National Autistic Society (The)

Middlefield Manor

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was undertaken on the 01 and 11 July 2016 and was unannounced. Middlefield Manor accommodates 15 adults in two houses named Cambridge House and Norfolk House. People who use the service have a learning disability and live with autism. Some people show distressed behaviour and need staff support with this. Middlefield Manor provides a large house with extensive grounds in a village setting.

The service had a comprehensive rating inspection in January 2015 and the overall rating was requires improvement. A responsive inspection was undertaken in December 2015 and the overall rating remained requires improvement.

The service had a registered manager who was present on one of the two days of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service supported individuals with very different needs in close proximity and there were some issues about compatibility. There was a greater awareness of these issues and there was a more proactive approach to safeguarding. Progress had been made in identifying risk and learning from incidents but further work was needed to ensure a better balance between safely, risk taking and supporting people to lead fulfilling lives.

The premises and equipment was managed to keep people safe. We saw that a range of checks were undertaken to make sure that the safety systems were working effectively. The environment was in an adequate state of repair and efforts had been made since the last inspection to make it more homely.

Medicines were not consistently well managed. We found numerical discrepancies and could not be assured that people were always receiving their medicines as prescribed. There were gaps in the records which could lead to confusion and these issues had not been identified by the audits. We have made a recommendation regarding this.

There were sufficient numbers of staff to meet people's needs but the service continued to be dependent on agency staff although made efforts to use consistent team members. Checks were undertaken on new staff to reduce the risk of the provider recruiting staff who were unsuitable.

Staff were positive about the training and the levels of support from the service management. We saw that staff received training on a range of areas including first aid, health and safety and autism. Staff also received training on how to defuse situations without the need for restraint. There were some gaps in the training for some individuals but the manager had already identified this and had scheduled further training to update staff.

Staff understood the principles of consent and told us that they had undertaken training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Mental capacity assessments and best interest decisions were in place and the manager confirmed that they had made referrals to the local authority as required by the legislation.

There were systems in place to support people with their nutritional intake and ensure that they had a varied diet. People were supported to maintain their health and staff accompanied people to appointments and scheduled checks with dentists and chiropodists. Where people had specific health conditions there were plans in place setting out how they should be managed and monitored.

The majority of staff knew people well and had good relationships with the people who lived in the service. There were systems in place to promote effective communication. Efforts were made to identity peoples preferences and ensure that people had choice.

Care plans were in place but were not fully completed and staff were not always familiar with the contents which meant that people were risk of receiving inconsistent care.

Appropriate systems were in place to manage complaints.

The manager was enthusiastic and committed to making changes to improve the wellbeing of the individuals who lived at the service. The manager was supported by a duty manager and senior staff. Staff told us that they were supportive and were positive about the developments in the service. Audits had been undertaken to ascertain the quality of the service and drive improvement. Progress had been made but some changes need to be further developed and embedded.

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 consistently safe.

Safeguarding and whistleblowing procedures were in place and known by staff.

There were systems in place to protect people from risks.

Staffing levels were adequate and were used flexibility to meet the needs of the people living in the service.

Medicines were not consistently well managed and we could not be assured that people always received their medicines as prescribed.

Is the service effective?

Good

The service was effective

People were supported by staff who had undertaken training relevant to their role.

The Mental Capacity Act and Deprivation of Liberty Safeguards were understood and efforts made to ensure that consent was requested and decisions were made in peoples best interests.

People were supported to access nutritious food

People were supported with their health care needs.

Is the service caring?

Good

The service was caring.

People were supported by staff who knew them.

People were supported to maintain relationships with those who were important to them.

There were systems in place to support decision making.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care and support plans were detailed but would benefit from further analysis and focus on independence. Staff were not always familiar with the contents and this meant that people were at risk of not receiving consistent care.

There were some issues about compatibility and maintaining a balance between management of risk and promotion of wellbeing.

Activities were available and some individuals benefited from these however this was an area that could be expanded further.

There were systems in place to manage complaints.

Is the service well-led?

Good

The service was well led.

The manager was approachable and visible and promoted a positive and open culture. Staff were motivated and told us that they were well supported.

Quality assurance systems were in place and there were greater levels of oversight.

Middlefield Manor

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 01 and 11 July 2016 and was unannounced. The inspection was carried out by two inspectors and a pharmacy inspector as concerns about medicines had been identified prior the inspection

Prior to our inspection we reviewed information we held about the service. This included any safeguarding referrals and statutory notification that had been sent to us. A notification is information about important events which the service is required to send us by law.

