living at Park Lodge all of whom had been placed there from out of area due to the specialist care that could be provided.

Due to the complex needs of people living at the home not everyone was able to share their views about the service with us but we did spend time with people in communal areas observing the care and support they received.

An established registered manager was in post and had been registered since October 2010. They had recently returned to work following a period of absence during which time an acting manager was overseeing the day to day running of the service. 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

We carried out a scheduled inspection of this service on 10, 16 and 17 September 2014. Breaches of legal requirements were found.

The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who used the service and others. Care and treatment was not always planned and delivered in a way that was intended to ensure peoples safety and welfare. Staff had not received all the training they needed or professional development, supervision and appraisal.

The provider submitted a report detailing the actions they planned to take to meet the legal requirements.

We completed a fully comprehensive inspection of the service on the 29 June 2015. This day was unannounced which meant the provider did not know we would be visiting. A second day of inspection took place on 30 June 2015 and was announced.

We found improvements in relation to staff receiving training in autism, appraisals had been completed and relative surveys had been completed.

We found risk assessments had been completed but they did not always contain sufficient control measures to keep people and their staff safe. Some people diagnosed with epilepsy enjoyed going swimming but we saw no evidence of risk assessments in relation to this activity.

People had a care record titled 'My Plan' which included area's of the person's life where they needed care and support. We found that this did not always detail specific strategies for staff to follow in relation to specialised equipment and it had not been kept up to date with people's communication needs or medicine administration.

The review and evaluation of documents had been completed on a monthly basis but the comments stated 'no change' or 'reviewed' therefore it was unclear whether the plan was still effective and appropriate.

Staff were supporting some people to take medicine in food as it had been recognised that they could not tolerate the taste or texture of specific medicines. Best practice would be for a doctor to authorise this as a best interest decision and for the process to be recorded in a care plan and risk assessment. We saw no evidence that this had been completed.

Health and safety checks were being completed by maintenance staff but they were out of date due to the person's absence from work. The registered manager thought they were being completed by another person from the maintenance team but had not checked so the fire log book and scheduled maintenance checklists were not up to date.

Deprivation of Liberty Safeguards (DoLS) had been authorised although some had now expired and we saw no evidence that further applications had been made although the registered manager confirmed they had done so. Care staff knew DoLS were in place but weren't able to explain what it meant for people's care.

Some best interest decisions were in place but they had not been reviewed. Although staff were seen to act in people's best interest the process for decision making had not always been followed in line with MCA code of practice.

Staff training was not up to date in relation to the provider's refresher time periods. This related to mental capacity and deprivation of liberty safeguards. Non-abusive psychological and physical intervention (NAPPI) training was not current. We also saw that staff training in relation to medicine administration was out of date and we saw no evidence of competency based assessments. Makaton training, which some of the people use to communicate, had been mentioned in the provider action plan following the September 2014 inspection but not all staff had received this training.

The provider was not meeting its own aim in relation to supervision as they were not on track to complete six supervisions a year with each staff member. This meant there was no formal process, by way of training and supervision to assess staff competency in relation to meeting the specific needs of the people they supported.

People's 'my plan' was not always kept up to date with changes in people's care needs. One person's care manager explained that the person was able to understand verbal communication and they confirmed that staff understood them even though their 'my plan' stated their preferred communication method was to use makaton and PECS.

Staff interaction with people was, at times, limited to functional task driven communication. Staff were

Summary of findings

observed to be having conversations amongst themselves over lunch rather than engaging with the people they were supporting. We also observed staff speaking about people rather than to them.

We saw audit tools were in place but these had not been completed. The registered manager told us they had not had a chance to complete any audits yet. This meant there was no effective and robust system in place to monitor and assess the quality of the service provision.

Safeguarding policies and procedures were in place and staff understood what their responsibility was in relation to reporting concerns. Accidents and incidents were recorded manually and electronically and one person had a behaviour chart which was being used to analyse the impact of a medicine change.

A range of health and safety risk assessments were in place and a fire risk assessment and emergency evacuation plan had recently been updated. Each person had a personal emergency evacuation plan and people were involved in fire drills so they knew what the fire alarm meant.

There were enough staff to meet people's needs and the registered manager said staffing levels were calculated based on people's activities. No dependency tool was used and they said there were no contracts in place specifying commissioned hours. One care manager told us one person was funded for five hours of two to one support each day if needed for community activities.

Recruitment was effective with the appropriate level of pre-employment checks in place. The registered manager explained they included people in the recruitment process as prospective staff would come to the service for a meet and greet opportunity and to go out on an activity with people so staff could assess their level of engagement and interaction. This information was then used in the staff selection process.

The staff team were long standing and had a good understanding of behaviour which may challenge. Documentation was in place which described potential triggers for behaviour; a description of the behaviour and how the staff should respond.

Medicines were stored safely and records were completed with double signatures and a senior administration check was completed for each administration. Records were kept when medicine was taken away from the service when people went home for a day or an overnight stay.

Freshly prepared food was on the menu every day and people were supported to have a well-balanced diet.

Health records were in place and seizure monitoring was used to inform meetings with one person's neurologist.

Activities plans were in place and staff completed a daily record of activities people had engaged in, although we did not see evidence of any analysis of people's enjoyment of these activities.

A complaints policy and procedure was in place. We could not see an audit trail of how one recent complaint had been managed in relation to the acknowledgement of how the complaint would be addressed and who by.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

Summary of findings

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.

You can see what action we told the provider to take at the back of the full version of the report.

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?

Requires improvement 

The service was not always safe. Risk assessments were not always robust and effective in identifying and managing risk.

Best interest decisions and relevant risk assessments were not in place for the preferred methods s of medicine administration for some people.

