Homes Caring For Autism Limited

Durlston House and Durlston Lodge

Inspection report

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Date of inspection visit: 17 and 22 September 2015
Date of publication: 21/12/2015

Ratings

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

Overall summary

Durlston House and Durlston Lodge provide accommodation and personal care for up to 14 people with autism. The accommodation is arranged into two separate houses with their own manager and staff team. At the time of this inspection four people were living in Durlston House and five people were living at Durlston Lodge. The home was last inspected in May 2013 and was found to be meeting all of the standards assessed.

A registered manager was in post. The provider (Homes Caring For Autism Limited) for Durlston House and Durston Lodge made the decision to have registered managers in both houses although both houses come under one Care Quality Commission registration. There is a registered manager at Durlston House and the manager for Durlston Lodge will be submitting an application to register as manager. A registered manager is a person

Summary of findings

who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.'

People were not always protected from inappropriate care and treatment as records were not always accurate or up to date. Report of incidents and accidents were developed following an event but they were not always analysed to assess that the most appropriate action was taken. Care plans and risk assessments were not updated following reviews.

Medicine management systems did not provide staff with clear direction on when and how to administer some prescribed medicines. Protocols for when required medicines such as anti-inflammatory medicines were not in place. Where creams such as local anaesthetics were prescribed the directions were "as directed."

People's mental capacity was not accurately assessed. The staff showed a good understanding of the principles of the Mental Capacity Act 2005 (MCA). However, MCA assessments for some people did not reach a conclusion on their capacity to make specific decisions. Best interest processes were not followed for people assessed as lacking capacity to make specific decisions. For example, care and treatment. The area manager told us MCA training was to be attended by all staff.

People were not able to discuss safety with us but two people told us they liked the home and their keyworker. A relative said their family member was safe living at the home. Staff knew the signs of abuse and the actions they needed to take for suspected abuse.

People's care and treatment was delivered by sufficient staff. People had one to one support during the day and some people had two to one support for community activities. Staff said the staffing levels were good. A relative told us recruitment and retention had been a problem at the home. The registered manager for Durlston House said new staff was recruited to vacant posts.

The staff promoted positive relationships with people. Staff were helping people to develop their independent living skills and to improve their privacy. Staff were supporting some people at Durlston House to lock their bedroom and to use assistive technology to gain entry to their locked bedrooms. One relative said staff needed to help people use communication systems which support the person to "articulate their wishes".

People's preferences, likes and routines were documented in their care plans. Care plans were developed on how staff were to support people to meet their needs. Relatives told us they were invited to reviews. They said at the review meeting they discussed their family member's care and were able to make suggestions on the delivery of care.

Where risks to people's health and wellbeing was identified risk assessments listed the actions needed from the staff to reduce the level of risk.

People, at times, used aggression and violence to express their emotions and as a means of communication. Behaviour management plans were devised on triggers and detailed how staff were to response to the behaviours exhibited. Staff used strategies and techniques to divert and diffuse aggressive and violent behaviours. We saw staff use the techniques to help people calm themselves. For example, giving people time and space to calm down.

Staff received appropriate training and support to meet people's needs. New staff received a comprehensive induction which prepared them for the role they were employed for. Staff skills were developed to ensure they were able to meet people's complex needs. For example, they attended autism awareness and positive behaviour management training. Staff had regular one to one meetings with their line manager where they discussed performance, concerns and training needs.

People were supported to raise concerns and complaints which the staff took seriously and the registered manager investigated. Relatives said they knew the procedure for making complaints. They said their complaints were taken seriously.

People were supported by staff that worked well together, knew the vision and values of the organisation and helped build a culture of choice and person centred care. Quality assurance arrangements were in place to monitor the standards of care. Action plans were developed where standards were not being fully met. People's views were sought through surveys and during care plan review.

Summary of findings

We made recommendations for the service to seek advice and guidance from a reputable source, about the management of medicines and about the principles of Mental Capacity Act 2005

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 needs improvement.

People were not fully protected from the risk of unsafe medicine administration. Medicine protocols were not developed for all "when required " medicines. Staff did not seek clear instruction for medicine from GP on how and when to apply cream.

Risk management systems in place ensured action plans were developed were risks were identified. Accident and incidents reports were not always analysed to determine if appropriate actions were taken following an event.

Sufficient numbers of staff were on duty to meet people's needs. People had one to one support from staff during the day and some people had 2:1 support for community activities.

Safeguarding processes and procedures in place ensured staff were able to identify the signs of abuse and were clear on the expectations placed on them to report suspected abuse.

Is the service effective?

Requires Improvement

The service requires improvement.

Staff were not given clear guidance on the decisions people were able to make and who helped them make decisions. The provisions of the Mental Capacity Act (MCA) 2005 was not used to ensure people's capacity to make decisions was assessed.

