Spectrum (Devon and Cornwall Autistic Community Trust)

Chylidn

Inspection report

Valley Lane
Carnon Downs
Truro
Cornwall
TR3 6LP

Tel: 01872863900
Website: www.spectrumasd.org

Date of inspection visit:
02 December 2015

Date of publication:
05 February 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Chylidn on 2 December 2015, the inspection was unannounced. The service was last inspected in January 2014, we had no concerns at that time.

Chylidn provides care and accommodation for up to five people who have autistic spectrum disorders. At the time of the inspection five people were living at the service.

The registered manager had stepped down from the position the day before our inspection visit. 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 was being run by the deputy manager with the support of the divisional manager. The divisional manager told us they would be making arrangements to fill the role in the near future. The deputy manager had a good knowledge of the service and people's needs.

This inspection was brought forward in response to information the Commission had received regarding staffing levels at Chylidn. On the day of the inspection we found there were sufficient staff on duty to support people to take part in individual activities. Although new staff had recently been recruited more experienced staff had left the organisation. This meant people with complex needs were being supported by an inexperienced team who lacked a comprehensive understanding of people's needs. New employees were sometimes shadowing care workers with limited experience. There was no robust system of supervision or staff meetings in place to help ensure staff received the support necessary to fulfil their roles.

People living at the service had complex needs and these sometimes impacted negatively on each other. While this had been identified and strategies put in place to minimise the effect on people this had not prevented the incidents occurring. People's autonomy within the service was affected as they were unable to access shared areas of the home as and when they wanted.

Recruitment practices helped ensure staff working in the home were fit and appropriate to work in the care sector. Staff had received training in how to recognise and report abuse, and all were confident any concerns would be taken seriously.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Mental capacity assessments and best interest meetings had taken place when necessary and were recorded as required. Staff had received training in the Mental Capacity Act (2005) and associated Deprivation of Liberty Safeguards (DoLS).

Systems to record changes in people's support needs and communicate them across the staff team were

not robust. A recommendation by an external healthcare professional that one person visit a GP had not been recorded in the communication book. As a result the appointment had not been made leading to deterioration in the person's health. Daily logs intended to record details of the care and support given to individuals contained gaps.

Staff were caring and respectful in their approach to people. They demonstrated a concern for people's well-being and reassured anyone who became distressed or anxious. Throughout the inspection visit staff checked that people were happy to talk with us or show us their rooms.

We found 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 this 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 entirely safe. Due to their conflicting needs people were not able to access communal areas freely and as and when they wanted.

There were sufficient numbers of suitably qualified staff to keep people safe.

People were protected by safe and robust recruitment practices

Is the service effective?

Requires Improvement

The service was not entirely effective. Staff did not receive the appropriate support to enable them to carry out their duties effectively.

The service acted in accordance with the legal requirements of the Mental Capacity Act and associated Deprivation of Liberty Safeguards.

People were supported to eat varied and healthy diets.

Is the service caring?

Good

The service was caring. People were at ease and comfortable with staff.

Staff reassured people calmly when they became anxious or distressed.

People's personal tastes were recognised and respected.

Is the service responsive?

Requires Improvement

The service was not entirely responsive. Systems to record information about people's changing needs were not robust.

People took part in a range of activities and were supported to access the local community.

There was a satisfactory complaints procedure in place

Is the service well-led?

Requires Improvement

The service was not entirely well-led. Some records were out of date or lacking in detail.

The registered manager had recently stepped down from their role. However the deputy manager demonstrated a good working knowledge of the service.

There were a range of quality checks and audits in place to help ensure the safety of the environment.

Chylidn

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 2 December 2015 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we reviewed previous inspection reports and other information we held about the home including any notifications. A notification is information about important events which the service is required to send us by law.

Due to people's health care needs we were not able to verbally communicate with people who lived at the service in order to find out their experience of the care and support they received. Instead we observed staff interactions with people. We met with four people, spoke with the deputy manager, divisional manager, a visiting relative and four care workers. Following the inspection we contacted three relatives and two external health care professionals to hear their views of the service.

We looked at detailed care records for three individuals, three staff files and other records relating to the running of the service including staff rotas and people's daily logs.

Requires Improvement

Is the service safe?

Our findings

People living at Chylidn had limited verbal communication. We did spend some time talking with people and observed the care and support being provided to them. We saw they were at ease with staff. Relatives told us they believed their family members were safe at the service.