A number of the people living at the service did not communicate verbally so we undertook a number of observations of care delivery. We also undertook a short observation framework inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the registered manager, deputy managers, team leaders and six care staff. We reviewed care and support plans, medication administration records, recruitment files, staffing rotas and records relating to the quality and safety monitoring of the service. Following the inspection we spoke with four relatives and four professionals about the service provided.

Requires Improvement

Is the service safe?

Our findings

Prior to the inspection concerns had been identified about medicine administration and we looked at the systems in place as part of this inspection. We found that medicines were not consistently well managed. Records did not always show that people were receiving their oral medicines as prescribed. We noted there were numerical discrepancies for some medicines where we could not account for them. When people took their medicines for periods of leave from the home, there were no detailed records of the medicines they brought back. There were internal audits in place to enable staff to monitor and account for medicines; however these were ineffective at identifying discrepancies.

Medicines were being stored safely for the protection of people who used the service and at the correct temperatures. We noted supporting information to enable staff handling and giving people their medicines to do so safely and consistently. There was personal identification and information about known allergies/medicine sensitivities, personalised medication support plans and written information on people's preferences about having their medicines given to them. When people were prescribed medicines on a when required basis, there was written information available to show staff how and when to administer these medicines. We noted records that showed people received prescriber reviews of their medicines. For a person with limited mental capacity to make decisions about their own care or treatment and who was refusing their oral medicines. There were records of an assessment of their mental capacity and best interest decisions to give them their medicines given to them dissolved in drink. In addition, there were records showing their doctor and pharmacist had been consulted about this. There was information about the medicines that people were currently prescribed, however, this sometimes inaccurately recorded medicines that had been discontinued by prescribers and so could have led to confusion and error. The manager provided us with records of medication training for staff authorised to handle and give people their medicines. The records showed that two members of staff had not received training since 2013 and that seven had not had their competence assessed to undertake medicine-related tasks since 2014 or earlier.

We recommend that the service seeks further advice from a reputable source on the management and oversight of medicines.

Relatives were generally positive about the staff and safety. One person described the service as good and another told us that there were, "People [my relative] trusts there." However another relative told us that things varied as it, "Depended on who was on duty," as some staff knew people better than others. Three people we spoke with were positive about the service and told us that they got on with staff and liked living there. Our observations of the interactions between people living in the service and staff were generally positive but some staff knew individuals better than others and were more confident in their interactions and proactive in terms of managing risk.

The service supported individuals with very different needs and this presented risks to individuals from bullying. The manager acknowledged that there were some issues about compatibility but told us staff were working in a more proactive way to keep people safe. He told us that he had increased staffing at key points in the day and one individual was due to move on to another type of service which may be more appropriate

for their needs. We saw that the manager was making efforts to protect people and staff were able to tell us how they intervened to promote individuals safety. We observed one person getting close to another person who lived in the service with whom there had been previous conflict which had resulted in an incident. On one occasion we observed a member of staff stepping between the individuals to distract and avoid any potential conflict. However we also observed that this was not always consistently undertaken by staff and on one occasion we observed the manager intervening to remind staff to observe and anticipate.

There were some positive signs that the manager was encouraging learning from incidents. There had been a number of incidents related to access to drinks and we observed that the drink station was in use and work was underway to develop a kitchenette which allow greater independent access to drinks.

Staff told us that they used restraint only as a last resort, if an individual was at risk of immediate harm. Studio III was the training provided for staff to equip them to manage behaviour that could lead to physical violence. Staff told us that they had completed training and used interventions such as deflection techniques to defuse behaviours which were challenging.

Staff told us that they completed documentation after any incident and these were analysed by the behavioural support worker who provided support and guidance on ways to prevent a similar situation occurring in future. They gave an example of one individual who became distressed when a number of people came into the swimming pool. They decided to leave the pool earlier before the end of the session and this meant that the individual was experiencing less distress.

The manager had notified us of events of suspected or potential abuse and was able to show us the actions they had taken to address these issues. This included raising safeguarding alerts to the local authority, responsible for investigating safeguarding concerns. We saw that records were maintained of any restrictive practice such as redirection and these were overseen by the provider.

Risks to people had been risk assessed. There were risk assessments in place for a range of scenarios such as leaving the building and travelling in the car. However we noted that one person had a risk assessment in place which stated that the individual throws things and heavy objects should be removed from the lounge. However we observed that there were a number of heavy wooden logs in the fire place and have recommended that this assessment is reviewed.
The premises and equipment was managed to keep people safe. We saw that a range of checks were undertaken to make sure that the safety systems were working effectively. For example checks were undertaken on fire safety equipment, water temperature and portable electrical appliances. The environment was in an adequate state of repair and efforts had been made since the last inspection to make it more homely with pictures and a display of other items some of which had been made by the people using the service.

