Homes Caring For Autism Limited

Wembdon Rise

Inspection report

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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

Overall summary

This inspection took place on 30 October 2015 and was unannounced. This was the first Care Quality Commission (CQC) inspection of the service since it was registered with CQC in September 2014.

The service provides care home accommodation and support for up to 10 people with a learning disability or autistic spectrum disorder. Care is provided in individual self-contained flats within three buildings on the same site. At the time of the inspection there were seven people living in the home with very complex care and behavioural support needs. People had severe autistic spectrum disorders and some of them also had sensory impairments. People had very limited or no verbal communication skills. They required one to one staff support within the home and needed two members of staff to support them when they went into the community. One person received two to one staff support at all times.

The service had a registered manager. 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.

Summary of findings

The registered manager said the service ethos was "To support people to achieve their full potential for improvement". To achieve this, the service focused on meeting each person's individual needs and aspirations.

In a recent satisfaction survey, people's relatives strongly agreed the service did everything they could to promote people's wellbeing and safety. Records showed the number of incidents had fallen significantly and people's medication needs had reduced since moving to the home.

There were sufficient numbers of staff to meet people's complex care needs and to help to keep them safe. The registered manager said they always tried to roster more staff than was strictly required and always had one person on-call in case of short notice absences.

Staff were knowledgeable about each person's support needs, behaviours and preferences. They received person specific training and were able to communicate effectively with people in ways people preferred. This meant people with restricted speech could express their views and preferences to staff.

Each self-contained flat was modern and well-proportioned. The registered manager said they tried to make the flats as homely as possible allowing for people's individual autism needs. The use of individual flats helped safeguard people with very complex needs from harm to themselves and others.

Staff spoke positively about the people they supported and were understanding and considerate of their needs. They took pleasure and pride in the progress people had made since moving to Wembden Rise. People's relatives commented on how caring and dedicated the staff were.

People were supported to spend time in the local community. People were taken out for a drive and/or for walks on most days. There were communication boards in people's flats detailing their daily routines and activities in easy to read and symbol format. People were free to refuse or choose different activities if they wished. One member of staff said "We don't make people do things, we just give them options".

Staff told us the registered manager promoted an open door culture and was very approachable and supportive to people, relatives and staff. We observed the registered manager was visible around the home and was always approachable to people and staff. He had a good understanding and rapport with each person in the home.

The provider had an effective quality assurance system which ensured the service maintained high standards of care and promoted continuing service improvements.

Summary of findings

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 safe.

There were sufficient numbers of suitably trained staff to help keep people safe and meet each person's individual needs.

People were protected from abuse and avoidable harm.

Risks were identified and managed in ways that enabled people to lead more fulfilling lives and to remain safe.

Good

Is the service effective?
The service was effective.

People received effective care and support from staff who were trained to care for people with very complex behavioural and communication needs.

People were supported to live their lives in ways that enabled them to have a better quality of life.

The service acted in line with current legislation and guidance where people lacked the mental capacity to consent to aspects of their care or treatment.

Good

Is the service caring?
The service was caring.

Staff and management were caring and wanted the best for the people they supported.

People were treated with understanding, dignity and respect.

Staff understood people's non-verbal communications and how each person expressed their needs and preferences.

People were supported to maintain family relationships.

Good

Is the service responsive?
The service was responsive.

People and their relatives were involved in decisions about their care and support, as far as they were able to be.

People's individual needs and preferences were respected and acted on.

People, relatives and staff were encouraged to express their views and the service responded appropriately to feedback.

Good

Is the service well-led?
The service was well led.

The service promoted an open, supportive and caring culture focused on meeting each person's complex needs.

Good

Summary of findings

People were supported by a motivated and dedicated team of management and staff.

The provider's quality assurance systems were effective in maintaining and promoting service improvements.

Wembdon Rise

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 October 2015 and was unannounced. It was carried out by one inspector. Before the inspection we reviewed the information we held about the service. This included previous inspection reports, statutory notifications (issues providers are legally required to notify us about) other enquiries and the Provider's Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make.

