Autism Initiatives (UK)

Lethbridge Road

Inspection report

2 Lethbridge Road
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This unannounced inspection of Lethbridge Road took place on 11 January 2017. The inspection was conducted by an adult social care inspection.

Lethbridge Road is a large detached house in a residential area of Southport. The service is run by Autism Initiatives and provides accommodation, care and support to six people with learning disabilities. There is parking available to the front of the property and a garden area to the rear. The home is located close to Southport town centre, giving access to public transport and other amenities.

The home was last inspected in November 2014, and was rated 'good' overall, with one domain, the safe domain, rated as 'requires improvement'. We found the provider was in breach of regulations relating to the safe management of medications. Following our last inspection the provider wrote to us and told us what action they were going to take to meet this breach. We checked this during this inspection, and found the provider had taken appropriate steps to address the anomalies found at the inspection in November 2014. The provider was no longer in breach of this regulation.

A registered manager was in post. 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.

During our last inspection in November 2014, the provider was in breach of regulations relating to the safe management of medications. We saw however, during this inspection that medications were now managed safely, in accordance with clinical guidance, and only administered by staff who had the training to do so. The provider was no longer in breach of this regulation.

Everyone we spoke with told us they felt safe and well cared for at the home.

Staff were able to describe the course of action they would take if they felt someone was being harmed or abused in any way. Staff had received the correct training in adult safeguarding, and information regarding who to contact was displayed around the home. Staff also told us they would not hesitate to whistle blow if they needed to.

Risk assessments were in place, and were detailed. They provided staff with information about how to keep people safe, while ensuring their rights and choice were respected. Risk assessments were reviewed every month as part of the quality assurance process, and any changes were implemented and discussed at key worker meetings.

Staff were being safely recruited to ensure they were suitable to work with vulnerable people.

There was a procedure in place for recording and analysing incidents and accidents.

Rotas showed there were enough staff employed by the organisation to deliver a safe, consistent service. Each person had the required number of staff working with them to help keep them safe and access the community.

There were regular checks taking place on the equipment in the home, such as the fire extinguishers, gas, and PAT (potable appliance testing).

Staff were aware of their roles in relation to the Mental Capacity Act 2005 (MCA) and DoLS. We saw that appropriate applications had been made to the Local Authority for people who were required to have a DoLS in place, and these were kept under review.

Staff were supported through regular training, supervision and appraisal. Supervisions were taking place every few weeks, and all staff had had an annual appraisal. The induction process for staff was in line with national guidance as well as the providers own requirements.

People were supported to eat and drink at times that fitted in with their routines. Each person had a dedicated section in the fridge where they kept their ingredients.

We observed staff delivering support and they were kind and compassionate when working with people. They knew people well and were aware of their history, preferences and dislikes. People's privacy and dignity were upheld. Staff monitored people's health and welfare needs and acted on issues identified. People had been referred to healthcare professionals when needed.

Care plans with regards to people's preferred routines and personal preferences were well documented and plainly written to enable staff to gain a good understanding of the person they were supporting. Care plans contained a high level of person centred information. Person centred means the service was tailored around the needs of the person, and not the organisation.

We discussed complaints with the registered manager. Complaints had been responded to by the registered manager and appropriately dealt with including any changes, which needed to be implemented because of the complaint.

Quality assurance procedures were robust and identified when actions needed to be implemented to drive improvements. We saw that quality assurance procedures were highly organised and processes had been implemented from another internal source to help support the service to continuously improve. We were shown these procedures by the registered manager during our inspection and how they worked.

Feedback had been gathered from people who used the service in the form of questionnaires. This was presented in a way people understood, containing a mixture of words and pictures.

We received positive feedback about the registered manager and the home in general. The registered manager clearly led by example, and had used innovative ideas to encourage and promote staff moral and teamwork.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People received their medications safely and in accordance with their wishes and preferences.

Staff were safely recruited to ensure they were able to work with vulnerable people.

Risks assessments were in place for people which were subject to regular review and any changes had been implemented.

Staff were able to describe the course of action they would take if they felt someone was being abused or neglected.

People told us they felt safe living at the home.

Is the service effective?