Routine checks to ensure the safety of the building were not up to date.

Recruitment was robust and the people supported were included in the process.

Is the service effective?

Inadequate 

The service was not always effective. Staff training and supervision was not up to date which meant the competency of staff was not being routinely assessed.

A recognised approach to managing challenging behaviour was used but staff hadn't had up to date training on this.

Best practice in relation to Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards was not fully understood and followed in line with the code of practice.

Is the service caring?

Requires improvement 

The service was not always caring. We observed staff spending a lot of time with people in an unhurried manner but they missed opportunities to engage and interact with people.

We observed staff having conversations amongst themselves and speaking about people rather than to them.

Staff were respectful of people's privacy and dignity in relation to personal care tasks.

Is the service responsive?

Requires improvement 

The service was not always responsive. Care records called 'My Plan' were written in a person centred and individual way but information was not always up to date or accurate.

People did engage in activities but there was no evidence of whether people enjoyed the activities.

There was a complaints policy and procedure in place although we could not see a clear audit trail of how a recent complaint had been managed.

Is the service well-led?

Inadequate 

The service was not well led. The service did not have effective and robust systems in place to ensure it was being well-led.

Summary of findings

Audit processes had not been implemented which meant there was no system to assess, monitor or improve the quality and safety of the services provided.

Quality assurance systems and audit processes did not ensure the service operated safely or effectively.

Park Lodge

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.

The inspection took place on 29 and 30 June 2015. Day one of the inspection was unannounced which meant the provider did not know we would be visiting.

The inspection team was made up of one adult social care inspector and one specialist advisor whose area of expertise was support for people with autism, communication needs and behaviour which may challenge services.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about.

During the inspection we met with all six people who lived at the service and spoke with three relatives. We spoke with six members of staff including the registered manager, senior care staff and care staff. We contacted the local authority safeguarding team who had no concerns about the service and we sought the views of care managers.

We looked at five peoples care records and three staff files including recruitment information. We reviewed medicine records and supervision and training logs as well as records relating to the management of the service.

We looked around the building and spent time with people in communal areas.

Requires improvement

Is the service safe?

Our findings

During our scheduled inspection on 10, 16 and 17 September 2014 we found the provider was not meeting the standard in relation to the way care and treatment was planned and delivered to ensure people's safety and welfare.

At the comprehensive inspection on 29 and 30 June 2015 we found there were risk assessments for choking, medication, epilepsy, swimming and many more, but each one was lacking in depth information around that risk. One person's epilepsy risk assessment had no information on triggers for seizures, what a seizure looked like or what action staff should take if the person experienced a seizure. We saw that a lot of the people being supported enjoyed going swimming but we saw no risk assessments in relation to how support someone whilst swimming if they had a seizure or how to support the person if they were travelling in a vehicle on the way to an activity. At the back of the file there were sheets for staff to sign to say the risk assessment and care plan had been reviewed and evaluated. We saw these were signed and dated but the comments were "no change" or "reviewed". This meant it would be difficult to analyse what was working for the person and what, if anything, needed to change in the support the person received.

One person had a best interest decision recorded around 'covert medicine', which had been signed by a doctor and dated February 2014 and had not been reviewed. We asked the registered manager about this and were told that the medicine was administered in the top of a banana every morning. We were told staff would tell the person their tablet was in the banana and the person would always eat the banana and therefore receive their medicine. We explained that the best interest decision was for a different medicine which was given in a glass of coke. We saw no evidence of a risk assessment or care plan in relation to medicine being given in a banana. Nor did we see a best interest decision.

We saw another person's health information also stated they were administered their medicine in a banana. It also stated that capsuled medicine should be opened and the contents put in the banana or on cereal. We asked the registered manager about opening capsuled medicine as this may have an adverse impact on the dosage the person received, or how the medicine worked. The registered manager said, "The tablet is placed on a spoon in front of [the person] and we say here's your tablet." They added, "I don't think they have any capsuled medicine. No, no they don't" This is not what we saw was recorded in the health information.

There was a risk assessment for disguising medicine in food dated December 2014 which stated the benefits as being that the person would successfully take their medicine. The harm would be to other people if they ate or drank the medicine. This had been assessed as unlikely. The precaution was that two staff administered the medicine. We saw no evidence of a best interest decision signed by a doctor to indicate that it was safe to administer the person's medicine in this way, nor did we see a mental capacity assessment had been completed.

This meant people were at risk of receiving medicine's in an unsafe manner as there was no evidence that the administration method had been agreed by the prescribing doctor.

A fire log book was in place for regular checks however these were not up to date, nor were the weekly water temperature checks. We asked the registered manager about this who said, "Oh they are usually done by maintenance but they've been off for six to eight weeks so they should be being done by the maintenance manager but they obviously aren't getting done." The quarterly check of fire signs hadn't been completed since 23 January 2015.

We saw checklists were in place for the use of a wheelchair and the first aid box but they had not been completed since March 2014. The registered manager appeared surprised and suggested they may be kept elsewhere. They were asked to check this but no up to date checks were found.

The emergency plan file included personal information sheets for hospital visits which included space to record people's current medicines but this was blank.

Each person had a missing person's form which included their photograph, and information on any defining features. There was no version control or information on when the photographs had been taken so we saw significant changes in people's appearances which hadn't been updated with new photographs.

Requires improvement

Is the service safe?

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One relative told us, "I'm very happy with the place, another told us, "I've no concerns."

