White Leaf Support Ltd

White Leaf Support Limited

Inspection report

8 and 10 Priory Avenue
High Wycombe
Buckinghamshire
HP13 6SH

Tel: 01494452676
Website: www.whiteleafcare.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

White Leaf Support provides care and accommodation at 8 and 10 Priory Avenue for up to 13 people with either learning disabilities or autistic spectrum disorders. At the time of our inspection 13 people used the service. One house accommodated people who were more independent and the other house supported people with more complex support needs.

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 a legal responsibility for meeting the requirements in the Health and Social Care Act and associated regulations about how the service is run.

The registered manager was not available during our inspection. A deputy manager managed the service while the registered manager was unavailable. We meet with the director of the service on the third day of our inspection.

Relatives provided us with feedback about the service. We received mixed views about the service. Comments included, "It's hard to keep a tab on what's going on. I am happy at the moment; I am keeping an eye on how things go." Other comments were, "I am 50% happy and hope things improve."

Relatives felt their family members were safe from harm and abuse. One family member told us, "[Our family member] is safe because it is a secure place." Staff were trained and knew their responsibilities in relation to safeguarding. Staff told us they would not hesitate to report any concerns they had. The service had sufficient staff to meet people's care needs and keep people safe. Supervisions were undertaken on a six to eight week basis. Staff told us they felt supported in their role.

Staff told us "It's good here. The more I'm here the easier it gets" and, "It's been busy; it's like jumping in at the deep end." All staff we spoke with told us they felt supported.

Safe recruitment processes were used when appointing new staff which included checks of criminal history of new staff using the Disclosure and Barring Service (DBS).Staff were trained and understood their responsibilities in relation to safeguarding.

Relatives told us there was a high turnover of staff and staff did not always understand the specific needs of the people living at the service. Comments included, "I am unimpressed. We were promised additional speech therapy for [name] but, we are still waiting. One comment we received was, "I met a member of staff by chance who used to work at White Leaf. They said the reason they left was because they felt 'out of their depth' in terms of looking after people." However, other families told us staff were well trained and knew their relative well.

We found the service acted in accordance with the Mental Capacity Act 2005. Consent was sought from people or their members who had legal authority to give it. People were supported at meal times. However, care records did not always contain information about each person's dietary needs.

Relatives did not always feel the support was individualised. Comments we heard were, "They have stalled in terms of moving him forward. There is not enough focus on moving on to the next stage".

Care plans did not always capture preferences, interests and aspirations. One care plan we reviewed was not completed in 'goals and hopes for the future'. Care plans and risk assessments were not regularly reviewed and kept up to date. One care plan we saw had a review due date of December 2016. However, this had not been completed at the time of our inspection.

Risk assessments did not always give staff clear advice and guidelines to follow.

Medicines were not always managed in accordance with best practice guidelines. For example, medication administration records (MAR) did not always show what medicines were given. We looked at MAR charts and found a total of 41 missing signatures over a period of time. Daily stock checks of medicines were undertaken. However, audits of medicines were not carried out to show discrepancies in medicine administration. We spoke with the deputy manager and they told us this was not something the service carried out.

When people had accidents and incidents these were not recorded correctly to identify the cause of the incident. For example, we saw on four occasions people had sustained bruising to their body with no explanation of the cause of the bruising. Other incidents such as episodes of challenging behaviour did not have details of follow up response to prevent reoccurrence.

There was no evidence of systems being used with people to aid their communication. Some parents told us communication was poor at the service. In light of this, one parent asked staff to write down events of the day in a specific diary to show what their family member had done throughout the day. However, they told us not all staff completed this.

People were supported to take part in a range of social activities to provide stimulation, and social contact. On both days of our inspection people were supported to attend community activities and social events. Staff promoted people's independence and supported them to exercise choice.

We did not see that care plans were reviewed on a regular basis or as needs changed. We saw several examples of care plans that did not reflect the current care being carried out.