The levels of staffing were adequate. The manager told us that the numbers of staff on duty had increased over the last year and the service operated with five staff on duty in each of the two units during the day. Each house had a shift leader and were managed on a day to day basis by one of the two deputy managers. On the day of our inspection, staff were visible and assessable and were able to respond to individual's needs. Staff we spoke with told us that the numbers of staff were sufficient to meet people's needs. We looked at the staffing rota and saw that these levels of staff were maintained although there was a number of staffing vacancies and a regular use of agency staff.

The manager told us that they still used agency to cover some shifts, but this had reduced. Where agency staff were used, these were supplied by the same agencies, to provide consistency. The manager told us that

he undertook supervision meetings and did some training with agency staff to review their progress and ensure that they were working in a consistent way.

We examined recruitment records and found these to be adequate. People completed an application form and we saw that references were taken up with the last employer and disclosure and barring checks undertaken to check that individuals were suitable to work in the care sector.

Staff knew who to contact if they had a concern about an individual's welfare. They were able to tell us about the procedures in place for whistleblowing and safeguarding and expressed confidence that they would be addressed by the manager and provider. The manager told us that he was working with staff to raise awareness of harm and the actions needed to protect people. He told us that he had undertaken further training with staff and his advice to staff was, "If in doubt report" and was working with the senior team on the process to use when raising a concern. This greater alertness had meant that there had been an increase in the number of concerns reported to the safeguarding team.

The service managed some individual's money on their behalf and we saw that the money was appropriately stored. Only a small number of senior staff had access to the keys and we saw that there was a system for signing money in and out. Receipts were logged and a running total maintained. We checked the records and the amounts of money for one individual and this tallied.

Good

Is the service effective?

Our findings

Staff told us they were supported in their role and received the training they needed to undertake their role effectively. They confirmed that they received regular one to one supervisions and these were undertaken frequently. All but one staff told us they have received a recent annual appraisal of their performance. The manager provided evidence of staff supervision and showed a matrix of training, although it was not all up to date there were plans to do so in the three months following the inspection. We saw lists on the wall of the office listing training dates and the names of the staff who were due to attend the different courses. Staff were positive about the training they had done and told us they have completed person specific training such as autism, epilepsy training and training for staff on diffusing situations without the need for restraint. Staff had also undertaken essential training for their role such as manual handling, first aid, mental capacity and safeguarding and health and safety. Some staff had completed some enhanced training and obtained nationally recognised courses. Staff told us training was good with lots of updates. All new staff completed an induction workbook and were shadowed by more experienced staff until they were confident to work on their own.

We observed staff asking people for consent and offering choices as part of providing support. 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 are called the Deprivation of Liberty Safeguards (DoLS). The manager told us that appropriate applications for DoLS had been made and the service was awaiting an outcome from the local authorities on the matter. Care plans contained mental capacity assessments and best interest decisions. We saw examples of decisions which had been taken in the person's best interest and the processes and consultation staff had undertaken to ensure decisions were lawful. For example one person required some health investigations to be carried out to ascertain if they had a medical condition/illness which might require treatment but they were unable to consent to treatment. Staff had supported them and involved medical specialists and others in making the decision.

People were supported to eat and drink. We observed people being supported by staff to make their own drinks and being offered drinks and snacks. Menu choices were agreed with individuals and a picture menu was available to help people choose. Records were kept of what people were eating and drinking in their individual's records and these evidenced that people were eating a varied diet. One person had specific dietary requirements and their own food cupboard. People's dietary needs, likes and dislikes were recorded as part of their plan of care. Staff told us people were involved in meal preparation both at the service and in their various day placements. We observed that one individual was supported to cook the evening meal and we saw that this was prepared with fresh ingredients. On the second day of the inspection people and staff of one of the houses were preparing for a barbeque.

People were supported to maintain their health. Relatives expressed confidence in the staff and one relative told us if there were any problems staff would take their relative, "Straightaway to the doctors." People's health care needs were recorded. Each person had a health care action plan and hospital passport. Staff told us that they would accompany people to hospital and the hospital plan enabled other health care professionals to see at a glance what people's main needs were and any special considerations staff would

need to know. We saw that one person had a diagnosis of epilepsy and we saw that there was a seizure management plan in place which outlined how staff should support the individual should they have a seizure. There was a system for logging any seizures and for identifying any increase in the numbers and type of seizure. The staff we spoke with were clear about the process to follow in an emergency.