A safeguarding policy was in place and Sunderland safeguarding board referral forms were used to raise any concerns or alerts. There was no log to record a summary of all concerns and alerts made but we saw that the last recorded safeguarding was in April 2014. We asked the registered manager if this was correct and they said, "I have contacted the safeguarding team for advice but they felt recent issues should be dealt with internally so it's been passed to the operations director." We saw a hand written record of this conversation had been placed in the complaints file but there was no record of the advice sought in the safeguarding file.

We asked the registered manager about their responsibility in relation to safeguarding. They said, "I would report potential abuse, neglect, any harm, theft, we don't have to report medicine errors now." They added, "We would contact the GP if there were any medicine errors and complete the back of the MAR."

Staff had an understanding of safeguarding and one staff member said, "Safeguarding is about ensuring people's safety, everything being in place to ensure safety."

The registered manager explained that accidents and incidents were recorded manually and transferred to an electronic system. They explained that if a trend was noticed, such as if someone became anxious each time they attended a particular activity the care plan would be amended accordingly. We saw that a behaviour chart had been used to map a person's behaviour in relation to a change in their prescribed medicines. This had led to discussion with the GP and an immediate review of medicine. Due to the immediacy of this decision there had been a lack of consultation with family members however the registered manager advised that a best interest meeting had been requested.

The registered manager said, "We keep receipts for all transactions, wallet checks are done and savings are in the safe so we can top up peoples wallets. All parents are appointees for finances apart from one person whose care manager is the appointee." An appointee is someone who manages a person's finances on their behalf if they have been assessed as lacking the capacity to do so themselves.

A range of health and safety risk assessments had been completed and reviewed on an annual basis, and this included legionella, slips and trips, lone working, wheelchair use and a protocol for the key pad entry system.

A fire safety policy was in place which specified the locations of fire extinguishers, fire call points and exit points. A fire risk assessment had been completed in May 2015 and a further risk assessment had been completed in relation to possible industrial action by the fire brigade although the likelihood of the risk was not recorded. There was a procedure in place for night time evacuations and information on occupied and unoccupied rooms. Each person had a personal emergency evacuation plan which included the level of support they would need to evacuate the building. Fire drill training was completed as were evacuation drills. People were involved in these evacuations and recognised the sound of the fire alarm but would need support to respond.

Periodic electrical tests, gas installation, legionella tests and portable appliance testing had all been completed and were up to date.

An incident management plan was in place which included emergency contact numbers for contractors. There was a Barchester healthcare policy on missing residents which was issued in 2010 with a review date of 2013. There was no evidence that this had been reviewed. There was an on call staff member available for emergency hospital care and staff instructions in the event of flood or fire as well as building plans and zones.

We asked the registered manager about staffing levels and they explained there were three waking night staff due to people being diagnosed with epilepsy. During the day they said, "Generally five staff, one cook and me [the manager]." They added, "There would always be someone in the house, either the cook or the admin staff." We asked for clarity if this would be when all people were out. The registered manager said, "No, no, it depends who was in. Sometimes they stay in on their own with [person] or if [person] is staying at home I would make sure I was around to support them." They added, "We generally have enough, sometimes it can be problematic with more staff. As long as people can get out at least once a day."

We asked how staffing levels were calculated. The registered manager said, "There's no format or criteria." We asked about contracts for commissioned hours but were

Requires improvement

Is the service safe?

told there was 'nothing specific.' The registered manager said, "It's based on people's activities and their timetable." We observed that there were enough staff to meet people's needs on the days of the inspection. One care manager told us they funded five hours of two to one support each day for community activities for someone.

The cook said, "I will sometimes drive people to appointments if we don't have a driver or stay in the house. I used to do support shifts but not so much now." They said, and the registered manager confirmed that the ancillary staff received the same level of training as all other staff and had access to people's care records.

The registered manager said, "The staff team are well established and long standing, people have moved for promotion but they are a well-established team."

We spoke with the registered manager about recruitment. They said, "The application forms go to [staff members name], we then get a call to see if they might be suitable and the person comes for a visit. We do a meet and greet session and they go out with people on an activity with staff. The staff provide feedback on the person's interaction and we make a recommendation as to their suitability." We saw that staff had recently followed this process. The registered manager added, "We are in the process of formalising it but we do get written feedback and we are listened to."

We saw that the recruitment processes were up to date and included Disclosure and Barring Service checks, obtaining two references and a fully employment history before applicants commenced in post.

Medicines were stored securely and we saw that the shift leader completed an administration checklist throughout the day to ensure the correct administration of medicines. There was also a daily handover sheet which was signed by two staff for each medicine administration. This was in addition to the medicine administration record (MAR) which was signed by the member of staff who had administered the medicine.

People's photographs, allergies and doctors details were in the medicine file along with fully completed MAR charts. There was a chart for completing when any medicines were taken out of the building, such as when visiting home which had been completed fully. Each person had a letter from the consultant psychiatrist stating that the person lacked capacity and medicine was prescribed in their best interest. This did not specify the medicine prescribed or the appropriate route for administering medicine.

There were homely medicine guidance notes for non-prescribed medicines which were signed by people's doctors but they were not dated.

Each person had a medicine risk assessment which was dated 18 July 2014. This was a standard risk assessment which included pre-populated information with a section for outcomes. The outcomes section had not been completed, nor had any review been completed. The registered manager said, "I think that's an old form put in place by a previous staff member, I don't think it's used anymore."

Inadequate

Is the service effective?

Our findings

During our scheduled inspection on 10, 16 and 17 September 2014 we found the provider was not meeting the standard in relation to supporting workers. In particular, we found staff had not received all the training they needed or professional development, supervision and appraisal.

At the comprehensive inspection on 29 and 30 June 2015 we found that some improvements had been made. Staff had received basic autism awareness training and had received an annual appraisal. Some improvements detailed in the provider's action plan had not been met.