During the inspection we visited each person's flat and met five of the seven people who lived in the home. We were able to have a very limited conversation with one person but the other people were unable to talk with us due to their complex communication and learning difficulties. To gain an understanding of people's experiences we observed staff practices and their interactions with the people in the home. We also reviewed the responses and comments given by people's relatives in the service's most recent quality assurance questionnaire.

During the inspection, we spoke with the registered manager, two supervisors and four other members of support staff. We reviewed three care plans and other records relevant to the running of the home. This included staff training records, medication records, complaints and incident files.

Good

Is the service safe?

Our findings

People had very limited or no verbal communication skills. We had a limited conversation with one person who responded positively when we asked if they felt safe and happy with the staff who supported them. In a recent satisfaction survey, people's relatives strongly agreed the service did everything they could to promote people's wellbeing and safety. They also stated people were happy to return to the service after visits to their family home. This showed people did not have anxieties about returning to the service and indicated they felt secure and well treated. One relative commented "[person's name] is doing well and we have no concerns".

We observed people were at ease and comfortable with the staff supporting them. Staff told us they had never had any reason to raise concerns about any of their colleagues but they would not hesitate to report anything if they had any worries.

People were protected from the risk of abuse through appropriate policies, procedures and staff training. Staff knew about the different forms of abuse, how to recognise the signs of abuse and how to report any concerns. Staff said they were confident that if any concerns were raised they would be dealt with to make sure people were protected.

The risks of abuse to people were reduced because there were effective recruitment and selection processes for new staff. This included carrying out checks to make sure new staff were safe to work with vulnerable adults. Staff were not allowed to start work until satisfactory checks and employment references had been obtained.

Care plans contained risk assessments with measures to ensure people received safe care and support. Risk assessments covered issues such as: support for people when they went into the community; participation in social and leisure activities; and environmental risks. There were risk assessments and plans for supporting people when they became anxious or distressed. The service used a 'Time Intensity Model' which outlined the appropriate actions to take at various stages of an incident. This included baseline behaviour, escalation, crisis, recovery and support, and post incident behaviour. All staff received training in positive behaviour management to de-escalate situations and keep people and themselves safe.

Records showed incidents were investigated and action plans were put in place to minimise the risk of recurrence. For example, following a number of medicine errors, additional staff training had been provided and more robust medicine administration and checking procedures had been introduced (see below). The number of incidents had fallen significantly and people's medication needs had reduced in the relatively short period since the home opened. The service reported all significant incidents to the relevant statutory authorities, as required.

Staff knew what to do in emergency situations. Staff said they would call the relevant emergency services or speak with the person's GP, or other medical professionals, if they had concerns about a person's health and welfare. The provider also had a specialist crisis intervention team to support local services with more complex care needs or to assist with managing major incidents.

The registered manager carried out regular health and safety checks to ensure the physical environment in the home was safe. The provider had a range of health and safety policies and procedures to keep people and staff safe.

There were sufficient numbers of staff to meet people's complex care needs and to help to keep them safe. The minimum staffing level on the day shifts was 11. This allowed one to one support for each person in the home, as well as sufficient numbers to support people to go out into the community on a two staff to one person basis. At night there was three waking staff, always including at least one male and one female member of staff. On the day we inspected there were 12 staff on duty in the morning and 13 in the afternoon. The manager said they tried to roster more staff than was required into a four weekly staff rota to allow for holidays, vacancies or other absences. In addition, they always had one person on-call in case of short notice absences. In emergencies, they could call on the provider's other homes or on the central support team for assistance. Staff told us there were always sufficient staff numbers to meet people's needs and also to take people out most days.

Systems were in place to ensure people received their medicines safely. All staff received medicine administration training. Medicine rounds were carried out by the shift leaders supported by a second member of care staff. One member of staff read the prescription and dose from the person's medicine administration record (MAR) and the

Good

Is the service safe?

other gave the medicine to the person. When the medicine round was finished the shift leader took the completed MAR sheets to the senior on duty for a further check to ensure the MAR sheets were correct. These checks helped ensure the correct medicines were administered to the right people.

Good

Is the service effective?

Our findings

Feedback from people's relatives showed the service was effective in meeting people's needs. When asked what they most liked about the service, one relative commented "The professionalism and dedication of the teams of staff". Similarly another person's relative said "The professional way staff conduct themselves and their commitment to their role".