People were supported to maintain a balanced diet.

Members of staff were supported to undertake their roles and responsibilities.

The training provided ensured the staff had the appropriate skills and knowledge to meet people's needs. Staff benefited from one to one discussions with their line managers.

Is the service caring?

Good

The service is caring.

People received care and treatment that was personalised. Members of staff knew how people liked their care to be delivered.

Members of staff were supporting people to increase their independent living skills. For example meal preparation and using keys to unlock bedrooms.

Life stories about people were not gathered by the staff. Past histories raises the staff's insight into people's identity.

Summary of findings

Is the service responsive?

Good

The service is responsive.

Care plans included people's preferences and gave staff guidance on how to meet people's needs. Relatives said they were invited to review meetings. They said at the reviews they were able to discuss their family member's delivery of care.

People were encouraged to raise concerns and complaints. Relatives said they knew the complaints procedure. They said complaints were investigated and resolved a satisfactory level.

Is the service well-led?

Requires Improvement

The service requires improvement.

People were not always protected from inappropriate care and treatment as records were not up to date or accurate. For example, care plans, risk assessments and incidents and accident report.

Quality assurance arrangements were in place to monitor the standards of care. Action plans were developed where standards were not being fully met.

The views of people about the quality of care were gathered through surveys. The views of their family and friends were gathered through surveys.

Working relationships between staff were good and the manager's leadership style created a culture of openness.

Durlston House and Durlston Lodge

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 17 and 22 September 2015 and was unannounced.

The inspection was completed by two inspectors. Before the inspection, we reviewed other information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

During the visit we spoke with two people who used the service, two relatives, the manager for Durlston Lodge, the registered manager for Durlston House, the area manager, five members of staff. Three staff were recently recruited to the home and a Communication Specialist from Head Office. A healthcare professional conducting a review of needs gave their feedback on their experience of the home.

We spent time observing the way staff interacted with people who use the service and looked at the records relating to support and decision making for three people. We also looked at records about the management of the service.

Good

Is the service safe?

Our findings

Medicines were administered by staff competent in medicine management. For some people their medicines were kept in lockable cabinets in their bedrooms. Staff signed the Medicine Administration Records (MAR) charts following the administration of medicines. The GP had agreed with the homely remedies the staff were able to administer. For example pain relief, cold and flu remedies.

Some people were prescribed with "when required medicines". For example, for pain relief and for agitation.

Protocols for when required medicines such as anti-inflammatory medicines were not in place. Where creams such as local anaesthetics were prescribed the instruction on application was "as directed." This meant staff may not have the correct instruction on when and how to administer the prescribed medicines or cream. This meant staff may not have the correct instruction on when and how to administer the prescribed medicines or cream.

The National Institute for Health and Care Excellence (NICE) Managing Medicines in Care Homes NICE quality standard [QS85] March 2015 states "If too few instructions are given to a resident (if self-administering) or the care home staff it can reduce the effectiveness of a medicine or even potentially increase the risk of harm. Clear instructions are therefore important to ensure resident safety. This is particularly the case with variable dose or 'when required' medicines (when a clear indication of the circumstances to administer the medicine is needed). therefore important to ensure resident safety.

Reports of aggressive incidents were completed by the staff. The behaviours exhibited before, during and following each incident were recorded. Some incidents and accident reports were analysed to consider ways of reducing the level of risk to people. We saw incident reports in Durlston House were not always fully completed by the staff or the manager. The staff's descriptions on the actions taken and the manager's reflection on this action was missing from some reports. For example, we saw reports of aggressive behaviours were not fully completed. This meant incidents were not always analysed to determine the staff used the most appropriate response to diffuse further incidents.

Behaviour management plans and strategies were developed to support people who at times used aggression and violence to communicate. Strategies to manage difficult behaviours were well developed and staff were mainly given guidance on managing their personal space. When people became aggressive two staff helped the person move from the situation and this was the most intrusive technique used in both homes and only used in extreme circumstances. Where staff used two person removal, the area manager had to be informed when this was used.

People were supported to take risks safely. Where there were risks to people's health and wellbeing action plans were developed to lower the level of risk. A member of staff at Durlston House said people were supported to take risks such as using knives to prepare vegetables and making refreshments. Another member of staff gave us examples on the actions taken to lower the risk for people who experienced seizures and for people with low weights. For example, audio monitors which the staff risk assessed in bedrooms for people with epilepsy and fortified drinks to help people maintain their weight.