We asked the registered manager if they held a training log for staff. They said, "There's a new organisational matrix which will flag when people need to re-do their training but I haven't completed it yet. The current system is a log for each staff member." The registered manager added, "We get a list of available training three months in advance so we can book people on courses."

The training file contained a list of 'training requirements' and refresher periods. This stated the following refresher periods: safeguarding to be completed annually; epilepsy two yearly; medicine workbooks two yearly; MCA/DoLS three yearly, NAPPI annually and manual handling annually. NAPPI stands for Non Abusive Physical and Psychological Intervention and has an emphasis on positive behaviour support when working with people whose behaviour may challenge services. We noted that autism and communication training was not on the list. The registered manager said, "Autism training is one off in induction but staff have had recent refresher training." We noted that the new training matrix did not include autism.

We analysed the training logs for a sample of staff and found that training was not up to date. In the provider action plan received following the last inspection the provider stated that all staff would be trained in Makaton. Makaton is a form of communication which uses signs and symbols and is used by some of the people living at Park Lodge. We saw that five out of seven staff had not received this training. The provider also stated that workshops in effective documentation keeping and report writing would be arranged for January 2015. We saw no evidence of this on staff training logs. Epilepsy training was also included in the action plan and we found that three out of seven staff had not completed the training. All staff had attended autism training.

Of the training logs viewed six of seven staff had out of date Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training; three staff had out of date manual handling training and five of the seven staff did not have up to date NAPPI training.

NAPPI focuses on the assessment, prevention and management of confused, unpredictable and aggressive people. The training is designed to support staff to assess the potential for challenging behaviour; be prepared at all times; prevent confused and unpredictable behaviour and deliver high quality care. As this training was out of date it meant staff and the people supported may be at risk and unprepared should someone present with behaviour that was challenging.

Six staff had out of date medicine training. We asked the registered manager about staff training for medicine administration. They said, "Everyone completed medicines workbooks. The training manager would then assess them and deem people competent. We don't have a training manager anymore so now there's a one day medicine training course. I think it's an 85 – 90% pass rate, you can re-sit it but can also be supervised administering medicines and assessed as competent." We asked about refresher periods for training and the registered manager said, "It needs to be clarified. If there was a medicines error we would go through supervision and sign off supervision as competent to administer."

The training logs included a space to record the completion of induction but this was blank on all the training logs we viewed.

We asked the registered manager how they knew staff had taken training on board and were using the learning to improve their practice and the way they support people. The registered manager said, "I've suggested a follow up check list about training to test staff knowledge, I brought it up about a month ago." They added, "There's no competency checks as a company at the minute."

We asked about supervisions and one senior care staff member said, "We have so many a year, there's no limit. Staff can ask for one and I'll do supervision so it might be on a medication return or on ordering medicines." They

went on to say, "New staff obviously have more supervision on the daily diary, incident reporting and health and safety." We asked staff about formal one to one supervision and one care staff member said, "Not one to one sessions."

The registered manager said, "Supervisions are used to go through new procedures, there's more of a move to a generic supervision based on how things are going but at the minute we do that once a year and do an annual appraisal. The use of the hoist was gone through in supervision on a one to one basis." Supervisions were being used as a training tool rather than as an opportunity to discuss staff performance and competency which in turn develops the quality of service provision.

The registered manager said, "We aim to have six supervisions a year and annual appraisals are all in date." Of the supervision logs we looked at we found that since the last inspection in September 2014 one staff member had received two supervisions; three staff had had one supervision and three staff had no recorded supervision. This meant the provider would be unable to meet their own standard of aiming for six sessions per year.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw documents titled best interest decisions. These forms stated, 'if a person has been assessed as lacking capacity, then any action taken, or any decision made for or on behalf of that person must be made in their best interest. People had recorded best interest decisions in relation to the management of their weekly allowance; the door key pad entry system; attending health appointments and the use of restraint following NAPPI. These all had the same date as September 2013 recorded on them and had been signed by the registered manager and the care manager. The document stated these decisions should be reviewed on a monthly basis. We saw no evidence of a monthly review. Nor did we see evidence of specific mental capacity act assessments to assess people's capacity in relation to specific decision making.

One person had an authorised Deprivation of Liberty Safeguards (DoLS) in their care records but we noted it expired in May 2015. The registered manager said new applications had been made but they were not able to produce evidence of this. We checked the notifications sent to CQC in respect of the outcomes of DoLS applications and saw that six authorisations had been granted in May 2014. One of which had a further authorisation in place which had been approved. The DoLS code of practice states, 'when an authorisation ends, the managing authority cannot lawfully continue to deprive a person of their liberty.' It goes on to state, 'If the managing authority considers that a person will still need to be deprived of liberty after the authorisation ends, they need to request a further standard authorisation to begin immediately after the expiry of the existing authorisation.' We asked the registered manager whether further authorisations had been requested, they said, "I think so, I'm sure I've done them." We did not see any evidence of this.

We saw two peoples DoLS applications. They identified that people may present with aggressive and challenging behaviour towards staff and identified potential triggers for the behaviour. It was recorded that staff manage this by responding with distraction and diversion. The application did not record that staff used NAPPI intervention which can involve the use of minimal physical restraint such as hand holding.

One person's risk assessment for monitoring epilepsy stated they had an epilepsy alert monitor attached to their bed. We asked the registered manager about this who said, "It's not a bed monitor it's a baby monitor." We asked the registered manager about a best interest decision in relation to this as it restricted the person's liberty as they were being monitored twenty four hours a day. The registered manager explained that they hadn't thought of that as it was ensuring someone's safety during the night.

