National Autistic Society (The)

NAS Community Services (Northamptonshire)

Inspection report

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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

This unannounced inspection took place on 30 November 2016. This domiciliary care service is registered to provide personal care to people living in their own homes. At the time of the inspection the service supported two people in 24 hour live in care packages in one house.

Although there was a registered manager in post at the time of our inspection, they had been absent since July 2016. 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 provider had failed to ensure they had oversight of the service which had led to a prolonged period of time where people did not receive their planned care. Since July 2016 people had received care primarily from agency staff that had not received the managerial guidance they needed to provide care that met people's needs. Although this had been recognised by the provider, it had taken until early November 2016 to employ a regular team of care staff and a team leader.

People were living with autism; they were cared for by a new staff team who were in the process of establishing trusting relationships. The provider was supporting new care staff with an experienced team leader and interim manager who could potentially build the team people required.

People were safeguarded by team leaders who supported staff to gain the knowledge and skills to safeguard them from potential harm and understand how to contact outside agencies if they had issues of concern.

People were receiving care from a new staff group who were undergoing training to gain the skills and knowledge they required to meet people's needs. All new staff continued to be under close supervision from the team leader.

Systems and processes designed to maintain the quality of care were not embedded into practice as there was a complete new management and care team. Where the provider had identified issues these had not been actioned in a timely way.

People had been recently assessed for their risks and care plans were devised to mitigate these risks. People received their care as planned. The provider had plans to regularly include people in their reviews; however, this had not been embedded into practice.

Staff did not always understand their roles and responsibilities in recording where people had been assessed for their mental capacity to make decisions. People were asked for their consent to receive care.

People knew how to make a complaint and a new system to manage complaints was in place; this required

embedding into daily practice.

People had enough staff allocated to them on a daily basis. People were supported to access their health appointments; however, the systems to ensure the support was available at the appropriate times required embedding into daily practice.

People could be assured that appropriate recruitment practices were in place.

There has been one breach of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the end 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.

People were safeguarded by a staff group who were supervised to understand their roles and responsibilities to safeguard them.

People received care from a regular staff group who required close supervision.

Risk assessments had been recently updated but required an established system to update them regularly.

People were supported to take their prescribed medicines; further systems were required to ensure that people received their medicines safely.

Appropriate recruitment procedures were in place.

Is the service effective?

Requires Improvement

The service was not always effective.

People were cared for by staff that were new and required close supervision during their induction.

People were not always supported to have a balanced diet.

People could be assured that the provider understand their roles and responsibilities under the Mental Health Act.

People were supported to attend health care appointments.

Is the service caring?

Requires Improvement

The service was not always caring.

People were building trusting relationships with a new staff group.

People's dignity was assured when they received personal care and their privacy was respected.

People were encouraged to make decisions about how their care was provided.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always involved in the planning of their care.

People were supported to engage in activities that reflected their interests and supported their well-being.

People using the service knew how to raise a concern or make a complaint. There were systems in place to respond to complaints which were in their infancy.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager had been absent for over four months, the new staff team and interim manager was not yet fully established.

People's quality of care was monitored but timely action was required to make improvements to the areas identified.

NAS Community Services (Northamptonshire)

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 30 November 2016. The inspection was unannounced and was undertaken by one inspector.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. We liaised with the local commissioners and safeguarding authority prior to inspection to gain feedback about the service.

During this inspection we spoke with two people who used the service and observed their interactions with staff. We also looked at care records and charts relating to two people. In total we spoke with five members of staff, including one care staff, two team leaders, the registered manager and the provider. We looked at three records in relation to staff recruitment and training, as well as records related to the quality monitoring of the service.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from unsafe care. Staff did not always understand what was required of them to safeguard people from potential abuse. There had been previous reports of neglect made to the safeguarding authorities, some of which had been substantiated and others still under investigation. The team leaders and bank staff had received training and understood their safeguarding responsibilities. One team leader told us "if you see something and you don't report it you are worse than the culprit." We met new staff that had been employed since the beginning of November 2016; they had not received basic training in safeguarding of vulnerable adults, they did not know how to recognise or report their concerns. There was no information readily available to staff, the people who used the service or their visitors on how to contact the relevant agencies if they saw or suspected abuse. We brought this to the attention of the provider who implemented processes to supervise staff to provide practical examples and experience of safeguarding vulnerable adults. We have been unable to test the effectiveness of this supervision.

The provider had a whistleblowing procedure for staff to follow if they felt their concerns were not being listened to. The procedure had not been well advertised, and we found that staff did not have access to the information or the confidence to report any concerns to outside agencies. The provider recognised this and were taking steps to include this information in people's supervision and staff correspondence.

People who were living with autism required staff that knew them well to provide their care; this was because they relied on routine and took time to build a relationship based on trust. There had been a period of months where people had not received care from staff they knew, as there were not enough permanent staff to allocate to their home; agency staff had been used. Records showed that people had experienced high levels of anxiety as a result of agency staff coming to their home so plans had been put in place to give advanced notice to people about agency and new staff coming to their home. The provider had recently employed new staff; however, they were still getting to know people and had not bonded as a team. We observed that people appeared comfortable in the company of new staff and their records confirmed this.