The safeguarding of vulnerable adults systems that were in place ensured people were protected from harm. The people living at Durlston House and Durlston Lodge were unable to discuss safety with us. Two people were able to indicate that they were happy in the home and liked their keyworker. A relative said their family member was safe living at the home and they were informed about important events. The staff showed a good understanding of the safeguarding adult's procedure and about their responsibility to report suspected abuse. Staff received safeguarding adults training and during supervision the safeguarding procedures were discussed. One member of staff working at Durlston House described an incident where a safeguarding referral was made. Members of staff knew it was their duty to report poor practice they may witness from other staff.

People living at Durlston House and Durlston Lodge had one to one support from the staff. The staffing rotas showed people had one to one staff support during the day. There were people who received two to one support as needed. For example, travel and community activities.

Staff at Durlston House told us people had one to one support from the staff and although the staffing levels were good there was a high turnover of staff. A member of staff said a core team of staff was no longer established which created inconsistencies. Another member of staff said there was a strain on existing staff as there were new staff on

Good

Is the service safe?

induction and some staff were on annual leave. A relative told us recruitment and retention of staff has been a problem for the service. They said this had an impact on the skills and understanding needed to meet people's needs. Another relative told us the staff had been "excellent in providing additional support during a hospital stay for their family member."

Vacant posts were advertised at Job Centres and on Open Days. Recruitment procedures ensured suitable staff were recruited. For example, staff applying to work at the home had to complete an application form, had a telephone interview followed by a face-to-face interview and a home visit day.

Suitable arrangements were in place for dealing with emergencies which may disrupt the smooth running of the service. The disaster recovery folder included individual profiles detailing important information and support needed by the person. Alongside were personal evacuation plans which gave information on how the person may respond to fire bells and the actions needed to safely evacuate people.

Requires Improvement

Is the service effective?

Our findings

People's capacity to make decisions about their accommodation and care was assessed. Staff used people's preferred communication method to assess people's understanding of specific decisions. Mental Capacity Act 2005 (MCA) assessments lacked a conclusion on people's capacity to make specific decisions.

We found conflicting information between MCA assessments and other documentation about people's capacity to make decisions. Where people were assessed as lacking capacity to make decisions, best interest procedures were not followed. For example, the name of the designated decision maker for the specific decisions was not included. The area manager told us MCA training was to be provided to all staff. They said MCA training was to become essential for all staff to attend.

We recommend that the service consider current guidance on the Mental Capacity Act 2005 and take action to update their practice accordingly.

People were supported to give consent about day to day decisions such as activities and clothing. A member of staff explained they used people's preferred method of communication to ensure people were able to give valid consent. For example, for some people Widgit (a system of words, pictures and symbols used to communicate with people) was the preferred method of communication. Another member of staff said people were not forced to accept personal care.

Deprivation of Liberty Safeguards (DoLS) restrictions were in place for people. DoLS applications to restrict were made to the supervisory body to restrict people from leaving the property and for access to medicines, harmful chemicals and the kitchen. Staff said people were subject to continuous supervision. They said where people lacked capacity and were placed at risk of harm applications for DoLS restrictions were made.

People received care and treatment from staff that were skilled and had an insight into their needs. Staff said the induction received was intense. They said the induction was over two weeks which included autism awareness training. Other training attended during the induction programme included fire safety, first aid and positive behaviour management. Shadow shifts were part of the induction which helped new staff gain an understanding of people's needs.

New staff said during their probationary period one to one meetings were weekly with their line manager. At these weekly meetings staff discussed their experience of shadow shifts, observations of people's behaviours and read care plans and risk assessments.

Existing staff said they had monthly one to one meetings with their line manager where they discussed performance, concerns and training needs. We looked at the supervision matrix for Durslton House and Durlston Lodge which showed staff had one to one meetings with their line manager. However, at Durlston House one to one meetings with the staff were not regular. The registered manager acknowledged one to one meetings had not been regular and described the reasons for them not taking place. At Durlston Lodge one to one meetings were regular and where meetings were missed they were re-scheduled.

People had a choice of meals and menus for the evening meal were arranged according to a four weekly plan. We saw at lunchtime people were supported to prepare their meals. We saw a good range of fresh, frozen and tinned food in both houses.

People were supported to maintain their health and wellbeing. Health action plans in place held information about the person's health needs, the professionals who support people with their needs, and the actions needed to stay healthy. Hospital passports were developed to ensure important information about the person was passed to medical staff in the event of an admission to hospital.

Good

Is the service caring?

Our findings

People received support from staff that knew their preferences. Staff said to develop positive relationships consistency of care had to be achieved. They said knowing people's routines ensured people's care was consistent. A member of staff told us people were encouraged to participate in household chores to increase their independence levels.

Relatives said the staff were caring towards their family members living at the home.

We observed members of staff in Durlston House consulting one person about their day's activities. Members of staff gave the person two options of activities. We saw staff ask the person to repeat the information about the day's routine to ensure they had understood when this person used repetitive behaviour.

