National Autistic Society

Middlefield Manor

Inspection report

The Street
Barton Mills
Bury St Edmunds
IP28 6AW
Tel: 01638 716910
Website: www.autism.org.uk

Date of inspection visit: 13 and 14 January 2015
Date of publication: 08/05/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

We inspected this service on 13 and 14 January 2015. Middlefield Manor provides accommodation, care and support for a maximum of 15 people who have Autistic Spectrum Disorder or Asperger's syndrome. There were 14 people living in the service when we inspected.

At our last inspection on 18 and 24 August 2014, we asked the provider to take action to make improvements in the management of medicines, staffing and assessing and monitoring the quality of the service. The provider wrote to us to tell us how they had implemented these improvements. At this inspection we checked to see if they had made the required improvements and found that action had been taken to manage medicines safely and more staff had been recruited. However, further improvement was needed to ensure quality assurance systems identified the shortfalls in the service, as found by us during the inspection. These related to the lack of assessment of people's capacity to consent to their care and treatment, failure to respond to people's needs, when they needed it, and failing to ensure staff had the skills, knowledge and experience to ensure people's specific needs were met.

Summary of findings

There was a registered manager 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.

Staff lacked knowledge about the Mental Capacity Act (MCA) 2005 and when this applied. This Act sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care or treatment. As care staff facilitated the majority of interaction with people who used the service their lack of understanding meant that issues relating to consent were potentially overlooked.

People identified as having communication difficulties, were not always supported to express their views and make decisions about their care, treatment and support. Advocacy support had been used in the past to help people make decisions, particularly those with limited communication. However, the manger confirmed that people had not been provided with information they needed to access advocacy support. Staff lacked training on how to effectively communicate with people to make complex decisions about planning their own care, or where required, treatment.

Although staff interacted with people in a caring and professional manner at times they did not respond to people's needs when they needed it and did not respect people's choices.

People, their relatives, social workers and staff were involved in meetings which reviewed what was working well and where changes were needed. However, these changes were not being updated in people's care plans, which meant that information held about them was out of date and not reflective of their current needs. Therefore staff could not be sure they were responding appropriately to people's changing needs.

Systems were in place which guided staff on how to manage risk and safeguard the people who used the service from harm or abuse. Staff could recognise signs of harm or potential abuse and knew who to report any concerns to. Procedures were in place to guide staff on how to ensure the safety of the people who used the service. These included checks on the environment and risk assessments which identified how the risks to people were minimised.

People were supported by sufficient numbers of staff. The provider had a thorough recruitment and selection process in place to check that staff were suitable to work with people who used the service. Staffing levels were flexible and supported people to follow their interests and take part in social activities and, where appropriate, education and work opportunities.

People were supported to see, when needed, health and social care professionals to make sure they received appropriate care and treatment. People were supported to have sufficient to eat and drink and their nutritional needs were being assessed.

The service was up to date with changes to the law regarding the Deprivation of Liberty Safeguards and at the time of our inspection they were working with the local authority to make sure people's legal rights were protected.

The manager was new in post. Staff told us they were knowledgeable, and inspired confidence in the staff team and led by example. Staff understood their roles and responsibilities in providing safe and good quality care to the people. The manager had improved supervisions, developed an appraisal system and introduced more staff meetings which had provided an opportunity for staff to have open discussions about the way in which the service was run.

People's complaints were listened to, addressed and used to improve the service. Systems were in place that ensured concerns about people's safety were identified, reported and acted on. Incidents and accidents were being reviewed, and monitored to identify reoccurring issues and, where required these were investigated. Outcomes of investigations into complaints, safeguarding incidents and accidents were used to improve practice and minimise the risk of similar incidents occurring.

We have made the following recommendations.

We have made a recommendation about staff training on the subject of the Mental Capacity Act 2005.

Summary of findings

We have made a recommendation about involving people in decisions about their care.

We have made a recommendation about the provider's quality assurance system.

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?

