Autism West Midlands

Gorse Farm

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?	Requires Improvement

Overall summary

This inspection took place on 1 April 2015 and was unannounced.

Gorse Farm is a purpose built residential home which provides care to 14 adults with learning difficulties in Solihull. Accommodation is provided in two separate bungalows for up to seven people in each. At the time of our inspection there were 14 people living at the home including one person who was living in an adjoining self-contained flat. The home has a day service facility for people who live at the service.

The service is required to have a registered manager. The 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 a 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 had not had a registered manager since August 2014. A new manager had recently been appointed and had been in post for four weeks at the time of our visit. They were in the process of registering with us.

Summary of findings

All the people and relatives we spoke with, told us staff were caring and we saw examples of this during our visit. People were encouraged to be independent by staff and care was provided with dignity and respect. We were told people liked living at Gorse Farm.

Relatives of people told us their family members were safe and the necessary checks required to ensure the home environment was safe, had been completed. However, management of the service had been inconsistent and the new manager had identified some areas that required improvement. People told us they knew how to make a complaint, however complaints had not been recorded, so it was difficult to establish whether complaints were dealt with to people's satisfaction.

People received their medicines when prescribed from staff who were suitably trained and competent to administer them. However, it was not clear if PRN (as required) medicine was always given consistently and effectively.

Staff had a good knowledge of how to safeguard people and were confident in understanding the different types of abuse and how to report this. Staff received training in areas considered essential to meet people's health and social care needs safely and consistently. Risk assessments were completed but these had not been reviewed adequately to meet people's changing needs.

People enjoyed the food at the home and staff were aware of people's dietary requirements. Some staff had a good knowledge of the needs of the people they were caring for, however due to staffing vacancies and high levels of agency staff, some did not. This impacted on the people living at the home as staff did not always know them and their individual needs well.

Staff understood they needed to respect people's choices and decisions. Assessments had been made and reviewed to determine people's capacity to make specific decisions. Where people did not have capacity, decisions were taken in their 'best interests' and these were documented.

The provider was meeting the requirements set out in the Deprivation of Liberty Safeguards (DoLS). At the time of the inspection, applications had been made for everyone at the service, under DoLS, for people's freedoms and liberties to be restricted if required.

People were given options about how they wanted to spend their day and were able to retain some independence. Family and friends visited when they wished and staff encouraged people to maintain a relationship with them. People often stayed overnight with their relatives for visits.

People were supported to pursue hobbies and interests. Activities were available and staff made use of mini buses to take people on trips regularly. Keyworkers were responsible for providing activities and did this in a way tailored to meet the person's needs. People told us activities could be improved further for people with a higher level of need.

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?

Requires Improvement

The service was not consistently safe.

Most relatives told us their family members were safe and staff understood their responsibility to report any suspected abuse. People's needs had been assessed but where risks had been identified, assessments were not current and this placed people at greater risk, as many had high level care needs. People received their medicines when prescribed from staff who were suitably trained and competent to administer them. However, it was not clear if PRN (as required) medication was always given consistently and effectively.

Is the service effective?

Good

The service was effective.

People and their relatives were involved in care planning decisions and people received the support they required from staff. Where people did not have capacity to make certain decisions, the provider worked in line with the Mental Capacity Act and was meeting the requirements of the Deprivation of Liberties Safeguards. People were offered a choice of meals and drinks that met their dietary needs. Staff made sure people received timely support from appropriate health care professionals when required.

Is the service caring?

Good

The service was caring.

Relatives told us staff were caring and that people were supported with kindness and compassion. Staff treated people with dignity and respect when providing care and were able to give us examples of how they ensured this was maintained. People were given choices about how they wanted to spend their time and were encouraged to be independent where possible with support from staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was inconsistency of permanent staff, and agency staff did not know people's individual needs well. This created anxiety for some people and at times affected their behaviour towards others. Care records included people's history and preferences but had not been reviewed regularly. Staff encouraged and supported people to get involved in activities they enjoyed but these could be improved for some people. People knew how to complain if they wished to, however these were not recorded, so it was not clear if people were satisfied with the response they received to any complaints made.

Summary of findings

Is the service well-led?

The service was not consistently well - led.

The management of the service had been inconsistent and due to this, staff did not feel well supported. Existing staff had felt pressured in supporting temporary staff and covering staff vacancies. The newly appointed manager was aware of these issues and had started to make positive changes. There were some systems to manage the effectiveness and quality of the service people received, but there were gaps in these which required further improvement.

Requires Improvement

Gorse Farm

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 1 April 2015 and was unannounced. The inspection team consisted of one inspector.