We found staff were knowledgeable about each person's support needs, behaviours and preferences. Staff provided care and support in line with people's agreed plans of care. They told us they received training in how to effectively meet each person's complex needs. This included general training in subjects including safeguarding, first aid, infection control, and administration of medicines. More specific service related training was also given including autism, epilepsy, positive behavioural management and individual communication strategies. Staff were also supported with continuing training and development, such as vocational qualifications in health and social care.

We spoke with two recently appointed members of staff. They had received a week long induction training covering the common health and social care induction standards as well as service specific training in autism awareness. They then shadowed experienced members of staff for five or six shifts to get to know people's individual support needs and communication methods. They received individual mentoring sessions on a weekly basis and monthly one to one supervisions. The competency, knowledge and skills of new staff were assessed over a six month probationary period to ensure they knew how to care for people effectively. Established staff also received one to one supervision sessions, every six to eight weeks, and annual performance and development appraisals.

Communication training included sign language, information technology (use of iPads with symbols), manual communication systems with pictures and symbols, and people's other preferred methods of communication. This enabled staff to communicate effectively with people; and it helped people who were restricted in their speech to express their views and preferences.

Staff said everyone worked well together as a really supportive team. This helped them provide effective care and support for people who lived in the home. One new member of staff said "I love it, it's such a good job and everyone is so good. There's always someone around to help you". People's individual care and support needs were discussed at shift hand-overs, staff supervision sessions and team meetings held every three weeks. This ensured people continued to receive appropriate and effective care.

We were given examples of how people with very complex needs and behaviours had significantly improved since moving to Wembden Rise. One person, who never used to go out, was now able to go for daily walks with staff and for trips out in the car. The number of incidents and use of 'as required' medicines had been significantly reduced across the board. For example, one person had medication to sedate them in their previous home when they needed their hair or toenails cut. They were now much calmer and settled and actually requested staff to cut their nails for them. The service had not needed to use any 'as required' medicines to manage the person's behaviours. The service kept the use of 'as required' medicines for the management of behaviours to an absolute minimum and always kept relevant professionals informed.

When people lacked the mental capacity to make certain decisions, the service followed a best interest decision making process. Staff received training and had an understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The MCA provides the legal framework to assess people's capacity to make certain decisions at a certain time. The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely.

The service had DoLS authorisations in place for five of the seven people and one application was in progress. The remaining person was under the age of 18 and therefore the DoLS legislation did not apply to them. All of the people needed certain restrictions to help keep them safe. We checked the DoLS authorisations and found they were all current and were being complied with. They were consistent with the risk assessments and care plans for the

Good

Is the service effective?

people concerned. The service regularly reviewed the restrictive practices with a view to reducing the number and impact of any restrictions on people's freedom and choices.

People had sufficient to eat and drink and were encouraged to have a balanced diet. People had their own individual weekly menus and their meals were prepared by staff in the person's own flat. People were involved in their meal planning to the extent they were able to be. Where people were unable to express a choice, they were offered alternatives and different meals were tried out until their preferences were established. Staff were knowledgeable about people's dietary needs and preferences. For example, they knew about one person's nut allergy, that some people needed their food cut up to avoid the risk of choking, and one person preferred to 'graze' eating small amounts throughout the day rather than a full meal in one sitting. One person had anxieties about food and ate a very restricted diet. The person was taking supplements to avoid deficiencies in essential nutritional requirements. Advice had been requested from a dietician.

People were supported to maintain good health and wellbeing. Each person had an annual health check and medicine review. We were told the local GP and other health professionals were happy to visit the home when requested. More specialist advice was sought as required from: the Rapid Intervention Team of the Somerset Partnership NHS Foundation Trust Learning Disability Service; a visiting occupational therapist; and the provider's central service support team. Care plans contained records of hospital and other health care appointments which showed people had access to a wide range of health professionals.

The home consisted of 10 self-contained flats plus a number of communal areas and staff offices across three buildings on the same site. The flats were modern and well-proportioned each with a lounge, kitchen, bedroom, bathroom and access to garden space. The registered manager said they tried to make the flats as homely as possible allowing for people's individual autism needs. The individual flats were more suited to people's complex needs than a communal shared living environment. This arrangement helped safeguard people and others from harm and ensured additional staff assistance was close by when needed.