Good

The service was safe. The provider had systems in place to manage risk, including safeguarding matters. Staff understood how to recognise abuse or potential abuse and how to respond and report these concerns appropriately.

There were enough staff to meet people's needs.

There were effective systems in place to provide people with their medication when needed and in a safe manner.

Is the service effective?

Requires Improvement

The service was not always effective. People's capacity to make decisions about their care and treatment was not always being assessed.

Staff had not been provided with training that gave them the skills and knowledge to ensure people's communication needs were being met.

People were provided with enough to eat and drink to maintain a balanced diet and had access to appropriate services which ensured they received on going healthcare support.

Is the service caring?

Requires Improvement

The service was not always caring. People identified as having communication difficulties, were not always supported to express their views and make decisions about their care, treatment and support.

Staff had developed positive relationships with people who used the service. People had their privacy and dignity respected.

Is the service responsive?

Requires Improvement

The service was not always responsive. Changes in people's needs were not being updated in their care plans. This meant that information held about them was out of date and not reflective of their current needs.

There was a complaints system in place to show that complaints were investigated, responded to and used to improve the quality of the service.

Is the service well-led?

Requires Improvement

The service was not always well-led. The provider did not have systems in place to assess and monitor the quality of the service.

There was a new manager in post. The manager was knowledgeable, and inspired confidence in the staff team and led by example.

People, their relatives and staff were asked for their views about the service and these were listened to and acted upon.

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 13 and 14 January 2015 and was unannounced. The inspection team consisted of an inspector, a Specialist Professional Advisor, whose specialism was in autism and an Expert by Experience. The expert by experience had experience of supporting people with autism.

We reviewed previous inspection reports and the Provider Information Record (PIR). This 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 looked at notifications received by the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law. We also looked at information we held about the service and safeguarding concerns reported to CQC. This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect.

We spoke with two people who were able to express their views, but not everyone was able to communicate with us verbally. Therefore we spent time observing the care provided by staff to help us understand the experiences of people unable to tell us directly.

We looked at records in relation to five people's care. We spoke with 13 staff including team leaders, care staff, agency staff and the registered manager. We looked at records relating to the management of the service, staff recruitment and training records, and systems for monitoring the quality of the service.

Good

Is the service safe?

Our findings

At our previous inspection we found the provider had not employed sufficient staff to meet people's needs. At this inspection we found that new staff had been recruited. People who used the service and staff told us that there was more staff available to meet people's needs. Three new staff had been recruited in September 2014. At the time of the inspection the manager had been in post for three months, during which time they had recruited a further six staff. The manager told us that they still used agency to cover some shifts, but this had greatly reduced. Where agency staff were used, these were supplied by the same agencies, to provide consistency. Some staff worked flexibly to support people to access the community and visits to family and friends.

The manager confirmed that staffing levels had been assessed according to people's needs. This included the provision of staff to meet the requirements of additionally funded hours, for one to one, or two to one support to access the community. There was enough staff to support people to carry on with their usual routines, such as going to day services, work, shopping and accessing places of interest in the community.

A thorough recruitment and selection process was in place to check that staff had the right skills and experience. Staff confirmed they had attended an interview and that all relevant checks, including a criminal records check and appropriate references, had been obtained to ensure they were suitable to work with people who used the service, before they were allowed to start work.

At our last inspection we found there was a lack of systems in place to manage people's medicines. At this inspection we looked to see if the required improvements had been made and found systems were in place that ensured staff consistently managed medicines in a safe way. We observed a member of staff administering the lunchtime medicines. They provided support to people, where needed to take their medicines. We checked the medicines being administered against people's records which confirmed that they were receiving their medicines as prescribed by their GP. Where people had been prescribed medicines for occasional administration to reduce distress and anxiety, guidance was in place for staff to make decisions when these medicines should be administered. Staff told us this was very rarely administered, and only as a last resort. Training records confirmed that staff had received up to date medication training, to give them the competency and skills needed to administer medicines safely.