We reviewed the information we held about the service. We looked at information received from relatives and other agencies involved in people's care. We also looked at the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also spoke with the local authority who shared they had visited recently and had raised some concerns about care records and risk assessments for people.

Before the inspection, we requested the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was received prior to our visit and reflected the service we saw.

Most of the people living at the home were unable to share their experiences of the care and support provided. Although we spoke with some people, we were mostly unable to obtain their views about the home. We spent time observing care in the two bungalows and the communal areas.

We spoke with two people who lived at the service, six relatives over the telephone, the manager and 10 staff. We looked at five care records and records of checks the manager made to assure themselves that the service was good. We observed the way staff worked and how people at the service were supported.

Requires Improvement

Is the service safe?

Our findings

Staff told us people were safe but some people had differing views. A support worker told us, "I think people are safe here" another worker told us, "Yes, people here are safe". A relative however, disagreed and said, "I think it's really gone downhill very fast". They told us there were too many changes of staff and this had affected the service and how safe it was.

The people living at Gorse Farm were at high levels of risk due to their complex needs. Risk assessments were completed on care records to identify where people may be potentially at risk, however the assessments were not current and many had not been reviewed since 2013. For example, one person had been identified as being at risk of falling and their risk assessment was dated January 2014. We saw this person was very mobile and had fallen recently, sustaining a serious injury. A staff member confirmed that they were at risk of falls and their risk assessment was not current. The risk had not been reviewed to make staff aware of this, and how it could be prevented or reduced.

We saw one person ate non consumable items, another person self-harmed and someone else had tried to abscond from the service previously. As high levels of agency staff were used, this increased the risk further as these staff did not know people well. We spoke with a staff member about risk assessments and they told us, "They have not been updated for a long time". The manager confirmed risk assessments should be reviewed every six months and they were out of date. They agreed the risk assessments had not been reviewed as required but they were beginning to address this now in the next few weeks.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us about safeguarding people at the home and were aware of their roles and responsibilities in relation to protecting people. They told us they had received training on how to protect people from abuse and were able to tell us about different types of abuse which could occur. We gave scenarios of potential abuse in certain situations and staff were confident in their responses of what they would do. One support worker told us, "I reported a safeguarding before" and explained this was investigated by the safeguarding team.

We looked at whether staffing levels were sufficient to meet people's needs. A support worker told us, "The level of staff is fine but there is a lot of agency staff". We looked at rotas and saw there were sufficient staff to meet people's needs. There were four staff vacancies at the home however these were being covered by agency staff. Four agencies were used by the service in total but the manager tried to use the same agency and staff when possible for consistency. There were some new staff in post and the manager told us recruitment procedures had been changed recently to make sure they employed the right staff to care for people. The manager planned to increase staffing levels further.

Systems made sure people received their medicines safely from staff who were suitably trained. Training was carried out via a national pharmacy, further in- house training was completed and competency checks were carried out by the manager twice yearly. One staff member told us this had lapsed a little recently. Medicine administration records (MAR) confirmed each medicine had been administered and signed for at the appropriate time. Some homely remedies such as vitamin supplements were given and this was in discussion with the GP.

Several people received PRN medicines (as required) and there were protocols and a care plan in place which detailed how this was to be given and when. The team leader's agreement was required before PRN medication was given to make sure it was appropriately managed and given consistently. However, we found support workers in each bungalow rotated as 'team leaders', so it was not clear if a consistent approach was always being used for agreeing PRN and whether the team leader was always following the protocol and monitoring this usage. We saw examples of when PRN medicine was administered more frequently when the person's normal support worker was not on duty, due to an increase in agitation.

One family member told us their relative had been very unsettled recently with all the new staff and PRN medication had been used to calm them, whereas staff who knew them would, "Talk them down" when they got anxious. A support worker told us about this, "[Person] has specific responses to things, if you don't know them; [person] will get anxious". A different relative gave an

Requires Improvement

Is the service safe?

example of when this person asked to know when they would next have their medicine. An agency worker did not understand them and so went to give them the medicine, even though they were asking 'when' they had it. The relative told us, "If I had not been there [person] would have been given the medication". They told the staff member, "You're putting things into [person's] body when it's not [person's] fault". They said they had complained to the manager and this had been addressed.

We discussed these examples with the manager, who agreed the use of PRN medication and the decision making in this process, would be investigated further.

Records showed accidents and incidents had not been recorded comprehensively. One person had fallen and this was documented in their care plan, but this information had not been recorded as an accident. The manager told us that support workers did not always fill in these forms for people that lived at the service, but they did for staff. This did not enable any patterns of falling to be noted for that person, which may have been used to help prevent these falls continuing. Appropriate measures were not taken to keep people safe when monitoring accidents and incidents.