Relatives felt the service was not always well-managed. Comments we received were, "The management are not open to parents" and, "We are not always listened to. It needs careful monitoring." However, the services commitment to improve was clearly evident during our inspection.

Audits undertaken did not highlight shortfalls. For example, care plan reviews had not identified that reviews had not taken place.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can

see what action we told the provider to take at the back of the full version of the report.

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 always safe.

Medicines were not always managed effectively.

The service did not always ensure risk assessments were current and up to date.

Relatives told us their family members were safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Visual communication tailor made for the people who used the service was not available.

People were not always cared for by staff that had up to date training.

Some people did not have effective management plans in place to ensure they received nutrition based on their needs.

Is the service caring?

Good

The service was caring.

Relatives told us staff were kind.

People's dignity was not always respected.

Bedrooms were not always personalised.

Confidential information was protected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care was not always reviewed regularly.

People's care was not always personalised to reflect their needs.

Relatives knew how to make a complaint. However, people did not have clear, easy to read information on how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Relatives were not always confident in the management of the service.

Audits were not carried out to identify areas in need of improvement.

A new management team at the service were committed to ensure improvements were made.

White Leaf Support Limited

Detailed findings

Background to this inspection

We carried out this inspection under the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 was an unannounced inspection which took place on 12, 13 and 18 April 2017. The inspection was carried out by one inspection manager and an inspector on day one of the inspection and one inspector on the remaining two days.

Before the inspection we reviewed all the information we held about the service. This included 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. We looked at notifications the provider was legally required to send us. Notifications are information about certain incidents, events and changes that affect a service.

As part of our inspection we spoke with three relatives of people who use the service. We spoke with three people living at the service. We also used the Short Observational Framework for Inspection (SOFI) to observe care and to help us understand the experience of people using the service who could not talk to us. SOFI is a tool used when people have communication difficulties.

We spoke with the deputy manager, the director of the service and four care workers. In addition we viewed care records, staff files, medicine records and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Relatives said their family members were safe from harm. Comments included, "[Name] is safe because it is a secure place" and, "He has one to one support when they take him out, so he is safe."

People were protected from abuse because staff were trained and understood their responsibilities in relation to safeguarding. We spoke with staff who told us what they would do if they suspected someone had been abused. A safeguarding policy was in place and a safeguarding chart was visible in the office. Training records confirmed staff had undertaken relevant training. However, we could not see an easy to read pictorial chart displayed for people with an explanation of what abuse was and why it was wrong.

Safe recruitment processes were in place. Staff records showed that staff had received Disclosure and Barring Service checks (DBS) prior to commencing their appointments. The DBS enables organisations to make safer recruitment decisions by identifying candidates who may be unsuitable for certain work, especially that involve vulnerable adults. This ensured that people were protected from the risks of unsuitable staff being employed by the service.

The service had sufficient numbers of staff to keep people safe and meet their care needs. This was observed during our visit. Staff told us, "We have enough staff to support people; if we need to we can call on bank staff." We were aware the majority of staff had joined the service in the past few months and there was a high turnover of staff.

Risk assessments captured people's identified risks. However, we could not see evidence how staff managed the person's risk. For example, one person had been identified at risk of absconding. We could not see clear guidelines on how this was managed. Another person had a condition which meant they had an insatiable appetite and strict limitations of food intake were required to ensure they did not gain too much weight which would have exacerbated their condition. However, we saw conflicting information in the person's care plan in relation to their food intake. Guidelines from the health professional were documented in a way that was difficult to understand. For example, calorie intake was conflicting and not clear for staff to follow. We asked staff what the calorie guidelines were for the person and all staff we spoke with could not confirm what the person should be consuming. We noted the person was having their weight monitored. The person had an increase in their weight of more than one stone in six months. We did not see any record of actions taken in relation to the weight gain. We were aware the person also had diabetes and the care plan documented the person should have their blood glucose levels checked several times each day. However, we found this did not take place.