Good

The service was effective.

The service was working in accordance with the MCA and associated principles and were aware of their roles and responsibilities in relation to this.

Staff had the skills and knowledge to support people in the home. This was demonstrated in staff training records and training course certificates.

Staff were well supported and engaged in regular supervision and yearly appraisals. New staff were inducted into their roles in accordance with the providers policies and procedures.

People were supported to access healthcare which they required and which met their needs.

People ate their meals when they choose in accordance with the own plans for the day.

Is the service caring?

Good

The service was caring

Staff were able to describe how they promoted people's dignity and respected their privacy.

People told us they were routinely involved in decisions concerning their care and support.

People received care which was kind, compassionate and met their needs. We heard people were spoken to with respect by staff.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised and contained information about people's likes, dislikes and preferences.

There was a complaints procedure in place and it was accessible for people who lived at the home. People told us that they knew how to complain.

There were activities available and people could choose what they did with their time

Is the service well-led?

Good

The service was well-led.

The registered manager was aware of their role and had reported all incidents to the commission as required.

People and staff told us they felt the home was well-run, and they liked the registered manager and the provider.

There was regular auditing taking place of care files, medication and other documentation relating to the running of the service.

There were quality assurance systems in place and people were regularly asked for feedback to help improve the service.

Lethbridge Road

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 11 January 2017 and was unannounced.

Before our inspection we reviewed the information we held about the home. This included the Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at the statutory notifications and other intelligence which the Care Quality Commission had received about the home.

During the inspection, we spent time with four staff who worked at the service, the registered manager and one of the area managers. We spoke with three people who lived at the home, and one social care professional who we contacted via telephone after the inspection had taken place.

We looked at the care records for the three people using the service, three staff personnel files and records relevant to the quality monitoring of the service.

Good

Is the service safe?

Our findings

During our last inspection in November 2014, we found the service was in breach of regulation relating to medication. This was because we found some people's records difficult to follow; especially those who had had medication changes recently. This domain was rated as 'requires improvement'. Following this inspection, the provider sent us an action plan detailing what they were going to do to ensure the breach was met. We checked this as part of this inspection. We found that the provider had made improvements and was no longer in breach of this regulation.

Medication was stored in separate locked room. The temperature of this room was recorded every day. Medication requiring cold storage was kept in a dedicated medication fridge where the temperatures were also logged daily. This is important because if some medications are stored at the incorrect temperature it can effect how the medication works. We spot checked the MAR [Medication Administration Records] for two people living at the home and counted their loose medications. We could see that all totals corresponded to the totals recorded on the MAR sheets. The MAR contained a plan for each person, a photograph of the person on the front and a list of the medication and what it was used for. People prescribed PRN (medication when required) had a detailed protocol in place which explained when the PRN was needed and why.

Some people were prescribed topical medicines (creams). These were stored safely and body maps were routinely used to show where topical creams should be applied.

Staff who were trained to administer medications had undergone medication training by a nurse who was employed by the company. They were then required to complete competency assessments which were reviewed every year. There were additional training checks in place which had been implemented by the registered manager. For example, we saw that staff were required to complete the medication round six times undisturbed whilst being observed by the registered manager or the deputy manager before they could be signed off as competent. Some staff had also completed a NVQ (National Vocational Qualification) training unit about medication as part of their qualification.

The medication policy for the home had been updated to include NICE (National Institute for Clinical Excellence) guidance.

The registered manager had also introduced an auditing tool which was personalised to suit each person living at the home which looked in depth at their medications, when they should be ordered, and what the medication should look like. The registered manager gave us an example of when the tool showed its effectiveness. Staff had noticed when completing the audit, that one person's tablets were not as described on the tool. They were a different colour. This prompted them to call the pharmacy to check that the medication was the right medication.

People told us they felt safe living at the home and they liked the staff. One person said, "I have been here a while, it is just my home." Someone else said, "The staff are excellent, they are the best thing about the

home." And "Yes I like living here very much."