People told us that they felt safe living in the service. 'House meetings' were held, every Sunday attended by people who used the service and staff. At these meetings people were asked for their views about the service, including if they felt safe. Staff showed us a communications folder they used to help people with no or limited verbal communication to tell staff if they felt safe, or if they were worried about something. Many of the staff had worked at the service for a long time and knew the needs of the people using the service well. They understood the support people needed and told us where people were unable to tell them verbally about concerns; they would be able to recognise signs of potential abuse by changes in their behaviour.

The provider's safeguarding adults and whistle blowing policies and procedures informed staff of their responsibilities to ensure that people were protected from harm. Staff had received safeguarding training and had a good understanding of the procedures to follow if a person who used the service raised issues of concern or if they witnessed or had an allegation of abuse reported to them. 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. Staff understood the difference between lawful and unlawful restraint practices, and were clear that restraint was only ever used as a last resort. Records seen confirmed this and showed that low level interventions and deflection techniques were effective in diffusing incidents of behaviours that were challenging.

Risks to people in their home, accessing the community and managing their health had been assessed. Risk assessments gave staff direction as to what action to take to minimise risk, and focused on the support people needed so that activities were carried out safely and sensibly. The psychologist, who was part of the provider's own behaviour support team, told us they addressed how staff responded to risk through staff meetings and training. These forums were used for staff to share information on how risks were managed; with the least restrictions

Good

Is the service safe?

possible whilst keeping people were safe. For example, due to the seriousness of the risk where a person had tried to get out of a moving car, this had been escalated to the provider's safeguarding lead and area manager. Following assessment and a best interest decision, a harness had been fitted with a secure buckle, enabling the person to still access the community in the car, but preventing them from getting out of the car whilst in motion.

The premises and equipment was managed to keep people safe. Routine servicing and inspection of equipment was being carried out by external contractors. Environmental risk assessments and fire safety records were in place to support people's safety. Plans for responding to any emergencies or untoward events were in place to reduce the risks to people. For example, emergency plans were in place relating to how people were supported to evacuate the service in an event, such as a fire.

Requires Improvement

Is the service effective?

Our findings

Although staff had received training in the Mental Capacity Act 2005 (MCA) they had varied understanding about when this legislation applied. Where staff had some understanding of best interest decision making they stated that they were not involved in the process. As care staff facilitated the majority of interaction with people who used the service this lack of understanding meant that issues relating to consent were potentially overlooked. This was further compounded by a lack of staff training around communication and a lack of aids available, to effectively communicate with people who used the service, to establish their capacity and to consent to their care, treatment and support. A review of five people's care plans found that one person had evidence of their mental capacity being assessed for taking their medication disguised in food and drink (covertly). There was no information in the other four care plans that demonstrated if their capacity to make decisions about their care, support or where required treatment had been assessed.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager had a good understanding of DoLS legislation and had completed nine referrals to the local authority in accordance with guidance to ensure that any restrictions on people were lawful.

The registered manager told us staff were encouraged to complete training and achieve recognised qualifications to develop their knowledge and skills. However, we found staff had not received recent training to effectively communicate with people. The majority of the people who used the service had either limited verbal communication skills, or none at all. Staff told us they used a specialist communication approach for people with autism; however they confirmed they had not received any formal training to use this approach and there was no visual evidence of this system being used. The lack of training meant there were times when staff were unable to communicate with people effectively. For example, staff told us where people were unable to tell them if they were in pain or felt unwell, they had to rely on their knowledge of the person to establish their health and general wellbeing.

Although staff had not received the training identified above, they confirmed they had completed a range of training that gave them the knowledge, qualifications and skills to carry out their roles. Training had included sessions about living with autism and providing personalised care. One member of staff told us, through this training they had changed their approach in the way they supported people, which had improved their quality of life. They provided an example, where one person's life was now based on what they wanted to do, instead of fitting in with routines set by the service. This person was now supported to work, do their own shopping and visit beauty clinics.