The last recorded blood sugar test was 30/03/2017.We spoke with the deputy manager who told us it was not possible to do this (check the person's blood glucose levels) as the service did not have any glucose testing strips. We noted the service had no testing strips for two weeks. We asked the deputy manager why the service did not have any testing strips. They told us the GP surgery had not sent them. We asked to have the contact details of the diabetic nurse who was involved in managing the person's diabetes. We were later informed by the service the healthcare professional is no longer involved in managing the person's diabetes.

This meant the person was at risk of not having their diabetes managed in line with current guidance and best practice. They may be at risk of having episodes related to their diabetes such as hypoglycaemia and hyperglycaemia. We did not see any guidelines for staff to follow in the event of these episodes. Furthermore, inadequately treated hyperglycaemia or hypoglycaemia could result in hospital admission for the person.

Medicines were not always managed safely. For example, we saw a total of 41 missing signatures on medication record charts (MAR) we viewed. We discussed this with the deputy manager who acknowledged the missing signatures. We asked what the audits of medicines showed and were told medicine audits were not carried out. However, we were aware that daily stock checks were completed. We saw these showed correct stock levels.

Accidents and incidents were not always recorded or followed up to keep people safe. For example, we could not see that accidents and incidents were reviewed to make sure themes were identified and actions taken. We reviewed a person's body map dated 04/11/16 where two bruises to their left leg and bruising above their right buttock were noted. This was signed by a member of staff but had not been documented in the services accident book to show how the person sustained the bruises or any follow up in relation to the injuries. Another body map dated 24/03/17 showed bruising to a person with no further information. An incident dated 12/06/2016 when a person was running towards the road whilst out on a walk with staff and other people living at the service did not record actions or follow up to prevent reoccurrence. Another incident dated 20/09/2016 showed a person became challenging and assaulted a member of staff and other people living at the service. We could see no evidence of any follow up into these events. We discussed this with the deputy manager and they told us the incident forms were all signed off by the manager and the director. This was referred to as the outcome page. However, these were not present in any of these events. We could not be confident that actions were taken to reduce the risk of further accidents to keep people safe.

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

Requires Improvement

Is the service effective?

Our findings

Relatives told us conflicting information in relation to staff skills and training.

Relatives said there was a high turnover of staff and staff did not always understand the specific needs of the people living at the service. One comment we received was, "I met a member of staff by chance who used to work at White Leaf. They said the reason they left was because they felt 'out of their depth' in terms of looking after people." Staff told us, "It's been busy; it's like jumping in at the deep end." Other comments included, "It's good. The more I'm here the easier it gets. Me and [another staff member] have found things that need doing. It's a challenge."

However, other families told us staff were well trained and knew their relative well. The training matrix we saw confirmed staff had received training in areas such as infection control, health and safety, fire training and autism awareness. However, we saw from the training matrix bank staff had not all completed required training. For example, fire training, infection control, Deprivation of Liberty Safeguards, Mental Capacity and health and safety had not been completed.

Not all staff had completed behavioural support training. Behavioural support training aims to minimise the use of physical interventions and emphasise sound behavioural support strategies based upon the supported person's needs. However, we were aware the provider was in the process of arranging for all staff to complete this.

People with learning disabilities or autism are often dependent on others for good communication related to their care. Staff told us, "They are pretty much non-verbal in this house."
There was no evidence of alternative communication systems being used with people to aid their communication. For example, we saw one person bringing their sandwiches back to the kitchen on several occasions during lunch time and pointing to the toaster. We heard one member of staff say to another member of staff. "I have no idea what he [the person] wants." After a couple more times of the person coming into the kitchen one of the staff realised that the person wanted to have toast rather than a sandwich. This may cause the person to become upset and agitated if they were unable to communicate effectively to alert staff of what they wanted.