We reviewed three files relating to staff employed at the service. Staff records viewed demonstrated the registered manager had robust systems in place to ensure staff recruited were suitable for working with vulnerable people. The registered manager retained comprehensive records relating to each staff member. Full pre-employment checks were carried out prior to a member of staff commencing work. This included keeping a record of the interview process for each person and ensuring each person had two references on file prior to an individual commencing work.

The registered manager also requested a Disclosure and Barring Service (DBS) certificate for each member of staff prior to them commencing work. A valid DBS check is a check for all staff employed to care and support people within health and social care settings. This enables the registered manager to assess their suitability for working with vulnerable adults One staff member we spoke with confirmed they were unable to commence employment until all checks had been carried out. They told us they completed an application form and attended an interview. They could not start work until they had received clearance from the DBS. This confirmed there were safe procedures in place to recruit new members of staff.

Staff were able to describe how they would raise concerns about people's wellbeing, and who they would speak to. Staff had received training in the principles of safeguarding but also the practicalities of how to raise an alert with local safeguarding teams. Their responses were in line with procedures set out in the service's safeguarding policies. Staff also explained the organisation's approach to whistleblowing, and told us they would be encouraged to report any bad practice or concerns. We saw information regarding safeguarding for people who used the service and relatives was readily available on the noticeboards in the office and the service user guide. People we spoke with confirmed they knew how to raise concerns should they have any. This demonstrated the registered manager had ensured safeguarding principles were understood by staff and people who used the service.

Risk assessments were regularly reviewed, and contained relevant and comprehensive information to help support people safely. We saw that each risk assessment was reviewed every week by the person's keyworker and the person. We saw that risk assessments covered all aspects of people's care and support needs, and contained relevant links to staff training protocols when needed. For example, we saw that one person was at risk of throwing objects when their behaviours escalated. As well as the risk and triggers being fully explained in this person's risk assessment, there were also links to the additional training the staff had undertaken to be able to support this person. We saw that another person was anxious when crossing the road, and their risk assessment instructed staff to take a 'peep and creep' approach when supporting them to cross, as they understood this and it worked best for them.

The service was documenting incidents and accidents. These were analysed regularly and any patterns or trends were taken into consideration for future reference. For example we saw that one person had a number of incidents when out in public. There was a pattern picked up that these areas were mostly crowded and noisy places, which caused the person to display challenging behaviours. We saw that a strategy was implemented after consultation with this person, to visit these places during quieter times during the week. Since this was implemented we saw that the incidents had reduced.

We checked to see if the relevant health and safety checks were completed on the building. We spot checked some of the certificates, such as the gas, electric and firefighting equipment and these were in date. We checked when the last fire evacuation test was and saw it had been completed recently. Everyone who lived at the home had a personal evacuation plan (PEEP) in place that was personalised to suit their needs.

Our observations showed there were enough staff at the home to be able to support people with their daily activities and hobbies. Rotas were person centred; this was because staffing was mostly determined depending on what activities people had planned for that day. For example, we saw that one person in home wrote their own weekly activity planner and brought it staff to show them how they wanted to spend their week. We saw that staff would discuss the practicalities of this plan with the person, and adjust their flexibility accordingly. For example, if the person wanted to go to town shopping and then to the cinema, staff might be required to work a longer shift. We saw that the rota was also displayed in a picture format where the photograph of each staff member who was due to be on shift was displayed.

Good

Is the service effective?

Our findings

People told us they felt the staff had the skills and experience to be able to support them. One person said, "The staff all know me." We spoke to a social care professional who told us that the staff were, "Skilled." We asked staff about their training and they all said that they felt the training was good quality and was updated regularly. One staff member said, "The training is good, because it actually relates to what we do, so it is helpful."

We looked at the training matrix which showed that all staff had attended training in subjects such as first aid, safeguarding, medication, autism, and conflict. We saw that each staff member had a file with all of their certificates stored, and we checked these. New starters completed an induction over the first twelve weeks of their role which was aligned with the principles of the Care Certificate. The Care Certificate is a set of standards health and social care workers can adhere to as part of their role. We saw that the registered manager had also completed training sessions with new workers which took them over the running the house. The registered manager had also arranged for new members of staff to be mentored by existing members of the team to ensure they learnt how to do things such as handover, count the money correctly and fill in certain types of forms. The registered manager said, "I'm not here all of the time, so I felt it was important existing staff took this role on to help new staff understand the system of how we do things."