Staff were asked whether they knew if people had authorised DoLS in place. A senior care staff member said, "Yes, I'm sure everyone does have a DoLS." We asked them how this impacted on the care they received. They said, "I don't have off hand knowledge of that but I know it's in best interests in the care plans" they added, "I'm sure the DoLS are for accessing the building."

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt supported and trained. One senior staff member said, "We do all the mandatory training, medication workbooks and autism awareness and mental capacity." Another staff member said, "There's good

support if you're injured at work." They added, "You can approach people with queries. Can discuss personal concerns if you need to. They are quite understanding, you can suggest training."

We saw a new starter was working through their induction workbook and had been allocated a mentor from the staff team. The induction included the people they supported, epilepsy and training, accident reporting, self-care and medicine management.

Staff had up to date appraisals which included personal achievements and goals; training; relationships with people; team working; use of initiative; motivation and knowledge of the aims of the organisation.

Staff were asked how they supported people whose behaviour may present as challenging. One staff member said, "We try to use diversion, so the things people like such as talking about the past or [person] likes us to use a different voice." They added, "We don't restrain on a daily basis." The registered manager said, "Self injurious behaviour; you can support physically by hand holding but they will slap anyway. Sometimes it's best to let them manifest." We asked staff how they managed self-injurious behaviour and one staff member said, "Sometimes we need to intervene so we might use full hand on arm restraint with verbal reassurances. Sometimes distraction works, it depends on their mood. They can go past the peak and then it takes time."

Another staff member described people's behaviour as, "Dangerous and destructive." This relates to the Lalemand behaviour scale which is a core document with NAPPI. It provides staff with an easy to use tool to identify, assess and respond to people's behaviour.

One person had a behaviour support plan which identified triggers for when the person may become anxious; it describes what the anxiety may look like in terms of the behaviour the person may display. The document then used the Lalemand behaviour scale to describe agitated behaviour, disruptive behaviour, destructive behaviour and dangerous behaviour. At each stage there was a description of the person's behaviour and instructions for staff to follow to ensure a consistent and safe response.

There was a four week menu in place which was kept on the inside of one of the kitchen cupboards so wasn't accessible for people. We asked if people had a choice of meals, one staff member said, "Oh yes, today there's sausage pasta, or sandwiches, chicken quarter pounders or I could do soup." We asked how people made this decision and were told "The staff ask people and they chose."

We spoke to the cook who said, "People don't have any specific dietary needs, no one has pureed foods or diabetes. One person does have their food cut up into quite small pieces." We asked why and they said, "I think due to them gagging at times." They added, "[person] doesn't like eggs but can eat them cooked in cakes and things." We saw that the person has an allergy to eggs but was able to eat them cooked.

We asked if people got involved in any cooking, we were told that some people did, such as making cakes or one person liked to chop fruit for fruit salad.

We did not witness anyone being offered a choice of meal and there was no pictorial information available for staff to use to support people to make a decision. When we suggested it may support and enable people to make a decision we were asked to explain how it might work.

People's care records included a section on what food they liked and disliked but we saw no evidence of how people had been supported to express their preferences.

Care records also included sections on health which included individual sheets for attending the dentist, chiropodist, doctor and opticians. Some of these records had recent entries but others didn't. We saw that one person had been prescribed adapted shoes to aid their walking but we saw that they were wearing sandals or no shoes at all. One staff member said, "Oh, they don't like wearing them."

One person had a seizure chart which had been developed between the registered manager and the person's family. This was used to record any seizures and was then used as a resource when attending six monthly appointments with the neurologist.

Another person's health information recorded that they suffer from a common, not serious but highly infectious skin infection. We noted there was no information about the condition, how to support the person with it or how it should be managed to prevent cross contamination.

People with autism may have sensory sensitivity which can include sight, sound, smell, touch and taste. Whilst we did not see any evidence of sensory assessments it was

Inadequate

Is the service effective?

recorded that one person was sensitive to touch and staff spoke of another person being sensitive to noise. Whilst the house was very big and people had large bedrooms with ensuite rooms which allowed them to have plenty of physical space around them there may be some benefits to the provider in researching autism friendly environments for people.

Requires improvement

Is the service caring?

Our findings

There were mixed views about the care people received. One person's relative said, "They care for [persons] needs very well." They added, "They do the best they can for individuals." Another relative said, "There are some very good staff," they added, "I don't think they know much about autism" and "Staff don't use [persons] preferred communication."

We completed an observation over lunch time and saw that people were supported on a one to one basis.

One person was sitting at a table with a member of staff just before lunch was served. They were asked if they wanted lunch and were asked to stop their activity. The staff member then left the table and went to answer the telephone. At this point a second staff member took over the support. This person had started eating their meal when the staff member got up and left the room, reappearing with an apron on which they supported the person to put on whilst they ate their meal. The staff member then noticed that the person's hair was loose so they left the room and went to get hair grips, putting this in at the dining room table. The person was then asked if they wanted a spoon as the staff member had noticed they were having difficulty with the fork.

We saw that this person had been assessed as at risk of choking and the risk assessment stated that they should have one to one support whilst eating.

We concluded that, due to a lack of preparation, the meal time experience was not positive for the individual and they did not receive support in an uninterrupted way.

Two other people were seated at a different table with one to one support. We observed little engagement and interaction between staff and the people they were supporting other than functional, task driven comments such as, "Are you finished", and "Is that nice." We observed staff engaged with each other and had conversations about eLearning, the world cup and their own home lives. We did not observe staff including people they were with in these conversations. Staff made comments like, "She loves salads doesn't she" and "She always eats everything of one type first." This was happening in front of the person whilst staff were sat with them.