Sometimes people could become anxious or distressed which could lead to them behaving in a way which could challenge staff or others. It had been identified that one person's needs and behaviour could impact on others. Their personal space was important to them and they could become agitated when other people were present. We saw recorded in incident sheets for November 2015 that; "[X] has been shouting at other service users nearly every day for the past few weeks." We were told these behaviours had been less frequent when fewer people lived at Chylidn but they had increased once the service was fully occupied. This showed X was more prone to anxious behaviours in a busier environment. Strategies had been put in place to protect people from the risk of being shouted at which could have a negative impact on their emotional and psychological welfare. For example staff ensured people were not using the same room at the same time as X when they were agitated. In addition two lounge spaces were available to use during the daytime to allow people choice and prevent them feeling they had to stay in their bedrooms to avoid X. During the inspection we observed one person coming into the office to wait until X had moved through the building in order avoid meeting them. Staff relayed to the person when it was alright for them to go downstairs to the shared living, dining and kitchen areas. This demonstrated people's autonomy within the premises was restricted as they did not feel comfortable or safe to access all areas of the building at all times. Although the risk to people's perceived safety, well-being and autonomy had been identified the actions taken to mitigate this were not sufficient.

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

Facilities were available to help ensure the safe storage of people's medicines. Care records contained detailed information about people's medicines and how they needed and preferred them to be administered. We checked two people's Medicines Administration Records (MAR) and found the amount of medicines recorded tallied with those held in stock. Some MARs entries were handwritten (known as transcribed). These should have been signed by two people as a safeguard. Some of the entries had no signature against them and some only one. There was a dedicated fridge available for those medicines which required refrigeration. A thermometer was in the fridge to allow staff to check the temperature was safe. We asked to see a record of temperature checks to ascertain if the fridge was working properly. However the deputy manager could not locate it. This meant we could not establish if the temperature was being regularly checked or if the fridge was in good working order.

Before the inspection the Care Quality Commission (CQC) had received information about staffing numbers at Chylidn being low and that this was, at times, putting the people that used the service and staff at risk. On the day of the inspection there were sufficient numbers of staff on duty to support people to go out on individual activities, attend appointments and engage in daily chores and routines. We looked at rotas for

November and saw the minimum staffing levels were met. We also saw support grids which showed which staff were supporting which people on any given day and people's individual daily logs. These showed throughout November, people had attended activities in the community with the support of two members of staff on most days. Staff and management told us staffing levels had been low in recent months across the organisation. However, everyone said things had improved recently following an on-going recruitment drive. The deputy manager assured us staffing had never fallen to a level which meant people were unsafe. Relatives told us they believed there were enough staff and their family members had access to regular activities in the local community.

Recruitment processes were robust; all appropriate pre-employment checks were completed before new employees began work. For example Disclosure and Barring checks were completed and references were followed up.

Care plans outlined the process to follow when people's behaviour challenged staff or others. This included information about possible triggers that might result in people developing anxiety and how to recognise when people were becoming distressed. Staff told us they were confident supporting people in any situation. Behavioural review sheets were completed following any incident. These were analysed on a monthly basis in order to highlight any trends.

People were protected from the risk of abuse because staff had received training to help them identify possible signs of abuse and knew what action they should take. Staff told us if they had any concerns they would report them to the registered manager and were confident they would be followed up appropriately. They were aware of the management hierarchy and how they would escalate concerns if necessary. Flyers and posters in the office displayed details of the local authority safeguarding teams and the action to take when abuse was suspected. This information was freely available to staff and visitors to the service.

People's monies were stored securely and only a limited number of staff had access to it. Records of expenditure were kept and audited daily by the deputy manager. In addition an external audit was completed monthly by Spectrum's finance team.

Requires Improvement

Is the service effective?

Our findings

Several experienced members of staff had recently left the service and half of the full time staff had only been in post for a year or less. Three had only started the week prior to the inspection and were still working through their induction. A relative told us; "You quite often see a new face." We discussed the reasons for the most recent staff departures with the deputy manager. They told us two people had left to work at other Spectrum services, one had decided to leave the caring sector altogether, one was on maternity leave and one had moved out of the county. People living at Chylidn had complex needs and the deputy manager and staff told us it took time to get to know them well. One member of staff commented; "It's been tough over the last couple of months with a lot of new staff……they have to learn a lot quickly." An external healthcare professional told us they had found the experience of the staff team to be; "mixed."