Staff were given regular formal supervision and appraisal which was recorded on their file every month. New staff were also given regular informal supervision and support by the registered manager and their assigned mentor every week. All staff had had an annual appraisal.

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). The DoLS provide a legal framework to protect people who need to be deprived of their liberty in their own best interests.

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. There was no one subject to a DoLS during our inspection. All the staff team had received training in the principles associated with the MCA and DoLS. We found staff understood the relevant requirements of the MCA and put what they had learned into practice. For example, we found that people who lived at the home were consulted with when important decisions needed to be made to check their understanding. The home used a process were they would 'weigh up' decisions and how well the person understood the decision they were making. One person had asked to go away on holiday. We saw a document was in place in the person's care plan, which showed how

the decision had been discussed with the person, including how their choice had been explored and the financial aspect of the holiday.

We saw from looking at records relating to people's medical and clinical needs, that this was being well maintained by the staff. Appointments were scheduled into people's daily activity plans and staff were allocated to support that person to attend the appointments. We saw staff completed documentation when they returned from the appointment with that person to show the outcome and additional information (such as any medication changes) which the staff would need to know.

We saw the home was well decorated with modern fixtures and fittings. People who lived at the home had helped to choose the décor of the home, and had also chosen how they wanted their rooms to be decorated. One person told us the home was due to be re-decorated, and they had chosen the colour of the walls.

People told us they had access to food and drink whenever they wanted it. We saw that the kitchen was not locked, and each person had their own delegated food cupboard with items in that they had purchased. Mealtimes were dependent on what activities people had planned for that day. The registered manager told us that people have 'house meals' three times a week as requested. This was where people who lived at the home dined together.

Good

Is the service caring?

Our findings

People we spoke with at the home told us they liked the staff and they were happy with their care. One person told us about their plans for the day; they said, "I choose where I want to go and then staff will help me plan my route. It is good here like that." Someone else said, "The staff are really kind to me, they treat me well." We spoke to a social care professional who told us they felt that the home was caring, and the staff were kind.

We asked staff to give us examples of how they protected people's dignity and privacy. One staff member said, "We ask people what they would like to do." Other comments included, "[When we support people with personal care] We close doors and cover them up with something, to protect their modesty." One staff member said, "I try to treat people how I would want to be treated." We heard staff addressing people by their preferred title throughout the day. A staff member told us, "We never leave confidential information laying around about other residents, we always keep everything private and secure."

We observed throughout the duration of our inspection that staff would knock on people's bedroom doors and ask permission to enter. Dialogue between people who lived at the home and the staff was respectful and familiar. Staff used positive words such as 'choice', 'promote' and 'independence'. We observed one person ask a staff member to support them attend a planned activity. The staff member was very respectful to the person, gently reminding them of what they had planned to do that day, including how much money they thought they would need to take, and whether they wanted lunch out or when they arrived back at the home. When we checked this person's support plan, we saw that having this type of structure was very important to them, as they liked familiarity.

Care plans evidenced that people had been involved in discussions and changes to their care needs. This was because they were signed by people using the service. Key worker meetings took place every week with people and their allocated keyworker. Care plans and any changes to care needs were discussed as part of this meeting.

For people who had no family or friends to represent them contact details for a local advocacy service were available, we saw that one person was receiving advocacy support at the time of our inspection.

We checked to see if people had information made available to them in a way which they understood. We saw that the provider had made various polices, including the complaints policy and safeguarding policy available in easy read to support people's understanding.

Good

Is the service responsive?

Our findings

Care plans demonstrated that the service was providing care which was person centred. This means based around the needs of the person, and not the needs of the organisation. There was highly detailed information available in each person's 'About me' folder which showed that staff were taking the time to get to know people. For example, we saw that one person, who had lived in Lethbridge Road for a number of years, had had their journey clearly documented, including what the staff had learned about them, how they liked to be supported, any triggers they had experienced and what parts of the person's support was not working well for them. The impact this had was that it allowed staff to learn from past experiences and offer good and meaningful support which the person was familiar with. This led to fewer incidents involving the person and because they were more settled they were able to engage more in other things that interested them.