Staff were regularly supervised to discuss their strengths and areas for development. New staff confirmed that they had or were in the process of completing an induction, which had helped them to understand and meet the needs of the people they supported and cared for. Two agency staff had completed shadow shifts with a senior member of staff and never worked alone, and felt confident in carrying out their roles. Both staff had since obtained a permanent position at the service and were in the process of completing their induction training.

Staff told us the support and training they received for supporting people with behaviours that challenged and the management of physical aggression provided them with the confidence to manage and diffuse situations. One member of staff told us, "The psychologist from the behavioural team, has a refreshing attitude, and provides live examples to help staff learning around encouraging and promoting positive behaviours."

The manager told us that they continually strived to improve their own practice and knowledge. They informed us that they had a good support network, stating that in the first two months they had received a lot of support from other managers and the area manager. They also kept their own training up to date. For example, they had signed up for management leadership training, as well as completing computer based learning around performance and management

People were supported to have sufficient to eat and drink. Mealtimes were flexible, people were observed eating their meals at times that suited them. People were able to help prepare and cook their own meals. One person told us they had made their own stir fry.

Staff were knowledgeable about people's dietary needs and what they liked to eat. A senior member of staff told us that each house had a budget, for weekly food, plus an

Requires Improvement

Is the service effective?

additional amount for extras, such as take away meals. People were involved in decisions about what they ate and drank. Where possible, people did their own food shopping with money allocated from this budget. A member of staff was observed supporting one person using pictures of food items to compile their own shopping list, based on meals they planned to make for the coming week. A six week menu planner using pictures and photographs of food was used as a guide to help people make choices. The menu had been developed based on people's known likes, preferences and cultural needs. There were at least two to three options daily to accommodate people's choice, including those who chose a healthy diet. If people did not want any of these choices, alternatives were available. The senior told us they were adding more pictures to the menu to try to offer more choice.

People were supported to maintain good health and receive on going healthcare support. Each person had a Health Action Plan (HAP) which detailed how they were being supported to manage and maintain their health. For example, we saw that people had routine annual health checks and access to healthcare professionals, such as their GP, when needed. People also had a 'Hospital Passport', so that if they needed to be admitted to hospital staff at the hospital had relevant information about the person, and how to support them.

We recommend that the service finds out more about training for staff, based on current best practice, in relation to the Mental Capacity Act 2005 and assessing people's capacity to consent to their care and treatment.

Requires Improvement

Is the service caring?

Our findings

Overall the support provided by staff to people who used the service was kind, supportive and caring. However, there were occasions when staff did not ensure that people's dignity was maintained. For example, one person had been unwell and despite there being three staff in the room, they did not respond promptly to their needs. When staff did attend to their needs, this was done in a way that focussed on the task of cleaning up, rather than focusing their attention on the person. Another person's care records stated that they shaved whilst having a bath, however this person was observed with facial hair growth. Two staff spoken with were not aware of when this person had last had a shave. When asked why this hadn't been done, they commented, "I don't know, I haven't done their personal care today" and "I don't know I'm agency."

At times the support provided by staff did not promote people's choice. For example, one person with no verbal means of communication had been provided with beans on toast for their lunch, and kept saying, "Coffee, Coffee" trying to hand a member of staff their cup. The member of staff told them "Eat that first then you can have a drink". The person continued to ask for coffee. After they had finished eating the staff brought them a cup of tea, rather than the requested coffee. Later on, the same person requested a biscuit, the same member of staff replied, "You can't have a biscuit now, you can have a biscuit with staff later on."

There was a lack of communication aids visible in the service for people to use to express their views. A senior member of staff told us communication folders were in the process of being developed to assist people to make decisions about their care, treatment and support, however these were held in the office and not immediately accessible to people. Because staff knew people well, they were seen to communicate about day to day choices. They told us they had learnt the signs and signals people used. A member of staff provided an example, where one person would shake their hand from side to side if they did not want to take part in the activity. They also told us, one person communicated using symbols which enabled them to make decisions about what they wanted to eat and how they spent their day. For example, they would attach a picture of horse to a board in their room, which signified that they were going horse-riding. Whilst these examples demonstrated that people were able to make their choices about daily activities known, systems were not in place to enable people to make more complex decisions about planning their own care, or where required treatment.