We looked at emergency procedures. Systems supported people in the event of an emergency and plans were documented so people could be assisted safely and effectively. These were known as personal emergency evacuation procedures (PEEPS).Staff we spoke with knew what to do in an emergency and the evacuation procedures. We saw 'Disaster Bags' had been assembled with items such as torches and phone numbers to use in an emergency. Contingency plans were in place to access a local venue if people could not return to the service.

Checks of equipment and maintenance checks were current and documented, such as water temperature checks. A maintenance person was employed to keep the buildings safe and checked equipment regularly. We saw he had been called out on the day of our visit to mend a door lock to the kitchen. We saw procedures and checks were thorough and ensured the environment remained safe for people at the service.

Good

Is the service effective?

Our findings

Some relatives we spoke with told us the care people received was good and they were happy with this. One relative told us about the service, "Yes I am happy". A support worker told us, "The guys are well looked after here". A different person confirmed this and said, "Service users get what they need, they are very well cared for". A family member gave an example of how staff had 'brought their relative on', saying, "[Person] is now calm and you can sit and have a conversation with them" whereas they could not before.

Many of the existing staff had been there a long time, but there were some people new in post. The new staff we spoke with told us they received an induction when they started working at the home, then shadowed other workers before starting properly. This enabled them to start to get to know the people at the service and their routines. Staff had the necessary checks completed and references sought to ensure they were safe to work in this environment.

Staff told us they received the required training to meet people's health and social care needs. This included health and safety training which one support worker told us was, "Useful for when we are cooking with clients". They also received training in how to manage people's challenging behaviour and in autism awareness. A support worker told us the autism training had been useful and made them understand, "Every day is different for people with autism". We saw one person had become very upset and their keyworker was skilled in diverting this person's attention away from this.

Staff gained people's permission before supporting them with care tasks and staff prompted people to make their own decisions about whether they wanted assistance or not. One person had refused to have a monitor in their bedroom even though they had a health condition that required monitoring. Staff accepted this and worked to find alternative ways to support them.

Staff told us about an 'ABC' form which they completed documenting unusual or changing behaviour. This was an 'Antecedent Behaviour Consequence' form and enabled patterns to be analysed around behaviour, so staff could monitor this and try to work with people more effectively.

Communication between staff was via several written channels, a communication book, a team leader communication book, a daily report sheet, night sheets and a summary book. We saw the communication book, which detailed important changes in people's care needs, had pages falling out which meant information could be lost. A support worker told us "Communication between staff in the bungalows varies, especially at weekends". We saw people's care files in one bungalow had no names on. We asked two staff why this was but no one was sure. The number of communication channels and disorganisation of these, posed a risk that people's care needs and changes may not be communicated effectively. This risk was increased with the use of temporary staff who may not know systems well. The manager told us this was an area they intended to improve in the next few months.

Staff alternated being the shift leader in each bungalow to gain experience of supporting and directing other staff. Regular staff meetings were resuming after a lapse and we saw minutes of these. Staff were given an opportunity to raise any issues they had at these meetings and told us they were useful to enable them to communicate with managers and other staff.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. Staff responsible for assessing people's capacity to consent to their care, demonstrated an awareness of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. This is a law that requires assessment and authorisation if a person lacks mental capacity and needs to have their freedom restricted to keep them safe.

Care records included completed mental capacity assessments. These gave details which were decision specific and in line with Mental Capacity Act legislation. We saw decisions were made in a person's best interests where they had been assessed as 'lacking capacity'. Staff we spoke with showed an awareness of mental capacity and what this meant for people at the service. We were told one person had refused to have the flu jab and had been assessed (with GP involvement) as having capacity to make this decision, so did not have this.

People enjoyed the food at Gorse Farm and we saw they were offered regular drinks during our visit. Staff ensured people's special dietary needs were catered for. For

Good

Is the service effective?

example, one person was lactose intolerant and staff ensured they had appropriate alternatives provided for them. People were given food choices and staff were flexible in catering for their individual needs. There were two choices given each day and staff told us if people did not want anything on the menu, alternatives were provided. Menus were planned weekly involving people who agreed what they would like to eat and meals were planned around this. However people did not participate in shopping for food as this was done by staff over the internet. People sat together to eat meals and one person who found it difficult to eat with others, ate separately with their keyworker, so they felt more relaxed during meal times.