One visitor was spending time with their relative in the communal lounge whilst everyone else was out. We observed that a member of staff stayed in the room with this relative during almost the full extent of their visit. We asked the visitor if they understood if there was a reason for this and they said, "I haven't asked for staff to stay, I have mentioned it before on a feedback form [residents survey] and I would like to spend time on my own with my [relative]."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also observed staff spending time with people before their evening meal. Again we observed that staff were chatting together. One person was sitting in their preferred chair watching TV or listening to staff chat and another person was asleep.

People's personal care was attended to in a discrete manner and we saw staff always knocked on doors before entering rooms. People were dressed nicely and we saw one staff member supporting someone with having their nails painted and having a pamper session.

Staff were not rushed and were observed to be spending all of their time with people. People were supported to go to an outside activity at least once a day, and staff said many people enjoyed to go out for walks or to the beach. The second day of inspection we saw staff chatting with people in a relaxed and engaged manner. There was a warm atmosphere and people were seen to be laughing and having fun with each other.

When staff needed to do any written work they sat at the table in the communal lounge with people while other staff members sat with people.

One staff member said, "We are a long standing team who know people well and understand people's communication. We use keywords or short sentences. People make their needs known to us." Another staff member said, "I connect well with people, we are of a similar age, I treat people like 'the lads'." They added, "Some people respond better to female staff but I connect with everyone here. Sometimes it doesn't feel like work, we do normal stuff, talk to people, go out places. I know peoples personality and what they mean and need. I try to cater for their needs as best I can."

Requires improvement

Is the service caring?

We asked whether people had advocates but were told that as peoples family members were actively involved in their care no one had an advocate at present. The registered manager said they had used Sunderland safeguarding in the past for advocacy services. We noted that one person's family had asked for an advocate but this hadn't been organised at the time of the inspection.

Requires improvement

Is the service responsive?

Our findings

During our scheduled inspection on 10, 16 and 17 September 2014 we found the provider was not meeting the standard in relation to care and treatment being planned and delivered in a way that was intended to ensure peoples safety and welfare. This was in relation to social activities; communication and training.

At the comprehensive inspection on 29 and 30 June 2015 we saw that a document called 'My Plan' was used for recording people's care records. This included specific sections such as 'about me,' 'communication,' 'sense,' and 'health.' Each section described the care the person needed from their point of view and information was written in the first person. There were associated risk assessments in the My Plan but these were not always effective (see safe section).

One person's 'Living my life' section included the specific routines they liked to follow with getting up, dressing and personal care and so on. We saw that the person used some specialised equipment but there was no specific care plan for staff to follow in relation to how to support the person. We asked the registered manager about this who said, "Staff have had a one to one supervision on how to use the [equipment]." This left the staff and the person vulnerable as they may not remember the detail and with no care plan to follow it may lead to inconsistent care and support which could place people at risk.

One person's communication section was detailed and described things the person liked to do and how staff should communicate with the person. It stated staff should use symbols or writing including PECs. PECs is a picture exchange communication system originally devised to teach people with autism the basic concept of communication, the system is built on established psychological principles (ABA – Applied Behaviour Analysis) which include shaping and reinforcement. The document also stated that the person had a velcro board for staff to put the PEC cards on to show the person what they would be doing for that part of the day. We asked staff and they were able to show us the cards which were very small but we were told that the person did not have a Velcro board and that staff just showed the person the cards.

It was also recorded that the person used Makaton. Makaton is a language programme using signs and symbols to help people to communicate. It is designed to support spoken language and the signs and symbols are used with speech, in spoken word order. This helps provide extra clues about what someone is saying. Using signs can help people who have limited or no speech or whose speech is unclear. Makaton is extremely flexible and people often personalise it based on their needs and motor skills so it is more accessible for them. We saw no evidence to show what the persons gestures meant so staff could staff use this as an aid to understanding and also use the same signs to communicate back.

We observed staff communicating with this person and noted they used verbal communication makaton and PEC cards. The registered manager said, "Everyone can understand and respond to verbal communication. Makaton isn't peoples preferred language as they respond to verbal communication." They went on to say, "Although those individuals were able to use makaton or PECs, staff continue to use verbal communication as this is also effective which is evident in the responses they receive from service users, such as the positive presentation of interaction and behaviour." They added, "Some individuals may need this to be reinforced using makaton and PECs as well."

We spoke with one person's care manager who said, "[Person] is able to understand verbal communication." They added, "The staff understood what [person] wanted and didn't want. They understand their needs without using PECS." We saw no evidence that the 'My Plan' section on communication had been updated to reflect this.

We saw there was a section on goal planning but this was empty. This meant there was no information on any goals or dreams people were being supported to achieve,

Another person's communication section detailed personalised information on how to speak with the person and how they would respond. There was very little information on how to offer choice of activity or meal for example. We did observe one member of staff ask the person if they wanted to set the table for the evening meal. The person nodded and followed the staff member to the kitchen then came out with the knives and forks to set the table so they had understood what was being said to them.

We did not see any specific section in the 'My Plan' which gave information related to the person's autism and how they related to the world, but there was some information

Is the service responsive?

on people's sensory needs throughout the My Plan. We saw that one person's plan stated they had sensory lights in the bedroom as they enjoyed watching the colours change. When we were shown the bedroom we could not see any. We did see some in someone else's room though. We asked the registered manager about this who seemed surprised and said, "They don't have any in their room." This means the 'my plan' had not been updated or was inaccurate.

