National Autistic Society (The)

NAS Community Services (Bath & North East Somerset)

Inspection report

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13 October 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an inspection on 12 and 13 October 2016. The inspection was announced, which meant the provider knew we would be visiting. This is because we wanted to make sure the provider, or someone who could act on their behalf, would be available to support the inspection. When the service was last inspected in January 2014 there were no breaches of the legal requirements identified.

NAS (National Autistic Society) Community Services (Bath and North East Somerset) provides care to people who have autism and other complex needs. The service enables people to live independently in their own home. At the time of our inspection the service was providing support to 13 people at Cambrook House and Willow House. One person was provided with twenty four hour support in their own home. They also provided an outreach service to 12 people.

A registered manager was not in post at the time of inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are "registered persons". Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service has experienced difficulties throughout the past 12 months as a result of recruitment problems. During this period they have been unsuccessful in appointing a manager to oversee Cambrook House. CQC have recently received a registered manager's application to oversee Willow House and the outreach service. According to the deputy area manager, the manager recruitment problems have resulted in some weakness, inconsistency and instability within the service. The staff did not feel well supported by the management team. The majority of relatives we spoke with raised concerns about the managers and the level of support provided to their relatives.

There were risk assessments in place for people covering various aspects of their support. Risk assessments had not always been reviewed at the timescale required. One person had a risk assessment in place for epilepsy. Their risk assessment had not been up-dated to reflect their changing needs.

Staffing levels were not sufficient to meet people's needs. We reviewed the August 2016 staffing rota. Against a commissioned total of 919 hours the service delivered 858 hours. Although the service had undergone an on-going recruitment drive they had been unsuccessful in appointing the required number of staff.

Staff members did not consistently receive regular training and supervision to enable them to carry out their duties. We reviewed the training records which showed people had not received all the necessary mandatory training as part of their induction programme.

We receive mixed comments regarding the staff and the service. Comments included; "I think they're fantastic. He's developed some lovely relationships with staff. They try to give him as much independence as possible". Other comments included; "Staff support is varied and not consistent. Some are very good. There

is not enough of them"; and "I think the care is insufficient. She's quite happy with it. I don't think they're engaging with her properly. The support is dis-jointed."

Good relationships had been established between staff and the people they provided care for. We observed positive interactions during our time at the service.

People's rights were upheld in line with the Mental Capacity Act (MCA) 2005. This is a legal framework to protect people who are unable to make certain decisions themselves.

People were supported to maintain good health and had access to external health care professionals when required. People's care records demonstrated that their healthcare needs had been assessed and were kept under review.

People were protected against the risks associated with medicines because there were appropriate arrangements in place to manage medicines.

Care records were personalised and described how people preferred to be supported. A care plan was written and agreed with individuals and other interested parties, as appropriate. There was information in people's files to describe the individual ways in which they liked to be supported.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 had not always been reviewed regularly.

Staffing levels were not sufficient to meet people's needs.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff members did not consistently receive regular training and supervision to enable them to carry out their duties.

People's rights were upheld in accordance with the Mental Capacity Act 2005.

People were supported to maintain good health and had access to external health care professionals when required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We receive mixed comments regarding the staff and the service.

Some relatives felt their relative's needs were not sufficiently met by the staff team such as encouraging people to be more active, engage in more activities and improve their diet.

Staff understood people's needs and demonstrated they knew how people preferred to be cared for.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Relatives in the main did not feel the service was responsive to their relative's needs, particularly regarding the activities programme.

Some relatives told us they did not feel listened to and their formal complaints had not been responded to.

Care records were personalised and described how people preferred to be supported.

Is the service well-led?

Requires Improvement

The service was not well-led.

There was not a registered manager in post.

The service had a programme of quality assurance audits and had identified some of the shortfalls found at this inspection. However, the provider had not improved the quality of the service by taking appropriate action to make improvements in a timely manner.

Staff did not feel well-supported by their managers.

NAS Community Services (Bath & North East Somerset)

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 12 and 13 October 2016. The inspection was announced, which meant the provider knew we would be visiting. This is because we wanted to make sure the provider, or someone who could act on their behalf, would be available to support the inspection. When the service was last inspected in January 2014 there were no breaches of the legal requirements identified. This inspection was carried out by two inspectors.

Before the inspection we sent a questionnaire to: staff members; people who used the service; relatives and friends; and community professionals. The response rate from the groups was 27.3% or less. The sample sizes are considered too small in isolation to make decisions on the quality of care but were used to inform our lines of enquiry on the inspection.

On the day of the inspection and the following day we spoke with six relatives. We received written correspondence from two relatives and one person who used the service. We briefly met two people in the communal area of Cambrook House. We also spoke with four members of staff, the manager at Willow House, the interim manager at Cambrook House and the south west deputy area manager.