The new staff group were getting to know people and were reviewing people's risk assessments as their needs changed. For example, staff had started to identify what specific circumstances triggered people's behaviour and how they expressed their anxiety. People's care plans provided instruction to staff on how they were to manage people's behaviours to ensure people's continued safety. This new approach to risk management was newly introduced and had not yet been embedded into practice.

The system for ensuring people received their medicines safely needed to be improved. Although people received their medicines as prescribed, there were additional procedures required to maintain people's safety, for example protocols to inform staff when medicines were required on an 'as required' basis. People were at risk of receiving or not receiving medicines when they required them as staff did not have sufficient guidelines to inform them when it was appropriate to administer these medicines. The provider had identified that not all staff that administered medicines had undergone all their training and their competencies checked; this was to be actioned with other training requirements.

People could be assured that appropriate recruitment practices were in place; checks had been made to establish that staff were of a suitable character to provide people with care and support. Records showed that staff had the appropriate checks and references in place. These included written references and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

People received care from staff that had not received all of the training they required to enable them to understand the needs of the people they were supporting.

At the time of our inspection we found that new staff were in the process of undergoing a six month probation period. Some had not worked with people with autism previously and therefore needed to develop the skills and competencies to care for people safely. During their probation all staff worked under the direct supervision of experienced staff and we saw that the provider had arranged for formal training to be provided in January 2017.

Staff had not always had the guidance and support when they needed it. The staff team was new, and had experienced many changes in management. There had been a lack of appropriate support for the high number of agency staff. The provider had recognised that staff required close supervision and support and had recently implemented this by seconding senior staff to look after this particular staff group. Staff now held team meetings where they could discuss how they were to be supported to meet people's needs. Regular individual supervision and appraisal were planned; this supervision was still in its infancy and had not been embedded into practice.

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. There is a need to ensure that the advice given by professionals is actioned and recorded any made on their behalf must be in their best interests and as least restrictive as possible.

Staff did not always understand their roles and responsibilities in relation to assessing people's capacity to make decisions about their care. The provider had identified that staff could not articulate their understanding of the mental capacity act and had arranged further training and supervision. People had been assessed as having capacity but their consent to care had not been recorded. People's records were not always consistent; there was a need to record where relevant professionals and others had been involved in assessing people's mental capacity particularly in relation to one person leaving their home unaccompanied. The provider had identified this as an action point from an audit on 4 November 2016, but had not taken any action to resolve this yet. There is a need to ensure that the advice given by professionals is actioned and recorded.

People were not always supported to maintain a healthy diet. People were involved in choosing what they wanted to eat and supported to go shopping on a daily basis to buy their food. Due to the lack of regular staff there was poor monitoring of people's diets to ensure they received food that made up a well-balanced diet. It was possible for people to have the same meal every day without this being identified by staff. The team leader recognised that more planning was needed to ensure people had a more varied diet and had this as an action point in their plan to improve the service.

People had not been supported to attend all of their medical and dental appointments; people had missed psychological assessments and dental check-ups due to the lack of continuity of staff. People had health action plans but these were incomplete. This had been identified by the provider who had taken recent action to ensure there were staff available that knew people to support them with their appointments which were taking place in the coming weeks. The systems and processes required to ensure people were supported to receive healthcare were new to this staff team and had not been fully embedded.

Requires Improvement

Is the service caring?

Our findings

People had not always had the opportunity to build a trusting relationship with staff as there had not been a regular staff team. There was a new staff team who were building the relationships with people in order that people would accept the care they were offered. We observed people had a good relationship with new members of staff. One team leader told us "In three weeks I have seen an improvement in [name's] behaviour, increased interaction and personal care."

We observed that the interaction between people using the service and staff was respectful and engaging. Staff had begun to get to know people's likes and dislikes, and supported people to engage in activities of their choice. Staff recorded what was important to people and spoke about how they were incorporating these in people's everyday lives. For example helping people to write down their plans for the day to have a schedule to follow to help reduce their anxiety.

We saw people playing their own music and relaxing in their own areas of their home. Staff respected people's privacy and were beginning to understand people's body language to gauge when they wanted to be left alone, or engage in conversation.

People had the opportunity to access an advocate when required, records showed that the provider arranged advocates where required.

People's dignity was assured when they received personal care and their privacy was respected; staff described how they helped people to receive their personal care by encouraging people to do as much as they could themselves and helping them to make choices about their clothing to suit the weather. People were encouraged to make decisions about how and when their care was provided and we observed staff discussing people's options.

People had opportunities to feedback their thoughts and emotions about the care they received. The provider had recently implemented a system of reading and acknowledging people's written and verbal feedback. This system was new and had not been embedded into daily routine.

Requires Improvement

Is the service responsive?