Visual communication tailor made for the people who used the service was not available. For example, we did not see personalised visual timetables, staff photo rotas and use of any signing systems, such as Makaton.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Families told us communication was poor. One relative told us they had not been informed when their

family member had fallen and injured themselves. They also commented that staff had not told them they (staff) had administered medicine to their family member just before the person went home for the week end. This resulted in the family also giving medicine to the person when they returned home. Which meant the person was overdosed on their medicine.

We saw conflicting and confusing information in relation to diabetes from a diabetic nurse who visited the service. The dietary update on 3/03/17 stated the person was only to have 1,000 calories each day. We spoke with the deputy manager about this they told us this was wrong and the person should have between 2,000 to 2,500 calories per day. None of the staff could confirm what the person was having in relation to their food intake. Furthermore, we could see no documented evidence of a food diary or management of the person's food intake. We noted the person had a condition which makes it difficult for them to control their intake of food. This meant that eating a balanced diet and monitoring weight was not in place to ensure the person's diabetes was managed and the person remained healthy.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principals of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found consent was sought from people and those who had legal authority to act on their behalf. DoLS applications were submitted appropriately to the local authority. Policies in relation to MCA and DoLS were in place. This showed the service acted in accordance with the requirements of the MCA.

People were able to have their meals at times that suited them. People who were able could prepare their own meals. We observed two people making their own lunch in the kitchen; they appeared at ease and interacted well with each other and the staff on duty. However, although the service had identified people with complex needs in relation to their nutrition, this was not followed through with a detailed management plan to ensure the person's identified needs were met.

Good

Is the service caring?

Our findings

Families we spoke with told us their family member received support from staff who were caring. One comment we received was, "Caring yes, [name] seems happy there and that's the main thing." Another comment was, "I am happy at the moment. I am keeping an eye on how things go."

People received care from staff who respected their dignity and treated them with kindness. We observed this during the latter part of the day when people had returned from their community activities. We saw staff and people living at the service in the lounge area relaxing and at ease in each other's company. We asked staff how they ensured people's privacy and dignity were respected and they told us they always knocked on people's doors before entering and closed curtains and doors when carrying out personal care. We saw consent was sought from people before staff entered their rooms.

The service had a large lounge area where people could relax and listen to music. Relatives told us they could visit at any time and were made to feel welcome when they did.

Most of the staff we spoke with demonstrated a good understanding of people's care needs. However, this was not always documented in people's care plans. We asked families whether they were involved in decision making for their family member. One relative told us, "I have to prompt them to remind them we need a review." Another comment was, "We have reviews of what's going on but I am not always given updates on other things." The relative was referring to information in general about what their family member had done during the day. They went on to say, "I am 50% happy, hoping that things improve."

People's bedrooms were not always personalised. We saw one person's room which was barely furnished and the chest of drawers was piled up with incontinence aids, which did not promote this persons dignity. This may have a negative impact on the person's well-being, in terms of identity and who they are.

Staff promoted people's independence and supported them to exercise choice. For example, staff told us, "The boys sort themselves out; we just have to prompt them sometimes." During our visit we observed people preparing their lunch.

Confidentiality of people's information was maintained. We noted that records were stored in the office which required a key to enter. Information about advocacy services was displayed with the contact details on the wall.

Requires Improvement

Is the service responsive?

Our findings

Care plan reviews did not always take place. One relative told us, "I have to prompt them to complete an annual review for [name]." Care plans we saw did not always focus on people's needs. For example, people who had diabetes did not have specific information for staff in relation to the management of their condition. We also saw a notice on the kitchen wall which said the person should have their blood glucose levels tested six times each day. However, staff told us this was not necessary and the person only checked their blood glucose levels when they needed to. We discussed this with the deputy manager and said this would be very confusing for new staff. The deputy manager agreed with us. In addition we saw a notice on another person's bedroom door which said the person needed to be checked every two hours, and there was a chart in the person's room for staff to sign when this was done. However, the chart did not record this happened. We spoke with staff and they told us that staff forget to sign the form but the checks did take place.