The manager told us that although one person had received advocacy support in the past, for the completion of a deprivation of liberty issue, no one at the service was currently receiving advocacy support. We saw that staff had supported people to complete satisfaction surveys. We discussed with the manager that advocacy support to help people, particularly those with limited communication, may have helped to obtain a more independent view of the care people received. An advocate is a person who represents and works with a person or group of people who may need support and encouragement to exercise their rights, in order to ensure that their rights are upheld.

A core of staff had worked at the service for a long time and knew the needs of the people well. Staff spoke in detail about the needs of people, including ethnic and cultural needs and had a good knowledge about their background, current needs, what they could do for them self, and where they needed help and encouragement. The continuity of staff had led to the development of good relationships with people who used the service. Our observations of the interaction between staff and people who used the service confirmed this. Additionally, we saw complimentary feedback from the McMillan nurses, district nurses and doctors surgery regarding the care and support provided by staff to a terminally ill person who was receiving end of life care.

People's privacy and dignity was respected. For example, staff knocked on bedroom doors before entering the room, whether the door was open or closed. This was confirmed by people using the service. A member of staff told us they had raised an issue where one of the bathrooms used by two people had no blind at the window. They had raised concerns about these people's privacy and dignity with the manager who had authorised them to purchase a blind.

Although there were no relatives and friends visiting at the time of our inspection, the manager and staff informed us people could visit at any time. Information contained in people's records confirmed this.

Requires Improvement

Is the service caring?

We recommend that the service seek advice and guidance from a reputable source, about supporting people to express their views and involve them in decisions about their care, treatment and support.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives were involved in planning their care and treatment. Annual reviews had been attended by the person's relatives, social worker and staff. However, although, these meetings reviewed what was working well and any changes in the person's care and support were agreed, these changes had not always been uplifted in to their care plans. Where the care plans had not been updated staff not involved in the person's review did not have access to the most up to date information about how they were to be cared for. The manager told us they were aware that care plans needed to be reviewed. A new care plan template had been produced by the provider and they were waiting to receive these. They had arranged workshops for staff to attend to discuss the care plans and to improve how staff reported to reflect people's general wellbeing and changing needs. Until these measures have been implemented staff could not be sure they were responding appropriately to people's changing needs.

People told us that they were happy living at Middlefield Manor. One person told us, "I like living here, you get used to mixing with people". Another person told us, "I get to do the things I want."

People were supported to follow their interests and take part in social activities and, where appropriate, education and work opportunities. People carried on with their usual routines, going to work, going to day services and accessing places of interest in the community. Staff talked passionately about the people they supported and had a good understanding of their individual personalities and things they liked to do. Staff told us with the recruitment of new staff they were able to take people out when they wanted to go. One member of staff provided an example, where [person] wanted to go for a walk, so they walked to the garage and they purchased a coke. The member of staff commented that Middlefield Manor is a much happier place, as people are supported to do what they want to do. Another member of staff told us that one person had asked to go out more, to make more friends. Staff had supported them to join a local befriending scheme. This person told us that they liked going there, and commented, "Yes, good" and smiled.

Staff told us they had access to behavioural therapy clinics, where they discussed people's individual needs and how best to support them during times when they experienced distress. From these meetings support plans had been developed providing guidance for staff to manage incidents where people's behaviour placed themselves or others at risk. Behaviour monitoring charts were being completed and reviewed regularly at the clinics with the person, their relative, psychologist and staff. Staff confirmed, following these clinics they were asked to read and comment on any revision to the behaviour support plans, so they were kept up to date in managing people's behaviours. This ensured people's behaviours were managed in a consistent and safe way that protected them and others from potential risks.