People accessed appropriate health and social care professionals when required. A relative told us, "Yes, people are definitely well cared for". One person had involvement from the psychologist and another person the dietician. Staff told us a frustration for them could be accessing services when it was the 'optimum' time for the person. For example, one person sometimes ate non consumable items and only at certain times would they be able to cope with going to see the doctor. Staff worked hard to try to arrange appointments to fit that person's individual needs. Staff were responsive in involving other professionals to support people and were effective in meeting their health needs.

Good

Is the service caring?

Our findings

People were complimentary about the staff at Gorse Farm, one person told us "I think the staff are caring". A support worker told us, "Everyone tries their best for the guys". One new staff member gave an example of having to ring another staff member at home because a person was asking for something repeatedly and they did not know what this meant. They told us "We find a way to understand and try to make them feel at ease".

Staff supported people to maintain their relationships with others. A relative told us, "Yes, staff are caring and they treat people with dignity". They explained when staff bring their family member home to visit them they can see this in the way they speak to them and said, "I am quite happy and [person] would tell me if they were not".

There were no restrictions on visiting times at the service; people could visit at times to suit them. We saw a sign reminding everyone that a certain family member called each week at a specific time and to make sure the person could answer the phone for this call, as it was so important to them. One person at the service told us "Yes, I like it here" and another family member told us how their relative was always keen to get back to the service following a visit to see them and this reassured them.

People were given choice and control as much as possible at Gorse Farm. There were no rules about going to bed or getting up, and people could choose how they preferred to spend their day. Staff we spoke with told us they were guided by what people wanted. An example given was when they took people out for the day, often staff would work over their hours, so the person did not have to leave earlier if they were enjoying their day out.

We saw staff knew how to ensure dignity and privacy were maintained in providing people's care. A support worker told us, "Dignity is a priority". They gave an example of one person who liked to undress and they would re-direct them and quickly offer a towel to cover them up. When assisting with bathing, towels were used to cover people for their privacy. Staff used listening monitors with some people who were at risk, due to health problems. They told us they considered their privacy in this situation and only used the monitors when appropriate and not at all times. Another person had a serious medical condition and staff would check them hourly at night by listening and went into their room every second hour. This was to try to minimise disturbing them at night and to retain their privacy. One person at the service occasionally required assistance at night and could become upset about this, staff would discreetly assist them to minimise their distress.

Relatives told us the staff respected people's independence. One person had struggled to live with other people at the service. A bungalow had been adapted for them to enable them to live independently but with staff support. Another bungalow was going to be built for another person who would benefit from a similar environment.

On the day of our visit it was someone's birthday. We saw presents had been wrapped for the person from the other people at the home and a cake made. Staff told us the presents included some 'sensory' items which the person would enjoy using and were suitable for them. We saw a list of relative's birthdays was kept so keyworkers would go with the person to buy gifts for them. A support worker told us, "Staff go the extra mile for people". Another person had a birthday due and the manager told us they were using the day centre to hold a party and were inviting all their family.

Requires Improvement

Is the service responsive?

Our findings

Some relatives told us they were pleased with the quality of care people received; one told us they were "Happy with the service". However other people were not. One support worker told us, "The consistency of staff is non-existent" and a different worker commented, "Inconsistency is not good for the clients".

Due to the high levels of agency staff, people did not always know staff well and some staff did not know people. We asked a staff member how care met people's individual needs and they told us, "It could be better". A relative we spoke with told us there were some new faces at the service and, "I prefer the same staff all the time". We saw inconsistent staffing meant the people at the service did not always get the personalised care they required from people who knew them. This led to people becoming anxious and unsettled and could affect their behaviour with both staff and other people at the service. The manager was trying to address this with new permanent staff and using consistent agency staff. Other staff told us, "Clients feel a bit insecure, seeing different faces" and "If people don't get the right response, they get anxious". One relative gave an example of a new staff member offering a person some food and they then realised they did not have any left. This caused the person's anxiety to escalate and the relative told us if they had known the person better, they would not have done this, knowing the likely reaction.

We looked at how the provider managed complaints and saw that the records of complaints had not been kept up to date. The last complaint recorded was January 2012 however we were aware a relative had complained about medicine recently. The manager told us that this had not been completed recently and recording had lapsed. They had plans to address this, however currently complaints were not being recorded or responded to so it was not clear if people's concerns were being addressed sufficiently.

People could feedback any concerns informally to staff and the manager planned to arrange relatives meetings shortly. A survey had been created for people at the home to feedback their views and this was in an accessible format for them, using pictures. We saw this had been completed by people at the service with support from staff and we saw some positive comments.