Good

Is the service caring?

Our findings

Comments from people's relatives showed the service was caring and dedicated to meeting people's individual needs. One relative commented "Thank you for providing my [relative] with a future filled with those who strive to aid their communication". Another person's relative said "I like the fact that [person's name] is treated as an individual. We are truly blessed and very happy for them".

Staff spoke very positively about the people they supported and were understanding and considerate of their needs. Staff stressed how rewarding and enjoyable they found their work. It was clear they took great pleasure and pride in the significant progress people had made since moving to Wembden Rise. One member of staff said "We try to promote and support people's independence in their daily lives".

Each person had a designated key worker with particular responsibility for ensuring the person's needs and preferences were known and respected by all staff. We found staff were very knowledgeable about each of the people they supported, regardless of whether they were the person's keyworker or not. We observed the interactions between people and staff were relaxed, friendly and caring.

People responded positively when staff spoke with them and staff appeared to understand people's communication methods and knew what people wanted. For example, staff could tell when people wanted their own space but were close at hand when people needed assistance. When we visited people's flats, some of the people started to display signs of anxiety at our presence and staff were quick to identify this and politely suggest we leave.

Staff engaged with each person in a way that was most appropriate to them. The provider's service support team worked with the service to develop appropriate communication strategies for each person in the home. For example, some people had iPads with an application which enabled them to express their choices using symbols and pictures. Other people expressed themselves through body language or through a limited number of short verbal phrases.

One person with very complex needs and behaviours was supported by two care staff throughout the day. The person had their own core staff team who knew the individual's needs and behaviours extremely well. The service ensured there was always at least one member of the person's core team available on every shift.

Staff respected people's privacy and dignity. Staff ensured the door to people's flat was closed and curtains or blinds were drawn when personal care was provided. A tinted film was used on windows where people would not tolerate curtains or blinds in their flats. One person sometimes preferred not to wear clothes and their preference was respected when they were in their own flat. Again, doors and curtains were closed and the person was supported by staff of the same gender.

People were supported to maintain relationships with their families. Relatives could visit or call the home as often as they wished without undue restrictions. Staff also supported people to visit their families, if this was agreeable to all concerned.

Good

Is the service responsive?

Our findings

People lacked the mental capacity to make certain decisions about their care but they were involved in decisions to the extent they were able to be. Staff understood people's non-verbal communication methods and helped them to express their choices in ways they could understand. One person's relative said "[Person's name] appears to be relaxed and happy and enjoying their life based on their own choices". Relatives were also encouraged to participate in discussions about people's care. One relative said "Staff were always attentive and happy to give an update". Another relative said "Any concerns have been reported to me promptly".

Each person had a comprehensive care plan based on their assessed needs. There was also a support plan which provided clear guidance for staff on how to support people's individual needs. This was cross referenced to the detailed care plan for further information. People's medical notes and appointments were stored in a separate medical file. Keyworkers reviewed people's general wellbeing and their plan of care on a monthly basis. They were responsible for updating support guidelines and ensuring they were appropriate to people's current needs. Senior staff checked the keyworkers care plan reviews to ensure they were person centred and focussed on the things that were important to each person.

Most of the people were unable to engage in group activities. However, the communal areas in the home were used by some people individually for a change of surroundings. People also sometimes chose to meet their relatives or other visitors in the communal areas. Important information and news about the service was usually communicated to people individually through their keyworker, in ways each person could understand.

Staff members of the same gender were available to assist people with personal care, if this was their preference. Because of certain behaviours, one person always had male staff to support them and another person always had female staff when receiving personal care. We observed this arrangement was in place on the day of our inspection.

People had their own individualised flats. Flats were furnished and decorated to accommodate each person's particular needs and preferences. Where people had sufficient mental capacity they had a say in the colour schemes and equipping of their flats. We observed the flats were generally quite minimalistic and decorated in neutral colours. This helped reduce sensory over stimulation for people with severe autistic spectrum disorders.