We looked at three people's care and support records. We also looked at records relating to the management of the service such as the daily records, policies, complaints, recruitment and training records.

Requires Improvement

Is the service safe?

Our findings

Risk assessments relating to the safety of people were not completed and reviewed regularly. There were risk assessments in place for people covering various aspects of their support. These included assessments for specific tasks such as trampolining, swimming and being out in the community. We saw that these risk assessments had not always been reviewed at the timescale required. For example, the risk assessment relating to use of the trampoline was written in 2010. It had been reviewed at various times but the last occasion was in January 2016 and there was a gap where the next review should have been recorded in May 2016. A recent care plan audit conducted by the deputy manager at Cambrook House identified that the risk assessments for one person all required a review.

One person had a risk assessment in place for epilepsy. The support plan for epilepsy in their health file was not completed but referred staff to the risk assessment. The last review of the epilepsy risk assessment was in January 2016. Further information in the file recorded how medication for this person was being withdrawn and therefore there was potential for the person to experience seizures. The risk assessment had not been updated following this. This meant this person was at risk because staff did not have clear and detailed information to follow in the risk assessment.

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

Staffing levels were not sufficient to meet people's needs. We reviewed the August 2016 staffing rota. Against a commissioned total of 919 hours the service delivered 858 hours. Although the service had undergone an on-going recruitment drive they had been unsuccessful in appointing the required number of staff. This has led to a failure to provide their commissioned contractual agreed hours with the local authority. There was a heavy reliance on agency staff. In the main staff and parents we spoke with thought staffing levels were insufficient to meet people's needs. One relative told us: "The support my son has recently been receiving has been compromised because of the inconsistency of care due to staff shortages and routine use of agency workers and staff not familiar with him and his particular needs."

One person told us that they were told at very short notice regarding staffing changes and had experienced no staff turning up at all. A health professional advised; "NAS have had difficulties recruiting and retaining experienced staff." The deputy area manager confirmed that the service was not contractually compliant to provide the hours they were commissioned for. The deputy area manager told us that the service is going to review their model of care with the commissioning local authority.

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

We checked the files of five of the most recently recruited members of staff. In each of the files we saw that references had been sought and a Disclosure and Barring Service (DBS) check carried out. A DBS check identified people who have been barred from working with vulnerable adults and children, as well as giving

information about any convictions a person might have. In one person's file we saw that there was information contained on their DBS disclosure that required further consideration. The recruitment decision was referred to a senior member of staff within the organisation and a decision made to employ the person but with 'robust monitoring' during the probation period.

Staff demonstrated a good understanding of abuse and knew the correct action to take if they were concerned about a person being at risk. In the main staff had received training in safeguarding adults. Staff told us they felt confident to speak directly with their manager. Staff understood the term "whistleblowing". This is a process for staff to raise concerns about potential poor practice in the workplace. The provider had a policy in place to support people who wished to raise concerns in this way.

People were protected against the risks associated with medicines because there were appropriate arrangements in place to manage medicines. Appropriate arrangements were in place in relation to obtaining medicines. Medicines were checked into the home and were recorded appropriately.

People's medicines were managed and received by people safely. People were receiving their medicines in line with their prescriptions. The training matrix identified that the majority of staff had completed medication awareness training. We were told by the deputy area manager that some people must have Midazolam trained staff with them and this was provided by the service. There were suitable arrangements for the storage of medicines in the home and medicine administration records for people had been completed accurately. We saw that PRN medication plans were in place. PRN medication is a medication that is taken only when needed. Care plans identified the medication and the reason why this may be needed at certain times for the individual.

People had personal evacuation plans in place in case of emergency in the accommodation. These described the support that the person would require in order to evacuate safely.

The provider had appropriate arrangements for reporting and reviewing incidents and accidents. The managers had access to a spreadsheet which recorded all incidents. This enabled them to identify any particular trends or lessons to be learnt. Where needed they could refer identified trends to a behavioural support team to analyse and take forward.

Requires Improvement

Is the service effective?

Our findings

Staff members did not consistently receive regular training and supervision to enable them to carry out their duties. We reviewed the training records which showed people had not received all the mandatory training as part of their induction programme. This meant that the service had not ensured that staff had completed an induction programme which sufficiently prepared them for their role. We were told by the deputy area manager that the training manager would liaise with the managers to coordinate, as a priority, those who had not completed mandatory training.

Staff did not receive regular supervision and did not follow the principles of their own supervision policy. Supervision is where staff meet one to one with their line manager. Following a DBS check It was identified that one person required 'robust monitoring' during their probation period. This decision had been documented and a copy of the decision kept on the person's file. However, when we looked at this person's supervision record we saw that the probation review document had not been completed and there was only one supervision record. The supervision record made no mention of the issue raised on the DBS form. The person had not received robust monitoring in line with the recommendation on the recruitment decision and this meant there was a risk that people were being supported by an individual who had not received effective supervision as identified during their recruitment.