New staff were required to complete an induction process consisting of a mix of training and shadowing more experienced staff. Due to the newness of many of the team this was sometimes difficult to organise. On the day of the inspection a new employee was shadowing someone who had only worked in the care sector for approximately four months and was therefore not yet significantly experienced in delivering care for people with complex needs.

Supervision records showed not all staff were receiving supervision regularly. Staff meetings were also infrequent and the last scheduled meeting had been cancelled. It is important there are systems in place to help ensure staff are well supported and have an opportunity to discuss any working practice concerns or training requirements. This is particularly relevant when supporting new staff.

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

Training identified as necessary for the service was updated regularly. Staff also had training specific to people's needs such as autism awareness. The induction process had recently been updated to include the new Care Certificate. Staff told us they were happy with the amount of training they received and found it relevant. One commented; "It's very good, quite extensive and the trainer really knows his stuff."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. One person required constant monitoring due to their health needs. Mental capacity

assessments and best interest meetings had taken place and were recorded as required. Best interest meetings involved staff, families and external professionals where necessary. Equipment was used to monitor the person at times and there were clear protocols in place for its use. Staff had received training in the Mental Capacity Act (2005) and associated Deprivation of Liberty Safeguards (DoLS).

People ate varied and healthy diets and everyone was involved in menu planning for the week. Care plans recorded people's preferences and dislikes as well as other relevant information. For example one person's care documentation stated; "I make all my meal choices but sometimes I may eat too much so please support me in the kitchen area."

People were supported to access other health care professionals, for example GP's, opticians and dentists. In addition people were able to meet with more specialised healthcare professionals according to their needs such as speech and language therapists. When people needed additional support to attend appointments due to their anxieties this was recorded to help staff support people effectively. Following the inspection visit we received information from the divisional manager regarding a complaint made by a relative. This was in respect of a recommendation by a visiting healthcare professional that one person should see a GP. This had not been acted on resulting in a further deterioration in their health.

Good

Is the service caring?

Our findings

We spent time observing how people spent their day and the care and support provided. Some people were able to talk with us but most people had limited verbal communication. People were relaxed and comfortable around staff. We heard staff speaking with people in a friendly manner offering reassurance when necessary. For example, one person became agitated and a member of staff went over to them and answered their query and then supported them to change the subject before they became fixated on it. This support was in line with what was in the person's care plan. A relative told us; "I've not yet met a member of staff who doesn't smile."

Care plans contained detailed information in relation to how staff should communicate with people generally. For example; "I prefer to initiate communication." There was information regarding what might indicate when someone was distressed and how to support them and recognise any triggers. There was also guidance for how to engage effectively with people, for example how to respond to someone and help them to move on if they started to repeat a phrase continually. A member of staff told us it was important to; "break the communication barriers."

People's privacy and dignity was protected. Staff asked people if they were happy to show us their rooms. One person refused and this was respected. Staff explained how another person took time to get to know new staff and preferred to approach them rather than have them entering their personal living area. They explained how they respected this preference and let the person build trusting relationships at their own pace to help ensure they were comfortable with whoever was supporting them.

Care plans included personal histories and information about people's backgrounds. This meant staff were able to gain an understanding of past events which may have contributed to who people were today. There were also sections to record people's beliefs and values. One person was very proud of their Cornish background and this was documented. Care plans also outlined what daily tasks people were able to do and what they would need support with. This demonstrated people were supported to develop independent living skills.

People's personal tastes were recognised and respected. People's rooms were highly individualised and decorated to reflect their interests and hobbies. One person particularly enjoyed decorating their room at Christmas time. They had been supported to do this by staff and their family. A relative told us their family member had a strong sense of individual style. Staff supported them to choose their clothes to reflect this on regular shopping trips.

We saw staff responded promptly and with compassion when one person became unwell. They were calm in their approach and spoke gently to the person while administering care. Actions were taken swiftly and arrangements made to check the person's well-being at the local hospital. Although the atmosphere was calm and unhurried the response was appropriate and expedient.

Requires Improvement

Is the service responsive?

Our findings

People's care plans were detailed and informative, outlining their background, preferences, communication and support needs. Where certain routines were important to people these were broken down and clearly described, so staff were able to support people to complete the routine in the way they wanted. Parts of the care plan were in easy read format to help facilitate people's understanding of them. For example one page profiles used photographs and limited text to outline what was important to and for people. Care plans were regularly updated. A new member of staff told us they found the care plans; "useful."