People were supported by staff to spend time in the local community on a regular basis. People were taken out for a drive and/or for walks on most days. The service had six seater vehicles with taxi style partition screens to prevent the driver from being distracted. During our inspection every person in the home went out for a drive or a walk at some point in the day. This appeared to be a high point of their day and was clearly eagerly awaited by people when it appeared on their daily activity boards. Staff told us they regularly took people out on trips to places of interest to them. For example, a person who liked aeroplanes had recently visited the air museum and a person who liked animals had visited a safari park.

We observed people making choices in ways that suited their individual communication methods. People had very limited verbal communication skills and often communicated through physical gestures, body language, or by pointing to symbols or pictures. We observed communication boards in people's flats detailing their daily routines and activities in easy to read and symbol format. People were free to refuse or choose different activities if they wished. One member of staff said "We don't make people do things, we just give them options".

We observed the registered manager was visible around the home and demonstrated an accessible and open approach when people or staff wanted to speak with him. Relatives also commented they were encouraged to feedback any issues or concerns to the manager or to other staff.

The provider had an appropriate policy and procedure for managing complaints about the service. This included agreed timescales for responding to people's concerns. We observed there was an easy to read complaints procedure on the notice board in the hallway of the main building. Records showed the service had received nine formal complaints in the last 12 months; six of these were complaints from neighbours. The complaints had been responded to appropriately and within the agreed timescales.

Good

Is the service well-led?

Our findings

The home was managed by a person who was registered with the Care Quality Commission as the registered manager for the service. Staff told us the registered manager promoted an "open door" culture and was very approachable and supportive to people, relatives and staff. One member of staff said "Everyone is so supportive and you can see the manager and seniors anytime you want. It's a really good home. They are all brilliant and always there when needed". There was a clear staffing structure in place with clear lines of reporting and accountability. Staff told us the provider's senior management also visited the home regularly and they were all very supportive and approachable "from the managing director down".

The registered manager said the service ethos was "To support people to achieve their full potential for improvement". They focused on meeting each person's individual needs and aspirations. Staff received both generic and person centred training to meet these service aims. This included a comprehensive induction for new staff and continuing training and development for established staff. It was reinforced at regular staff meetings, shift handovers and monthly one to one staff supervision sessions. The person centred approach was also supported by the provider's policies, procedures and operational practice.

The provider operated a quality assurance system to ensure they continued to meet people's needs effectively. The registered manager carried out a programme of weekly and monthly audits and safety checks. The provider's area manager carried out monthly visits to the home and audited all key aspects of the service. Where action was needed this was noted on a quality assurance review form and progress was checked again at the next visit. The requirement was only signed-off once the necessary actions had been implemented. For example, work was nearing completion on converting one of the buildings, known as the Coach House, into a self-contained flat for a person who would shortly be moving to the home.

People's relatives and other representatives were encouraged to give their views on the service. They were able to contact the management and staff at any time as well as at regular care plan review meetings. Satisfaction questionnaires were also circulated every six months to relatives and staff from the provider's head office to gain feedback on all aspects of the service. The most recent survey results showed relatives agreed, and in most cases strongly agreed, that the service provided good care and support and management and staff were approachable.

The provider participated in forums for exchanging information and ideas and fostering best practice. These included fortnightly internal managers meetings, quarterly management training events, multi-agency meetings, conferences, seminars and through membership of the Registered Care Providers Association. They also accessed a range of online resources and training materials from service related organisations. These included the British Institute for Learning Disabilities, the Epilepsy Society, Autism Awareness and the Care Quality Commission website.

The provider employed a specialist crisis intervention team to support local services with complex care and communication issues and major incidents. They also used an expert in autistic spectrum disorders to provide autism training and to give advice on supporting people with particularly complex needs and behaviours.

The service fostered good links with local health and social care professionals. Specialist support and advice was sought from external professionals when needed. This helped to ensure people's mental and physical health needs were appropriately met. The deputy manager said "We need to work closely with all sorts of professionals. I think they like to engage with us because they find our service particularly interesting and complex".

Although people had very complex needs and behaviours they were supported to get involved in the local community to the extent they were able to. Staff supported people to go out most days of the week. This ranged from walks and trips out in the car; to meals out, shopping and visits to places of interest to each person.