Good

Is the service caring?

Our findings

The people we spoke with indicated that they liked the staff. Relatives were also largely positive and told us that they had a "supportive "relationship with the staff.

We saw that people were enabled to maintain relationships with family members. Relatives told us that they had recently been invited to a partnership day where they spent the day in the service and joined their relatives for a meal. Some people visited their families at weekends and we observed one person using a mobile telephone to speak to their family and also were using Facebook. Relatives we spoke with told us that staff supported their relative to use skype and told us that this worked well and helped them maintain regular communication. One person had an advocate but we did not see a lot of support for people without family support. For example in people's care plan there was a diagram which outlined people's circles of support but for some of the people we case tracked this only included health care professionals and staff. There was very little information about people's friendship groups, advocates or volunteers and it was agreed that this was an area that the service could develop with the people. Families however told us that special days such as birthdays were celebrated and one of the people who lived in the service was supported to make a birthday cake for other individuals.

Staff knew people well and had good relationships with them. One family member said, "Some staff know [my relative] inside out." A number of staff told us that they had supported some individuals for a number of years and knew them and their family well.

During our observations we saw good interactions from staff whilst supporting people. We observed people coming up to staff and initiating contact with them, staff gave reassurance and information as appropriate. Staff were attentive and knew what people were communicating from their body language, for example they knew that one individual wanted a drink and another wanted some help to find an object.

The manager said they were working hard to change the culture within the service and give people greater choice and control over their life. They told us that they had recently had a lot of input from the Local Authority who had been running dignity workshops for all the staff. Staff told us that these had been positive and made them think about how they supported individuals and share good practice examples.

Efforts were made to support people to make choices for themselves. One visiting professional told us that the person they supported was very involved in decision making at the service and staff involved them in making decision about how they spent their time. We saw that there was information in peoples care plans about people's individual needs and preferred routines. Bedrooms had been personalised to reflect people's interests and some people were supported by visual information which helped them make choices. Staff told us that they used the TEACH system with a small number of people. This is a pictorial system of communication and staff said that they used this to prepare people for what was happening and indicate meal times. We observed that people were well dressed and had smart comfortable clothing.

People had privacy in their own rooms. People either had keys or door locks designed around their needs

such as one person used a finger print for authorisation. We observed that personal care was provided discreetly.

Staff told us that weekly meetings were held with people to ascertain their views. Questionnaires about the quality of the service were undertaken with people who used the service although participation was low and it was not clear what changes had been made as a result. Relatives were also asked to complete a survey on a yearly basis and we looked at the results of the last survey which were positive.

Requires Improvement

Is the service responsive?

Our findings

The feedback we received from families about the service was inconsistent with some telling us that it had improved but others were less positive. Some people told us that their relative had been in a number of previous placements which had been unsuccessful and they seemed to be, "Very happy" at this service. Others however said their relative, "Gets down sometimes," or, "Doesn't always want to return" to the service after visits to relatives.

People did not always receive consistent personalised care and support. Care plans were in place and contained information about peoples care needs and preferences. However the care plans varied in quality with some being informative and detailed and others less so. Some of them were written in an "easy read" pictorial format so that people could understand them clearly. However they were not working documents and a number had large gaps and information was not always easy to find or was unavailable Some people had goals listed but some individuals had none identified and families did not know what they were and told us that their relative would benefit from working towards greater independence. Monitoring was not consistently good so for example staff told us that individuals were weighed on a monthly basis but when we checked we saw that some individuals repeatedly refused and the weights were not always transferred into the care plan which meant that they may not be monitored as closely as they should.

Staff were not all aware of the contents of the care plan and this meant that they did not always work in a consistent way. For example we observed staff supporting one individual to make themselves a hot drink but when the individual later indicated that they wanted a drink another member of staff responded very differently, telling the individual to "sit down and I will get it for you." A relative told us that it had been agreed that they would use a communication book to improve communication between them and the service but this was not used consistently by staff.

People had behavioural support plans which were put together by health care professionals working for the National Autistic Society. Positive behaviour plans, detailed how staff should positively engage with people and included reflective practice so should an incident occur staff would look at why it occurred or what they could do differently to support the person. Risk assessments were in place to support safe activities and these were reviewed to ensure the steps staff took remained appropriate. Staff said it was crucial to forward plan and anticipate what might hinder an activities success and gave us examples of this. Some people using the service found change difficult particularly at handover time when some staff left and new staff came on duty. To help ease this staff had routines that they followed and there were photographs boards in place showing which staff were on duty.