We also found a further member of staff whose probationary period documentation had not been completed. They had begun employment in November 2015 and only one supervision had been recorded in March 2016. This was a discussion about a specific incident that had occurred and not a full discussion about their overall performance. Conducting regular supervisions would ensure that staff competence levels were maintained to the expected standard and training needs were acted upon.

Some relatives told us that they did not believe that all staff were sufficiently trained to undertake their role. This was supported by the records seen. One relative told us; "Most are well-meaning but they're not equipped to deal with agitation."

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

People's rights were upheld in line with the Mental Capacity Act (MCA) 2005. This is a legal framework to protect people who are unable to make certain decisions themselves. Although staff training on the MCA required up-dating there was evidence that staff understood and followed the principles of the Act. For example, there was an individual who required particular measures to ensure their safety whilst outside of the home. A mental capacity assessment had been carried out on the person to assess their ability to consent to these measures. Following this a best interest decision had been documented. Relevant professionals had been involved in the decision, including the person's social worker and staff working with the individual. For another individual we saw that a best interest's decision had been completed in relation to a medical procedure that needed to be completed. This meant that people's rights were protected in line with the MCA.

People's nutrition and hydration needs were met. People had enough to eat and drink to keep them healthy. People were involved in choosing their own menus, food preparation and cooking. People's preferences for food were identified in their support plans. One person had expressed concerns that staff did not always check their food and this has resulted in food becoming mouldy. One relative did express concerns about their relative's poor diet. The relative felt the person could be more proactively encouraged with their food preparation and diet.

People were supported to maintain good health and had access to external health care professionals when required. People's care records demonstrated that their healthcare needs had been assessed and were kept under review. There was a health action plan in place for each person that recorded their health needs and any guidance or appointments relating to healthcare professionals. One relative did not feel that their relative had been sufficiently supported to attend their health appointments.

Requires Improvement

Is the service caring?

Our findings

We receive mixed comments regarding the staff and the service. Comments included; "I think they're fantastic. He's developed some lovely relationships with staff. They try to give him as much independence as possible." Other comments included; "Staff support is varied and not consistent. Some are very good. There are not enough of them"; "I think the care is insufficient. She's quite happy with it. I don't think they're engaging with her properly. The support is dis-jointed"; "Most are well-meaning. They give the impression that they care. There are occasional staff that have been incredibly good but they have left"; and "Some staff go above and beyond in communicating and ensuring there is the best possible care, while others seem to have such a laxidasical attitude, which appears to be allowed." Some relatives felt their relative's needs were not sufficiently met by the staff team such as encouraging people to be more active, engage in more activities and improve their diet.

The staff we spoke with felt that staffing levels were not enough and at times this affected staff morale. However, they were committed to their role and the people they support. Good relationships had been established between staff and the people they provided care for. We observed positive interactions during our time at the service. Staff communicated with people in a meaningful way, taking an active interest in what people were doing, suggesting plans for the day and asking how people were feeling. Staff offered support to people with their plans. They took people out, helped with chores and spent one to one time with people.

Staff demonstrated they had a good understanding of people's individual needs and told us they understood people's preferences. Staff were knowledgeable about people's different behaviours and specific needs. One member of staff told us of the de-escalation techniques utilised when one person expressed challenging behaviour. They advised that the person is: "high functioning. He can cook well. Today is a free day and he has a packed lunch and went on a boat trip. He needs to keep active."

People were encouraged to make their own choices. For example we saw that one person had been involved in choosing the date of their planning meeting and who they wished to attend. They were encouraged to do this by being shown photographs of staff. This person was also supported to choose what food they wanted at their meeting. It was recorded that the person had attended their meeting and interacted well with everyone. This ensured that the person could express their views and were listened to.

There was also evidence that people were supported to be independent where possible. For one person we read the various ways in which they needed support to complete everyday tasks such as making and changing the bed, using the washing machine and cooking. One relative felt that their relative was not sufficiently supported. They told us that their clothes were not clean and they didn't assist with issues such as body odour.

People's privacy and dignity in the main was maintained. Staff respected people's personal care routines and choices. One member of staff told us; "[Person's name] needs help with personal care. We help with pads, showering and washing. We try and help him to be independent." One person did express a concern

regarding the personal care received. Their care plan meeting notes state; "I need a lot more reminders to wash and make sure my body and hair are clean and don't smell." Staff enabled people to undertake tasks themselves, such as food preparation and conducting household chores. People's personal space was respected. One member of staff told us; "[Person's name] won't eat when I'm in the flat."

Requires Improvement

Is the service responsive?

