

National Autistic Society (The) Knoll House

Inspection report

Somerset Court
Harp Road, Brent Knoll
Highbridge
Somerset
TA9 4HQ

Tel: 01278760555
Website: www.autism.org.uk

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Ratings

Overall rating for this service	Requires Improvement ●
Is the service safe?	Requires Improvement ●
Is the service well-led?	Requires Improvement ●

Summary of findings

Overall summary

About the service

Knoll House is a detached bungalow situated in the extensive grounds of Somerset Court which is owned by the provider. The home accommodates seven people who have autism and complex support needs. At the time of the inspection seven people were living at the home.

The service had not originally been developed and designed in line with the Registering the Right Support guidance. This guidance was implemented in 2017 after the service had registered with us. This was because there were five other registered care homes set in the grounds of Somerset Court in close proximity to Knoll House. The registered manager had personalised the service to reflect the Registering the Right Support Guidance.

People's experience of using this service and what we found

Risks relating to people choking were not being safely managed. People had guidelines in place detailing how staff should support them, however these were not always followed, which put people at risk.

The governance systems in place had not identified shortfalls in the management of risks.

Medicines were managed safely. People were protected from potential abuse. Staff felt confident to raise concerns and were aware of external agencies they could contact.

There were enough staff available to meet people's needs. Staff were recruited safely.

People's relatives and staff commented positively about the management of the home. People were involved in the running of their home. Staff told us there was good moral and a positive team culture.

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

Rating at last inspection

The last rating for this service was good (published January 2020).

Why we inspected

The inspection was prompted in part due to concerns received about a choking incident. A decision was made for us to inspect and examine those risks.

The information CQC received about the incident investigation indicated concerns about the management of choking. This inspection examined those risks along with infection control and the management of health-related risks.

We inspected and found there was a concern with risks relating to choking so we widened the scope of the

inspection to become a focused inspection which included the key questions of safe and well-led. Please see the safe and well led sections of this full report.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

During the inspection the registered manager and provider submitted an action plan to describe the action they had taken to mitigate the risks we identified.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Knoll House on our website at www.cqc.org.uk.

Enforcement

We have identified breaches in relation to safe care and treatment and governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below.

Requires Improvement ●

Knoll House

Detailed findings

Background to this inspection

The inspection

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

This was a focused inspection to check on a specific concern we had about assessing risk, safety monitoring and management.

Inspection team

The inspection was carried out by two inspectors.

Service and service type

Knoll House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection

We gave 48 hours' notice of the inspection to ensure we could manage the risks related to COVID-19.

What we did before the inspection

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection

We reviewed a range of records. This included four people's care records and two people's medicine records. We also reviewed records relating to the management of the service such as incident and accident records, recruitment records, health and safety records, meeting minutes, training records and audits. We

carried out a short visit to the service to complete observations. We spoke with the registered manager, lead manager, area manager and quality manager.

After the inspection

We spoke with five staff and the registered manager via video calls. We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We requested feedback from four relatives.



Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- People were at risk of choking because staff were not consistently following people's professional assessments and guidance relating to foods they could eat safely. We found examples in people's records of staff recording that people had eaten food not in line with the guidance.
- We also found one person's care plan contained different information to the professional's care plan. This increased the risk of staff giving people food that was outside of their professional care plan.
- Whilst the registered manager informed us there had been no choking incidents or near misses in the home, by not following the guidance staff were exposing people to the risk of choking.

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

- We discussed this with the registered manager and provider who took immediate action to address this.
- We found other risk management plans were detailed and staff were aware of the risks and management plans.
- Individual and personalised emergency plans were in place to ensure people were supported to evacuate in an emergency. One person's evacuation plan needed to be reviewed and updated, the registered manager told us they would complete this.
- The service environment and equipment were maintained. Records were kept of regular health and safety and environmental checks. Fire alarms and other emergency aids were regularly tested and serviced.

Using medicines safely

- Clear records were kept of medicines administered which helped to ensure the effectiveness of medicines could be monitored. Some handwritten entries on the medicines administration records (MAR) were not signed by two staff members. This is good practice as it reduces the likelihood of a recording error. We discussed this with the registered manager who told us they would remind staff to double sign handwritten entries.
- Medicines were stored securely and safely, including those requiring additional security.
- People received their prescribed medicines safely from staff who had been trained to carry out the task.
- Some people were prescribed medicines, such as pain relief, on an 'as required' basis. Protocols were in place to guide staff on how to administer these medicines.
- People had medicines profiles in place that were kept up to date.