One relative told us they were involved in planning and reviews about their family member's care and felt able to discuss any issues with staff. They told us staff were very supportive of them and the person that lived there. However, another family member said their relative's care needs had changed but they had not been made aware or the decision taken about increasing their medication, even though they should have been involved in this. Care reviews were held six monthly. We saw assessments on people's care records which were 'person centred' and detailed people's preferences and histories. Other assessments were evident around areas such as continence and other health needs.

One person had English as a second language and staff had learned some of the language to communicate with them and support them. We saw a 'social story book' in one person's room which they used to communicate with staff. A 'key ring' system was used by staff on days out. The key ring had pictures attached, so people could show support workers what they wanted, if they could not verbally communicate this. We saw each room at the home had a picture on the door to help people identify what the room was and we saw people use this to assist them.

Although there were some activities available, there was scope for some further development of these, especially for people with higher level needs. Some people told us they did group activities. One staff member said, "We could do with more in-house activities for people" and another staff member commented, "The more challenging people don't get to do as much". A relative told us, "There is not enough activities, definitely not".

The day service usually ran from Monday to Friday however it was not running on the day of our visit as they were re-organising this facility. We saw a schedule of activities including cooking, arts and crafts and board games were available for people. Support workers cooked meals with people to increase their skills and involvement in the kitchen and we saw one person making a chocolate cake. Upstairs was a 'chill out' room and a room where video games could be played. The day after our inspection, a trip was planned for some people to the safari park and we saw a holiday on a barge in Wales was being investigated by staff. People went out with support workers as a one to one activity, for example, shopping or for coffee.

Requires Improvement

Is the service well-led?

Our findings

The service was required to have a registered manager in post however the registered manager left this service in August 2014. Following this, another manager was appointed who left at the beginning of 2015. At the time of our visit a manager had been appointed and the process for registration was underway. This manager was responsible for another small service locally as well so spent some time on another site. This was an ongoing arrangement and meant they had the additional responsibility of managing another service alongside Gorse Farm.

Staff told us they had found the changes had been difficult and one staff member told us, "There has been a succession of short term managers" and it had been "Disappointing". A different worker said it had been, "A shambles", but now "The new manager seemed to be getting things in place and it is early days". Staff were concerned about the inconsistency of managers for them and the effect on people that lived at the service. Some staff had been absent and permanent staff had to support temporary staff further.

The manager told us about challenges and priorities for them at Gorse Farm. They told us staff recruitment was a priority and the systems the provider had for this were being improved. They were in the process of employing more staff and were running recruitment days to aid this. They told us they were aware of the reliance on agency staff and that this was disruptive for people.

They told us there had been, "Gaps in paperwork" when they came and it had lapsed in some areas such as risk assessments, complaints and accidents. Records of accidents and incidents that had been completed but were not analysed to identify any emerging trends or patterns. The manager was focused on improving these areas as a priority. The local authority commissioning team had identified some issues around paperwork and had been assisting them to make improvements. 'Health Action Plans' detailing people's health needs, had recently been reviewed by the manager, and these were now up to date. They had begun looking at some risk assessment in the day service as well.

Staff meetings were now being held monthly to support workers and the manager was changing these so both bungalows met jointly. They told us existing staff had not had appraisals or supervision meetings recently but these meetings were now being held. A support worker told us about these meetings and said "Managers will listen to you". We saw staff were being supported in their roles and responsibilities by the new manager.

Changes were also being made to the environment. The serving hatch from the kitchen to the dining rooms had been closed so now people went in the kitchen and got involved in making their own meals with staff. The manager said they were making lots of changes to improve the service but did not want to do this too fast to unsettle people even more. For example, new equipment had been purchased and re-decoration previously. This had raised the anxieties of some people living at the service. The manager told us they felt this had been done, "Too quickly" and people did not have time to adapt. They told us people with autism generally, "Don't like change" and they were aware they did not want to disrupt people further with too many changes too soon.

The manager said on the positive side, the staff had been very welcoming to them and they saw staff wanted the best for the people living at Gorse Farm. There were plans to develop the grounds further and make them more suitable for people to enjoy. The manager told us the provider was good in that, "They will spend money for people individually" to improve the service for them.

Various quality checks and audits of the service were carried out by the manager and staff. Some of these checks included the safety of the environment, equipment and health and safety. We saw these had recently been reviewed and were comprehensive.

The manager understood their legal responsibility for submitting statutory notifications to us, such as incidents that affected the service or people who used the service. We saw these had been documented and the manager had notified us of incidents following their appointment.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment People's care and treatment was not always delivered in a safe way because risks to them were not regularly assessed and mitigated. Regulation 12 (1)(2)(a)(b).