Our findings

Care records were personalised and described how people preferred to be supported. A care plan was written and agreed with individuals and other interested parties, as appropriate. There was information in people's files to describe the individual ways in which they liked to be supported. For example, their preferred routines were described, their particular ways of communicating and what support they required with their medicines. This information helped staff to support people in a person centred way. There was also information about people's lives prior to them receiving support from the service

Where people demonstrated behaviours that challenged, there were plans in place to support the person. These plans outlined the potential triggers for particular behaviours and gave guidance to staff on how best to provide support. For example, for one person it was important to use short simple sentences when interacting with them. A 'distractor bag' containing favoured items could also be used to divert the person's attention. We also saw clear information about the way in which people communicated and whether they were able to follow verbal instructions. For example we read that one person would tap an item to request it. We observed one person interacted with a member of staff by asking a series of questions. The member of staff answered them and following this another member of staff explained that for this person it was important that their questions were answered in a particular way. This was an example of staff understanding the individual needs of the person.

Recording systems were in place to detail events when a person had experienced behaviour that challenged. Staff recorded what situation had led to the behaviour and what had been done to support the person. This gave opportunity for staff to reflect on how effective their support was when managing particular behaviours.

Although involved in care planning meetings relatives in the main did not feel the service was responsive to their relative's needs, particularly regarding people's activities programme. One relative told us that they went to a care planning meeting in March and they had received no feedback until September. Comments included; "Care plans are not always followed and there is a big attitude of 'make-do' rather than what is person-centred"; [Person's name] spends long periods of time in his flat. He has become de-skilled"; "The nurse said it would be useful with consistent team support and no agency. For [person's name] there are too many faces. He likes music, horse-riding, swimming and the city farm. They don't seem to have the skills to get him out. [Person's name} does not have consistent support and is not as active. There is no analysis of why he doesn't want to go out. They're not trying different strategies"; "It has not been a happy experience. There is no person-centred element of what [person's name] wants to do. There is a complete lack of consistency." One person told us; "At the beginning when I was about to move in I was assured there would be social activities, so far there has been rare activities."

One relative spoke very highly of the service provided to their relative. They told us; "He engages in meaningful activities such as music, Bath city farm, trampolining and art club. They take him clothes shopping and enabling him and trying to develop his independent living skills."

It was difficult to establish whether the provider's complaints protocol was being followed. No information was held on their complaints folder. The deputy area manager told us that they would ensure that a revised complaints/compliments file is actioned to include a front page index; date received, reference number, date responded, actions, additional comments and when complaint was closed. Some relatives told us they did not feel listened to and their formal complaints had not been responded to. The deputy area manager told us that they held numerous logged emails evidencing concerns and their responses to them.

Requires Improvement

Is the service well-led?

Our findings

The service has experienced difficulties throughout the past 12 months as a result of recruitment problems. During this period they had been unsuccessful in appointing a manager to oversee Cambrook House. CQC have recently received a registered manager's application to oversee Willow House and the outreach service. According to the deputy area manager the manager recruitment problems have resulted in some weakness, inconsistency and instability within the service. This had resulted in areas of the service requiring improvement. Adequate staffing levels had not been maintained. Risk assessments have had not been kept up-to-date to ensure people's needs were met. Staff members did not consistently receive regular training and supervision to enable them to carry out their duties. Staff and relatives did not feel listened to. Relatives did not feel their relative's needs were consistently met. The service had a programme of quality assurance audits and had identified some of the shortfalls found at this inspection. However, the provider had not improved the quality of the service by taking appropriate action to make improvements in a timely manner. We were told by the deputy area manager that this has largely been due to a lack of a consistent leader in post.

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

The staff did not feel well supported by the management team. One member of staff told us; "The staffing levels are not enough. Although the staff team are amazing and committed there has been increased sickness and there is low morale. There is not enough support from the manager. We would like continuity." Staff did not receive regular supervision and staff meetings were not held regularly. This meant that staff were not kept up-to date with issues surrounding the service.

The majority of relatives raised issues about the managers and the level of support provided to their relatives. Concerns included; Poor Management practices; Inadequate communication with staff and other partner agencies; management turnover; and inadequate staffing levels affecting support provided. One relative told us; "The local authority are well aware that the service is non-compliant in terms of delivery of the contract that is in place. The parents of the young people in Cambrook House have made strenuous efforts to work with NAS over a number of years but we have usually been side-lined and frustrated in our efforts." We were told that some relatives are intending to take their relatives out of the service. The deputy area manager told us that they are working hard with the commissioning local authority to resolve the issues of concern and are in the preliminary stages of reviewing their model of care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments relating to the safety of people were not completed and reviewed regularly. Staff did not consistently have clear and detailed information to follow in the risk assessment.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had inadequate systems in place to improve the quality and safety of the service.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels were not sufficient to meet people's needs. Staff did not consistently receive regular training and supervision to enable them to carry out their duties.