Systems and processes to safeguard people from the risk of abuse

- The provider had safeguarding systems in place. Staff knew how to identify abuse and were aware of how to report it, including through external channels such as the local authority. One staff member told us, "I have never seen anything worrying, if I did, I would definitely report it."
- One relative told us, "I know [name of person] is safe and I have no worries at all."
- Safeguarding incidents had been reported to the local authority and the Care Quality Commission (CQC).

Staffing and recruitment

- Safe recruitment systems were in place to ensure suitable staff were employed.
- Staffing levels were based around people's individual needs.
- Relatives told us they had no concerns about staffing.
- Staff told us there were enough staff on each shift and regular agency staff were used where required to provide consistency of care.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was using PPE effectively and safely.
- Routine staff testing was not yet available for the service sector. However, we were assured that the provider was accessing testing for people using the service and staff, via alternative means when necessary.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks could be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Learning lessons when things go wrong

- Some people could get anxious leading to occasional incidents where they displayed harm to themselves or others. There were detailed care plans in place giving staff guidance on how to respond to people at these times.
- Staff told us incidents happened rarely and when they did, they were manageable. One staff member told us, "We can go months without an incident. When they do happen, they are manageable, afterwards we have a debrief. We have a discussion and think about the situation and immediately put things in place to ensure it never happens again."
- Staff recorded incidents when they occurred. Where incidents and accidents had occurred, action had been taken to minimise the risks of reoccurrence. Incident forms were completed and reviewed by the registered manager and the providers behavioural support lead, who had oversight of the service.

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Although action had been taken to prevent another choking incident on an organisational and service level, we identified shortfalls in care planning and staff practice at Knoll House which put people at the potential risk of having a choking incident. The governance systems in place had not identified these shortfalls.

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

- Following an incident of choking at another service the provider had shared organisational learning and an action plan. Action was taken to identify all people who were at high risk of choking as well as other key risk areas. Information was cascaded to the staff, staff received training, care plans were reviewed and observations were carried out in the home by the provider's quality team.
- The registered manager told us how learning from incidents had been cascaded to the team via supervisions and team meetings. We reviewed documents where learning from the choking incident had been discussed and shared.
- The Care Quality Commission (CQC) had been notified by the provider and manager of incidents which had occurred in line with their legal responsibilities.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Relatives commented positively about the staff team and how their relatives were supported. One relative told us communication was, "Excellent" and went on to say how supportive the staff had been during the COVID-19 pandemic.
- Staff spoke positively about the culture of the service and staff team. One staff member told us, "Our team morale is really good, we support each other."
- Staff told us the registered manager was always available and approachable. One staff member told us, "[Name of registered manager] is fantastic, so supportive and approachable." Another commented, "[Name of registered manager] is marvellous, they are very involved, their door is always open and you can

approach them with any concerns."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager understood their responsibility to let others know if something went wrong in response to their duty of candour.
- Our previous inspection rating was displayed at the service and was clearly in view for people to see.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Residents meetings were held for people to express their views and be involved in the running of their home. Areas covered included, going out in the community, if people were happy or sad and in-house activities.
- Staff told us people's views were sought on a day to day basis. One staff member told us, "They [people] advocate for themselves, they choose what they want to do and we give them choices. They are massively involved in running their own home."
- Staff confirmed they attended staff meetings. One staff member said, "We have our meetings on video calls now. We can discuss any concerns and raise things and I do feel listened to."

Working in partnership with others

- The service worked in partnership with other organisations to support care provision. For example, a range of health professionals.
- The registered manager told us they received regular calls and support from the local authority during the COVID-19 pandemic.

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
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance.</p> <p>The providers governance systems were not effective at monitoring and mitigating the risks relating to the health, safety and welfare of service users. Regulation 17 (2) (b).</p>

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.. People were not protected from the risk of choking because staff were not following professional guidance. Regulation 12 (2) (b)

The enforcement action we took:

We served a warning notice on the provider and registered manager.