Our findings

People were not always involved in planning their care and care plans had not been regularly updated. The new team leader had recently re-assessed people's needs and developed care plans that instructed staff on how to meet people's needs. The team leader understood the need to involve people in the planning of their care and had plans to involve people as their relationships and trust in the new staff developed.

People's personal history, individual preferences, interests and aspirations had not been included in the planning of their care. The new staff team were building relationships with people to better understand them and incorporate this into their care plans. The team leader told us "we are aiming to help people to set their goals and help them to achieve some more independence."

New staff were getting to know people's emotional needs; the staff demonstrated how they had identified some of the triggers that led to behaviour that challenged others and had communicated this in staff handovers and care plans. Staff had shared their experiences with other staff to build a more consistent plan of communication and way of providing care that would improve the care people received.

Staff were allocated to people for specific number of hours per day. We saw that during these hours, people received one to one care where they chose what they wanted to do, such as carry out personal care or choosing their meals and shopping for these. One person liked to visit coffee shops; the staff took time to help them choose where to go and supported them to do this. We observed that people created a schedule of what they wanted to do and staff helped them to keep to their timetable. Improvements were required in planning ahead for people to achieve longer term goals.

People knew they could make a complaint to the team leader or manager. An easy read notice was displayed in their kitchen to inform them how to contact the service to make a complaint. We saw that people had written letters to the provider with their concerns, and recently a system had been put in place to respond to these letters and take action as a result. For example, people had complained that they did not have regular staff providing care; the provider had recruited permanent staff. There was a complaints policy and procedure in place that team leaders were supporting new staff to follow. The provider was aware that the complaints system was not fully embedded and had put processes in place to ensure that people's views were heard.

Requires Improvement

Is the service well-led?

Our findings

There had been a long term failing to oversee the management of this service. The provider failed to recognise that the service should be registered as a provider of personal care and allowed the registered manager to state that the service was dormant when they were providing personal care.

The provider carried out quality audits that were efficient at identifying where improvements were required in the service, but actions to remedy had not always been put into place. There were some audit findings that dated back to February 2015 that had not been actioned by the registered manager, such as the lack of staff appraisals, medicines competencies or updated health action plans.

There was a registered manager in post, however, they had been absent from the service since July 2016. During the period of time up leading to the registered manager's absence and the months following, the provider failed to provide a service that met people's needs. There were not enough staff with the skills, knowledge and relationships with people to provide for their care.

Evidence from safeguarding alerts raised by other agencies and a lack of action taken as a result of staff raising concerns led to people not always receiving their planned care. People had not been supported to attend their health appointments and their risk assessments and care plans were not updated. Agency staff had been left without supervision, leading to people not receiving their personal care. One example of this was agency staff allowing one person to have a shower with their clothes on as they had not provided suitable supervision.

Care staff had been recently employed and had not completed all of their training; they required close supervision. It had taken the provider until November to place an experienced team leader to oversee the care and establish systems to assess monitor and mitigate the risks associated with people's health, safety and welfare. These systems were not fully established into every day practice and could not yet be relied upon to ensure people received a good quality of service.

People did not have a plan towards their independence as commissioned; people did not have any goals to learn skills that would mean they could provide their own personal care or have coping strategies to manage their emotions and behaviours when in public situations. The provider did not have a plan to work with people to establish what goals they would like to achieve or how they would like to be involved in planning their care.

This is a breach of Regulation 17 (1, 2a and b): Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had recruited an interim manager to oversee the service, commencing 1 December 2016. The provider demonstrated they understood their responsibilities which included notifying the commission of incidents or changes to the service, such as the absence of the registered manager.

The provider had completely changed the staffing and management of the service in the last four months following indications that the quality of care had deteriorated. There had been a number of safeguarding concerns which reflected the lack of management and systems in place to protect people.

Up to early November 2016, agency and bank staff provided the daily care, which left people receiving care from staff that did not know them. There had been concerns from other agencies about the care people received during this time. Since November 2016 the provider had employed a new staff team including an experienced team leader. This changed the experiences of people using the service, which were now more positive; at the inspection we observed that people were receiving care that met their needs. The provider told us "I feel like I know this team now, we are building relationships and supervision."

The provider carried out a quality monitoring audit on 7 November 2016 where actions had been identified in readiness for the new interim manager to implement. There is a need for timely actions for the issues identified by the audits.

The culture of the team had not been established; the provider and the team leader were working together to achieve their vision to provide care that was individualised. The systems and processes designed to support staff were in place but needed to be embedded into every day care. The staff we met were enthusiastic and wanted to make the team work, one member of staff told us "It's important that we keep the same staff for continuity, people respond well to people they know."

The provider had sought people's opinion about the care they received and investigated where people had expressed their anxieties and concerns about the service. The provider had listened to people about the need for a regular staff team.

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 17 HSCA RA Regulations 2014 Good governance The provider failed to have sufficient systems and processes in place to establish and operate effectively to ensure compliance. The provider failed to assess, monitor and improve the safety of service users. The provider failed to mitigate the risks relating to the health, safety and welfare of service users.