Comments from one relative were, "I am unimpressed. We were promised additional speech therapy for [name] but, we are still waiting." This could mean delays in therapy may restrict the likelihood of improved levels of communication, to enable the person to communicate effectively and make choices.

One relative told us they were still waiting for the outcome of an investigation into an incident that happened at the service. Risk assessments were not regularly reviewed and kept up to date. For example, we saw one person's risk assessment and care plan had not been updated since November 2015. We discussed this with the director of the service who told us this was incorrect dating and the care plan had been updated in October 2016 and was due to be reviewed again in April 2017. In addition, we saw one person who was on a weight monitoring chart dated December 2016. On the chart we saw the person should have a gluten free diet only. However, we could see no documentation of this in the person's care plan. We asked staff about the person's food requirements and they told us the person no longer had their weight monitored and they were not sure if the person had a gluten free diet. This may mean if the person does not follow a gluten free diet they may suffer the consequences of digestive issues.

People were able to attend activities in the community such as FADE club, going to the cinema and going out for meals. FADE is a dance and exercise club. It was clear from our observations that people had an active life and enjoyed the activities they attended. On both days of our inspection were saw that people were attending community based events.

Relatives we spoke with said they knew how to make a complaint. A complaints policy was in place to ensure complaints were handled appropriately by staff and relatives knew what to do in the event they needed to complain. However, we did not see information in an easy read format displayed for people who used the service. This meant that in the event of any concerns a person may have they would not be aware of the correct action to take. We looked at the service's complaints folder and saw a complaint from a family member dated 13/03/2017 we could see that a follow up meeting took place on 17/03/2017 where the complaint was discussed with the Managing Director, dealt with and resolved.

Requires Improvement

Is the service well-led?

Our findings

Relatives felt the service was not always well-managed. Comments we received were, "The management are not open to parents" and, "We are not always listened to. It needs careful monitoring." However, we were aware of management changes within the service at the time of our inspection and the current provider was keen to make changes to enable improvement.

Comments from staff included, "The only concern is communication, being aware of what we are all doing", "I have been supported well since I have been here" and, "I enjoy my job; there have been quite a few changes. The downfall is communication."

A training matrix was in place to ensure staff had completed essential training. However, we noted this had not been kept up to date because it did not reflect training some staff had completed. One member of staff told us they had completed their administration of medicines training. However, this was not showing as completed on the training matrix. We discussed this with the deputy manager and they told us the member of staff had completed this training but it had not been updated on the matrix. This demonstrated the service did not ensure records were accurate relating to staff and subsequent training.

The service did not have effective systems to regularly monitor the quality of care people received. The service did not carry out medicines audits to show discrepancies in how medicines were managed. For example we noted several missing signatures on medicine charts and these were not detected by the service. Care plan audits had not highlighted some care plans had not been reviewed and updated to reflect people's current needs. Without checks on the safety and quality of care, the service could not identify areas for improvement.

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

A white board located in the office was a means of communication for staff. We saw a message for staff which read: 'The house is in a mess! I will be doing a house inspection tomorrow morning without fail; the house must be well presented'. This was signed by the deputy manager. This demonstrated autocratic leadership which may not inspire staff to work as a team. However, we were told that daily house meetings were in progress to help with communication between staff.

We saw that safeguarding information was displayed in the office along with details of how to contact the local authority safeguarding team. DoLS information was also displayed and available in an accessible format for people.

Feedback was sought from people and their families to seek their views about the way the service was run. We found the provider held meetings with families. We saw the previous meeting was in December 2016 the

agenda was to discuss holidays and payments during this time. The next meeting was planned for July 2017.

It was clear that people were involved in the running of the service. For example, one person told us how they tested the smoke alarms and ensured that the fire doors worked correctly. Another person told us they looked after the signing in book for visitors and staff. This was confirmed when the person asked us to 'sign in' when we first arrived at the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Visual communication tailor made for the people who used the service was not available

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Accidents and incidents were not always recorded or followed up to keep people safe

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not have effective systems to regularly monitor the quality of care people received