One person's Lalemand behaviour scale stated that if they reached the destructive level of behaviour staff were to, 'explain the behaviour is bad, and reinforcing it with a makaton sign.' NAPPI includes the principles of positive behaviour support which is both positive and proactive. Positive means increasing and strengthening helpful behaviours through 'reinforcement' (not using punishment or negative consequences to reduce the challenge). Proactive means anticipating where things may go wrong and preventing that from happening rather than just reacting when things go wrong. Telling someone their behaviour is bad is not a positive approach.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were asked what autism meant for people. One staff member described it as, "A learning disability, it affects social interaction, communication and imagination, the triad of impairment. Routines and obsessions are important to people. They need structure and routine." Another staff member said, "It's a mental disability affecting social skills and communication. People have got to have a routine. It's a variation of a learning disability."

One person had an assessment that had been completed by an "enabling therapy service." This provided a detailed assessment in relation to the persons sensory needs and identified that the person was hypersensitive to touch and hearing. The assessment stated that the person 'required a structured daily routine.'

We asked staff about activities and they said people enjoyed to go swimming and to the sauna, go to the gym or for walks. One staff member said, "We have our own allotment between another Swanton house and Park Lodge and we grow our own veg. There's a swing there that [person supported] enjoys going on because it's usually quiet up there." Another staff member told us people had been to the theatre and to the cinema although this could be dependent on people's mood. We asked if people used the autism friendly cinema but they said no they used the 'normal' one which is why it was mood dependant. Staff may benefit from researching autism friendly activities and cinema screenings. An autism friendly cinema screening means the environment is adapted to the needs of people living with an autistic spectrum condition. This means the lighting will be on low and the noise is turned down, there are no trailers and people can move around and take their own food and drink into the cinema.

We saw one person sitting with a staff member whilst the staff member did some colouring in. We asked if the person should be involved in colouring in and were told that they liked staff to colour in whilst they watched. Staff asked the person which colour they should chose next and what part of the picture to colour in. this approach was recorded in the persons My Plan.

Weekly activities planners were in place in people's 'my plan and' were broken down into morning, afternoon and evening activities. We did not see any evidence of assessments of the activity in terms of whether people had enjoyed it or not so it was difficult to assess the value of the activities. People were seen to be spending time in their rooms, or engaging in the same activity in the house for long periods of time. Staff were completing activity sheets to record what activities people had engaged in that day but there may be benefit in recording what worked and what didn't work in these activities in order to further assess activities people may want to engage in.

We asked how people were involved in planning their care. The registered manager said, "No parents have sat down and been included in My Plan." They added, "Care plans are based on pre-assessment information and what we know about people. We use the parents and social worker assessment though. I know we need to look at more specific autism aims and outcomes for people."

At the back of each 'my plan', there was an annual review of people's care. We saw that the last reviews happened in April 2014. The registered manager said, "Annual reviews are held in service, sometimes care managers from out of the area come through." They added, "We try to just have one review so we match it up with the care manager's review."

A concerns, compliments and complaints file was in place. A complaint logging form was completed for each complaint, which had space to record the description of

Requires improvement

Is the service responsive?

the complaint, the person managing the complaint and the outcome. There was also space to record the commencement and completion of the complaints process. There was no log which gave an overall picture of all complaints received. There was a pro forma for the acknowledgement of complaints.

The complaints file recorded the last complaint as being received in 2012. The registered manager showed us another file which also included complaints. We saw a copy of the complainants letter and saw that they had been contacted however this was not recorded on the organisations complaints logging form and we saw no evidence that a complaints acknowledgement letter had been sent. All the information was handwritten on loose leafs of paper.

The complaints procedure that was currently being followed was titled Barchester Healthcare complaints procedure and was dated December 2011. This procedure states that all complaints should be logged and an acknowledgement letter sent within three days. Within 21 days the complainant should have a written outcome setting out the investigation undertaken, the outcome of the investigation and any actions taken to address issues. If the complainant remained unhappy it should be escalated to the regional operations director who should notify the complainant of their involvement in reviewing the complaint within 3 days. Within 21 working days a written outcome should be sent. We did not see any evidence of this in the service.

Inadequate

Is the service well-led?

Our findings

During our scheduled inspection on 10, 16 and 17 September 2014 we found the provider was not meeting the standard in relation to assessing and monitoring the quality of service provision. In particular, we found the provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

At the comprehensive inspection on 29 and 30 June 2015 we saw that feedback surveys had been sent to family members and team meetings were being held on a monthly basis.

We saw files containing a full range of Swanton policies which had implementation dates of 2013 and review dates in 2015. We asked the registered manager if they were the current policies. The registered manager explained they were currently following Barchester care policies and procedures as the Swanton policies were being updated and rolled out. This could lead to confusion and failure to follow the correct procedure as there were policy folders from both Barchester Care and Swanton Care. The registered manager said, "I'm sure they are pretty similar."

The registered manager told us they were in the process of transferring paperwork, including care records from the previous provider to the current provider of Swanton Care & Community. We asked when this change in organisation had happened and they told us 18 months – two years ago.

There were Swanton pro-forma audits in place for staff files; documentation; medicines and an infection prevention and control quality improvement audit but none of these had been completed.

We asked the registered manager what audits were currently being completed and they said, "We have a counter administration record for medicines and the shift leader checks it daily and does a MAR chart check."

We asked about care plan audits. The registered manager said, "They aren't done as effectively as they should be. They are kept in the care record." We saw no evidence of care plan audits during the inspection. We did see monthly evaluations of care records which consisted of a signature and a date. There was no record of any changes or updates. This was not an effective method of auditing care records as we saw that some information in people's files was out of date.

We asked the registered manager again about quality assurance and they said, "I've not had chance to do any audits yet." We asked whether any provider visits took place to complete audits and the registered manager said, "We don't do Reg 16 visits anymore and no audits have been completed as yet by senior managers but they will be done by the regional director." Regulation 16 visits used to be completed by providers as an audit of quality.