We observed in Durlston Lodge the staff supporting one person returning from a community activity to use their computer tablet for some relaxation time. We saw another person was being assessed for further support with communication skills using his computer tablet and also some jigsaw puzzles. We saw a third person return home from their morning activity and then went out again on another activity with a different staff member to support.

People rights were respected by the staff. We saw people in Durlston Lodge were able to access the communal areas, they had keyfobs to access their own bedrooms and touch pads for exit. A member of staff in Durlston House said they were supporting people to develop their skills to lock their rooms and gain entry to their rooms with keyfobs.

Good

Is the service responsive?

Our findings

Care and Support plans described people's preferred routines and their likes. A one page profile was included in the care and support files which described the person's likes, routines and support needs. A health care professional told us told us the staff had a good knowledge of people which reduced the person's level of anxiety. Relatives told us they were kept informed of important events. They said at the monthly review meetings their feedback was sought which gave them an opportunity to make suggestions and discuss their family members care.

Staff said there were handovers when shift changes happened and communications books were used to update staff on people's current needs.

Personal care plans described the actions needed by the staff to support the person to meet their assessed needs. Where people were assessed at risk of low weights staff kept a record of their food and fluid intake. The records of fluid and food intake helped staff to identify deteriorations in person's health.

Individual profiles were developed for people with epilepsy who experienced seizures. Profiles gave staff guidance on how to support the person during a seizure. For example, the triggers of a seizure, the actions needed from the staff and rescue medication plan

Where people used aggression and violence to communicate, their behaviour was assessed using the time intensity model (TIM). TIM described the possible triggers of aggression, the behaviours which show an escalation of difficult behaviours, how to identify the person was in crisis and the behaviours showing they were recovering. Staff described the diversion and diffusion techniques needed to handle difficult behaviours. For example, one person was asked to return to their room to calm down when staff observed their behaviour was becoming difficult to manage. The person used techniques which helped them use time and space to regain control of the behaviours. A healthcare professional said de-escalation plans were good.

People were encouraged to raise concerns and complaints. The complaints icon was accessible to people on the board in the hall and the procedure was on display. People were able to hand the icon to a member of staff who took their complaint to the manager. A complaints icon was also accessible on each person's tablet and staff were able to support people to raise their concerns.

At Durlston Lodge one complaint was received recently from a family about the delivery of care. The complaint was investigated and resolved to satisfactory level.

Relatives told us they knew the procedures for making complaints. A relative said, "if I had a concern and I wanted to, I can pick up the phone and speak with the managing director".

Requires Improvement

Is the service well-led?

Our findings

Records which protected people from inappropriate care and treatment were not appropriately maintained. At Durlston Lodge we found reviews of care plans had been delayed and some reports had not been filed. At Durlston House care and treatment care plans were not up to date or accurate. For example, the support guidelines for one person on how to manage aggressive behaviours were not reviewed since August 2014. We saw four incidents of aggressive behaviours had occurred but the support plans were not reviewed. The reports of incidents where people became aggressive did not reflect on how the incident was managed. The registered manager based at Durlston House told us there was learning from this period. For example,to avoid not having up to date records better admission assessment processes were to be developed.

This was a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A registered manager was in post. The provider (Homes Caring For Autism Limited) for Durlston House and Durston Lodge made the decision to have registered managers in both houses although both houses come under one Care Quality Commission registration. A registered manager was in post at Durlston House and the manager for Durlston Lodge will be submitting an application to register as manager.

Quality Assurance arrangements in place ensured feedback was gathered from people, relatives, staff and professionals. Staff supported people to complete surveys about the care and treatment provided. The managers of both services said the response was low. They said this was because at present the survey format was not suitable for people with autism. For example, facial expressions were used. Relatives responded with their suggestions for improvements and relatives forums were introduced from their feedback.

Reports following visits from the area manager were devised on the standards of quality they had assessed. The area manager completed audits at every visit according to a proforma. The reports for September 2015 included an action plan with timescales. For example, updating care plans and risk assessments.

The staff at Durlston Lodge and Durlston House said their respective managers were good and were approachable. A member of staff at Durlston House said staff meetings were monthly and there were opportunities at these meetings to make suggestions.

The registered manager of Durlston House explained the challenges encountered with the day to day management of the home. They said challenges arose with the induction of staff as a thorough induction was needed to prepare new staff for the role they were to perform. The manager of Durlston Lodge told us the current challenge was supporting people who exhibited extreme behaviours which challenged the service. They said during these periods the priority was to ensure there were sufficient staff on duty and guidance was in place to support people when they were in crisis.

The manager of Durston Lodge described the vision of the home as promoting choice, respect, dignity diversity equality and person-centred care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The records maintained did not ensure people were protected from unsafe care and treatment.**