A number of people had lived together for many years, however their needs were not all compatible and there were reported incidents between people which had resulted in injury. The current building meant people had shared living space and at times found this difficult. We observed one person with their hands over their ears as they clearly found the noise made by some of the other people who lived in the service difficult .Staff were problem solving and trying to find creative solutions, so for example on the evening of our visit staff took two individuals to the providers local day centre to watch a film and have their tea

enabling them to have some quiet relaxation time. Other solutions however were far from ideal so for example one person's care plan stated that they were "Having dinner in the hallway to avoid ongoing situations….and they were happy with this."

We observed that staff spent significant periods watching and observing to pre-empt any indicators or distress. The staff told us that some individuals could be "unpredictable" and we, "keep our distance" and "we separate them to make it easier."

The focus of staff was about keeping people safe and maintaining control. This meant that there was not always a lot of initiative or positive engagement with the people who lived in the service. We observed that the interactions were largely responsive rather than being engaging or proactive.

People had access to individualised activities and work was underway to develop this area and ensure that people had full lives. The manager told us this had proved difficult as the funding arrangements in place for people were for shared support whereas some people required one to one staffing for activities. The manager said he was discussing this with local authorities and some changes had been made as a result. Our observations were that while progress had been made some people's activities were more fulfilling and richer than others, so for example some people were busy but others had significant periods with no scheduled activities. One relative expressed concern about this and told us that, "The quiet ones can get left behind."

People had individual plans which showed what activities were scheduled and some people accessed a range of activities on some days of the week which included traditional day care placements, volunteering and work based activities. Visits were also made to local pubs and sports facilities and people had opportunities for individual holidays and days out. The service had a range of transport they used to transport people but people had also access to taxis' and were able to walk to the local town. The provider had recently built a sensory room in the garden which was used by a number of people using the service where they could go and relax. New cycles had been purchased and there were plans to use these with some individuals.

There was a complaints procedure in place although a number of people who lived in the service would be unlikely to be able to raise concerns independently and would need to rely on family or staff to do this on their behalf. The manager told us that they sent out a copy of the policy to relatives each year. Relatives we spoke with told us that they knew how to make a complaint on their relative's behalf but the majority told us that they had no cause to do so. One relative told us that if there is a problem, "The staff can generally work things out." We looked at the records of complaints and saw that one complaint had been received within the last six months and this had been investigated and responded to appropriately.

Good

Is the service well-led?

Our findings

The staff spoken with felt the manager had made an impact on the service and had provided clear leadership and direction. One member of staff said, "There is a better atmosphere now." Staff said morale had improved. They felt supported by him and said he worked alongside them and knew people well. Staff told us that there had been lots of changes within the service. They felt there was now greater continuity and more individual time for people using the service which they said had helped to reduce tensions between individuals.

Our observations were that the manager was enthusiastic and committed to making changes to improve the wellbeing of the individuals who lived at the service. Progress had been made and it was positive to observe a greater focus on choice and opportunity although some changes were not yet fully embedded or consistently implemented. However the manager was clear about what needed to change and had a plan to address the issues. This included the introduction of reflective practice where staff were encouraged to reflect on incidents and look at how things could be done differently.

The manager was visible and accessible and we observed the manager directing staff appropriately. The manager was supported by two deputy managers who had worked at the service for some time and who managed the two houses, working alternative shift patterns to ensure that one or other of them was generally available.

Staff told us that there were regular team meetings and observed that there were handovers between shifts to ensure that staff coming on duty were aware of people's needs and any changes. This was supplemented by a communication book and daily record.

The manager told us that they were well supported by the area manager and resources were available to drive improvement. We saw that there had been some investment in the fabric of the service, with the development of the new kitchenette, the sensory area and carpets. There was also greater attention to detail and some of the issues that we had found at the last inspection such as there not being shower curtains or toilet paper had been addressed.

A quality assurance system was in place to drive improvement which included a development plan and visits by managers of the providers other services who reviewed the care and produced a report. We looked a copy of a recent report and saw that the format included looking at areas including safe, effective, caring, responsive and well led. Records were viewed and observations undertaken and where shortfalls were identified these were the subject of recommendations for the manager to take forward.

Oversight was also provided by the providers behavioural support lead who staff visited the service and undertook observation of the care on a regular basis, Again a report was produced which lead to recommendations and actions. There were also audits in place to evidence that the staff minimised risks to people by ensuring equipment was used correctly and sufficiently maintained. We looked at fire audits as there had been some remedial actions identified by the fire authorities. The areas of concern had been

addressed. The service completed routine checks on equipment, provided training, held fire drills and had a work based fire risk assessment.