Daily logs were required to be completed throughout the day for each individual. These were used to record any changes in people's needs as well as information regarding appointments and activities attended and people's emotional well-being. In addition there was a communication book to record more general information which needed to be shared amongst the team. There was no system in place for a formal verbal handover between shifts which meant it was important staff read the logs and communication book in order to keep up to date with any changes. We reviewed the daily logs and noted there were a number of gaps in the records and some of the entries were lacking in detail. The communication book was used for general information and it would not have been appropriate to record personal information in this way as it was in a communal area which everyone had access to. These two factors meant information may not have been recorded as required. As reported in 'Effective', in one case an appointment to see a GP had not been made as recommended by a visiting healthcare professional as the advice had not been recorded anywhere. This had resulted in the person's health further deteriorating. An external healthcare professional told us there was; "a lack of paperwork" within the service.

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

People were supported to take part in a range of pursuits which were meaningful to them and reflected their individual interests. Throughout the inspection visit people were coming and going from the service. Some activities were regular such as visits home and to college. Others were more spontaneous such as local walks, visits to coffee shops and shopping trips. One person developed their own rota on a weekly basis and staff supported them to take part in the activities they had chosen. The deputy manager told us this was something they used to do for the person until they had gradually developed the skills to do this alone. Staff told us people were well known in the local community. One person played in the local bowling league and used the swimming pool and snooker hall regularly.

There was a satisfactory complaints procedure in place which gave the details of relevant contacts and outlined the time scale within which people should have their complaint responded to. There was a complaint from the previous year recorded in the complaints log which stated the complaint had been resolved. However the record was not dated and so we were unable to establish if this had been completed within the appropriate time frame.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had decided to step down from the role the day before the inspection. The service was being managed by the deputy manager with the support of the divisional manager. The deputy manager demonstrated a sound working knowledge of the systems in place and the organisation of the service. Apart from records of the medicines fridge temperature checks they were able to locate all the documents we asked for in a timely fashion. However the deputy manager was due to take some planned leave in the near future. The divisional manager told us they would be overseeing the service until permanent arrangements for the management of Chylidn had been put in place. Due to the relative newness of some of the staff team it is particularly important the service has a robust management hierarchy in place. Following the inspection the provider contacted us to inform us of the plans for the management of the service. This demonstrated the organisation was able to respond in a timely fashion to unforeseen changes in the management structure.

There was a key worker system in place. Key workers are members of staff with responsibility for the oversight of care planning for a named individual. Each person had an assigned keyworker and there were plans to identify second keyworkers for everyone for additional support and to help ensure one was usually available.

We found gaps in records in several areas. As noted earlier in the report there were gaps in daily logs and information had not been recorded as necessary leading to one person not receiving medical treatment in a timely fashion. A training matrix pinned to the office wall was out of date. A supervision grid was also out of date and in order to establish when supervision had been carried out it was necessary to go through individual staff files.

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

Spectrum held monthly manager meetings to give managers from across the organisation an opportunity to share good working practices and discuss any local issues. The deputy manager was intending starting to attend the meetings for additional support and information.

Spectrum communicated with the staff team via newsletters and emails. In order to try and improve links between care staff and the external organisation a Works Council had been re launched to allow representatives from all levels to have a voice within the organisation. In addition a questionnaire had been developed for all stakeholders including staff. This was being trialled in two services. An open day was planned for February 2016 to allow staff an opportunity to discuss any concerns or ideas they had for individual services and organisational practices.

Relatives told us they were kept up to date with their family member's well-being generally as well as any information regarding health appointments. One commented; "They send us lots of paperwork and we can ring and chat about anything." Another said; "If there's anything wrong they ring right away, they're spot on."

There were a range of quality assurance systems in place which were used to identify shortfalls. Checks and audits were made in areas such as medicines, records, fire safety and the environment. Records showed that incidents were analysed and monitored. These were used to improve the service and reduce the risks of incidents re-occurring. Quarterly audits based on the Care Quality Commissions key lines of enquiry (KLOE) were carried out by the provider. Any highlighted issues or areas requiring improvement would result in an action plan with a clearly defined time frame. The registered manager had responsibility for producing a monthly report.

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 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 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way to service users because the provider was not doing all that was reasonably practicable to mitigate against identified risks. Regulation 12(1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established or operated effectively to enable the registered person to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17(1)(2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive the appropriate support, supervision and appraisal as necessary to enable them to carry out the duties they were employed to perform. Regulation 18(1)(2)(a)