Personalised information was a theme which was apparent in all if the care plans we saw at the home. One person's file contained information informing staff of what textures of clothing they liked to wear. We also saw how one person was supported to communicate their feelings by writing things down rather than speaking, and the plan advised what the staff must do to support that person.

The registered manager described the initial assessment process they had recently followed before someone moved into the home. We saw this was not a rushed process. Visits were planned between the person, the staff and the registered manager to get to know them and learn their routines. We saw that this formed the basis of the personalised information in the person's care plan, and we saw how staff would add to this plan the more they learned about the person.

Information regarding people's personal care routines were clearly documented in a way which promoted their independence. For example, we saw that one person liked getting themselves washed and dressed, however, they would use all of the shower gel/shampoo at once, this was part of their behaviours. Due to the expense of this, and the dignity issue, because this person wanted to be in the shower alone, the staff came up with a solution. Each day, small bottles would be filled with the person's shower gel/shampoo, which they used all at once. This made the person happy, and there was no cost or dignity implication.

Important information regarding people's choices were also documented in their care plans. We saw information which stated, 'Give me no more than two choices'. This was because the person would become overwhelmed if they were asked to choose from lots of different items, this could cause them to become distressed

We looked at complaints and how the complaints procedure was managed in the home. We saw that the complaints procedure was displayed in the hallway of the home and was accessible for people to view. People and relatives we spoke with told us they were aware of the complaints procedure and knew who they would go to if they wanted to complain. The procedure clearly explained what people had a right to expect when they raised a complaint and the timescales as to when they should expect their complaint to be responded to. Everyone in the home told us they knew how to complain, most people said they had

never had a cause to complain. One person told us, "I would tell the staff." We saw that one complaint was being investigated and had been escalated following the appropriate guidelines as set out in the organisation's policy.

We saw that meetings for people living at the home were taking place every month and the next one was planned for the next few weeks.

Good

Is the service well-led?

Our findings

There was a registered manager in post who had been at the home for twelve months.

Throughout our inspection the registered manager was very transparent and confident about their role in the home, and what was expected of them. New systems, such as the mentoring system and new approaches to medication auditing, had been implemented and developed by the registered manager. Our discussions with the registered manager demonstrated that they knew people and their care needs well, and this was also evidenced in the presentation of care plans.

The culture of the home was warm and friendly. Staff and people who lived at the home were complimentary about the registered manager and the provider. One staff member said, "[Registered managers name] is great, they always get stuck in and are approachable." A healthcare professional told us, "The registered manager is very good." Other staff members said the management was, "Fair", "Kind" and, "Knew what they were doing." All of the staff we spoke with told us they would recommend working for the organisation.

We saw that team meetings were taking place every month, the last one had taken place in November and we viewed the minutes of these, as well the previous months. We saw topics such as safeguarding, training and health and safety were discussed.

There were audits for the safety of the building, finances, care plans medication and more regular checks like the water temperatures. We saw any recommendations were being followed up with a plan of action by the registered manager. In addition to their own auditing systems, there were also peer audits being completed by other managers from other services within the organisation. We saw that all of the monthly information from the audits were sent to the quality assurance manager, who made unannounced visits to the service to check the actions identified were being carried out.

The registered manager did their own weekly audit of the building and regular care plan checks. This showed that the provider was looking for ways to continuously develop their approach to quality assurance.

The home had policies and guidance for staff regarding safeguarding, whistle blowing, involvement, compassion, dignity, independence, respect, equality and safety. There was also a grievance and disciplinary procedure and sickness policy. Staff were aware of these policies and their roles within them. This ensured there were clear processes for staff to account for their decisions, actions, behaviours and performance.

We looked at how the registered manager used feedback from people living at the home and their relatives to improve the service. We saw that feedback was mostly face to face through meetings with people's keyworkers due to the small size of the home. We saw that the manager had sent out multiple choice questionnaires. The results had been analysed. We saw 100% of people said they liked living at the home.

The registered manager was aware of their roles and responsibilities and had reported all notifiable incidents to The Care Quality Commission as required.