We asked the registered manager what the priorities were for the service. They said, "People's support and care plans come first; priority is the welfare of service users. If we get the care and well-being wrong it's more difficult to put things right."

A 'home development plan' for 2015 was in place but this referred to another Swanton Care and Community Service on two occasions. This was pointed out to the registered manager who confirmed that the plan was specific to Park Lodge. There were specific sections which directly related to the domains CQC inspects against. Areas for improvement had been identified such as room refurbishment under 'safe'. Under the effective section the improvements were in NAPPI training and behaviour profiles and training in communication. Under caring the improvements were detailed as training, supervision, monthly provider visits and collecting photo evidence of activities. Under responsive improvements included monitoring people on a daily basis and liaison to ensure people's needs were met. Well-led was in relation to developing an open and transparent culture; listening and making changes; and increasing staff confidence to make decisions with and for people.

We saw no actions in relation to the completion, update and transfer of information onto the new care records for people; there were no actions in relation to introducing the Swanton policies and procedures to the team, nor were there actions in relation to audit and quality assurance procedures. The registered manager said, "I know work is needed on My Plans and I know we need a process of audits."

The action plan did not detail who was responsible for making the changes and what the timeframe for

Is the service well-led?

completion was. There was no review of any actions to indicate if they had already been completed. We asked the registered manager about this who said, "It's my responsibility, there's no review of actions other than at the end of the year."

Relatives surveys had been completed and comments included 'recruiting more staff who were competent to drive the vehicles; that at times activities didn't happen due to staffing levels, that people enjoyed live music in local bars and swimming but it sometimes didn't happen; that a private space was needed to visit their relative with a sofa that was comfortable and not broken. There was also comment that some people were noisy and unpredictable; that someone had been assessed as needing a signing rich environment which wasn't available due to staff not being sufficiently trained and the communication was limited in relation to peoples self-harming behaviour.

These concerns had not been included on the home development plan. We asked whether an action plan had been put in place and the registered manager said, "It will be done with the regional director and then we'll respond to people." There was no time frame for this to be put into place.

Audits had not been completed and the service development plan had not identified the concerns noted during the inspection although the registered manager had acknowledged care records and audits were areas which needed to be improved. People were not protected against the risks of inappropriate or unsafe care because the quality of the service was not regularly and robustly assessed and monitored. This meant there was no effective system to assess, monitor and mitigate any risks in relation to the health, safety and welfare of people, nor was there a system to ensure an accurate and complete record in respect of the care and treatment provided to people

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A bedroom audit had been completed although there was no room recorded. This included infection control, health and safety and fire safety. Actions included that the bathroom floor needing replacing and the maintenance team had been informed and it had been documented in the maintenance file. We could not see the date that this had been completed.

A manager's monthly housekeeping audit had been completed in June 2015. This assessed the environment including the reception areas, visitor's toilet, bedrooms, lounge, corridor and stairwell. The service had been assessed as green scoring 101 out of 108.

The registered manager went on to show us a draft business plan template that was being rolled out by the organisation which included a SWOT analysis. A SWOT analysis assesses the strengths, weaknesses, opportunities and threats to service provision. There was also an action plan which assessed what is important, why it's important, how it will make a difference, the action that was needed, whose responsibility it was and the target date. This had not yet been completed for Park Lodge.

We asked the registered manager what it was about Park Lodge that made it a specialist service for people living with autism. They said, "The structure we offer, the environment, as people have lots of space, the training we offer, the continuity in staffing and the experience of staff." Staff confirmed that they also thought the staff team and the environment was what made Park Lodge a specialised service.

The registered manager said, "There is handover morning and afternoon. It's verbal but write it down if there's anything major." They added, "Meds keys are handed over, the daily diary and a list of tasks to do."

Team meetings were held on a monthly basis although there were no minutes available for Mays meeting. The set agenda was to discuss each person and staff could add any other business. Topics discussed included people's holidays and their food and nutritional needs.

Two surveys had been completed for relatives, one was an organisational survey and one had been instigated by the registered manager. The organisational friends and family survey for 2015 showed that families felt staff approachability was excellent, they felt they had a good level of involvement in care planning, that there were enough staff and that the choice of food and menus was good. Some relatives had commented that activities were good and met people's needs, others that people didn't always have the opportunity to attend activities or attend the activities that they enjoyed.

Inadequate

Is the service well-led?

The survey completed by the registered manager had been done so in December 2014 all the comments were positive other than one with regard to activities not happening often enough but it was also recorded hat the relative appreciated it was being looked into.

We asked the registered manager whether they held resident and relatives meetings and they said, “Only at reviews. There is a suggestion that every quarter we hold an open forum but we don’t do anything other than reviews at the minute.” People’s relatives told us they felt involved in people’s care and were sure that if there were any care records they wanted to see they would be able to do so.

We asked how the team remained up to date with new developments and best practice. The registered manager explained they received regular publications such as Caring Times and Caring UK. They also received regular press releases with articles about current and new legislative practice and organisational developments.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People's care and support was not always delivered in a person centred and respectful way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider did not fully understand the principles of MCA and best interest decisions in seeking people's consent

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider was not meeting its own requirements in relation to training and supervision which meant the competency of staff was not being assessed and monitored.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The assessment of risks to the health and safety of service users was not robustly managed. Care plans were not effective in meeting people's current needs.

The enforcement action we took:
A warning notice was issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective systems in place to assess, monitor and improve the quality and safety of the services provided.

The enforcement action we took:
A warning notice was issued.