The provider's concerns, complaints and compliments policy outlined clear stages of the complaints procedure with a timescale. Staff told us they were aware of the complaints procedure and knew how to respond to complaints. The complaints file contained an easy read version of how to make a complaint, using symbols, and faces, for example depicting if someone was happy or sad to help people to make their feelings and views known. However, this was contained in the file and not displayed on notice boards for people to access, should they need to. The complaints log confirmed there had been one complaint made about the service in the last 12 months. We saw this had been appropriately investigated in a timely manner in line with the provider's complaints policy and used to improve the service.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection we found the provider did not have an effective system to regularly assess and monitor the quality of service that people received. At this inspection we found that although improvements had been made by the manager to implement a quality assurance system this had failed to recognise and address issues identified by us. These related to the lack of assessment of people's capacity to consent to their care and treatment, failure to respond to people's needs, when they needed it, and failing to ensure staff had the skills to support people with communication difficulties, to understand information and make decisions about their care.

In the three months that the manager had been in post there had however been some quality assurance audits undertaken and used to improve the service for people in some areas. For example, medication audits were being completed weekly, monthly and bi annually to check that medicines were being obtained, stored, administered and disposed of appropriately in accordance with nationally recognised pharmaceutical guidance.

The manager provided evidence to show that questionnaires had been distributed to people who used the service, relatives and staff to obtain their feedback about the quality of the service. At the time of the inspection five out of 18 questionnaires had been returned by relatives. These provided positive feedback about the service and reflected that people were being encouraged and supported to develop their social skills, which had resulted in more participation in the local community. The manager told us in addition to questionnaires, they had a range of systems in place to obtain feedback about the quality of the service, such as individual service reviews with relatives and other professional's, informal feedback via day to day conversations and communication from the staff team and 'Parent Partnership Days'. On these days relatives were invited so that they were able to meet and share information with staff and other families. The manager told us they used this feedback to continually improve the quality of the service for people.

The manager and staff understood their roles and responsibilities in delivering quality care to people which was safe, effective, caring, responsive and well-led. There was a positive staff culture in the service and they were led by an enthusiastic manager to deliver good quality care. Staff told us that the manager was very knowledgeable and inspired confidence in the staff team, and led by example. They said that the service was well organised and the manager was approachable, supportive and very much involved in the daily running of the service. One member of staff commented, "The manager is enthusiastic, she encourages staff to share that enthusiasm to provide good support for people who use the service." The manager told us she worked alongside staff which provided them with the opportunity to assess and monitor the culture of the service, and identify where improvements were needed.

The manager recognised the need for continual improvement in the quality of the service. They attended meetings with managers from other services owned by the organisation which provided a forum for discussion to help drive improvement, review new legislation and the impact this had on the delivery of the service. They informed us that one of the biggest achievements had been dealing with staffing levels. This had been more difficult than anticipated, due to rural location of the service and recruitment changes within the organisation. They advised that they now had the challenge of moving the service forward, by developing the staff to provide more individualised care and support. The manager recognised to do this staff needed more training to understand and promote care that was centred on people's individual needs, without placing unnecessary restrictions.

Staff told us that the manager had improved supervisions and had developed an appraisal system. They said they had also introduced more staff meetings which had provided an opportunity for staff to have open discussions about changes being made by the provider and the way in which the service was run. Staff told us they felt there was an open and honest culture in the service. They said they were able to approach seniors and the manager, and that the manager treated them fairly and listened to what they had to say. Staff said they would approach them at any time if they had a problem or something to contribute to the running of the service.

The manager had taken action to address shortfalls in the service. Concerns about people's safety had been identified, reported and acted on. Documentation showed that the manager took steps to learn from such events and put measures in place which meant they were less likely to happen again. The outcome of the investigations into a

Requires Improvement

Is the service well-led?

complaint had led to improved security and recognition that the premises needed refurbishing. The manager confirmed they had been given a budget to do this, and said long term the provider planned to develop Middlefield Manor into flats or building separate dwellings in the grounds to move away from a large residential service to independent living, within a safe environment.

We recommend that the service seek advice and guidance from a reputable source, about the implementation of a robust quality assurance system so that shortfalls in the service are identified and addressed.