Nestlings Care Ltd

Heaton House

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service effective?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

The published date on this report is the date that the report was republished due to changes that needed to be made. There are no changes to the narrative of the report which still reflects CQCs findings at the time of inspection.

About the service

Heaton House is a residential therapeutic placement for children aged under 18 with emotional and mental health needs. The primary regulator is Ofsted because Heaton House is categorised as a children's home. However, the provider, Nestlings Care Ltd, is also registered with the Care Quality Commission because they carry out the regulated activity 'Treatment of disease disorder or injury' from this location.

Heaton House is a home providing accommodation for up to four children. At the time of our inspection there were three children living at Heaton House.

Children's experience of using this service and what we found:
Children told us that they felt included in their care. They understood their treatment plans and they felt able to raise concerns when they needed to.

The location had recently undergone some refurbishments. The children spoke positively about the changes that had been made. Children had choices about what they ate and took an active role in choosing daily activities.

Children told us that they didn't always hear the outcome when they give feedback on their care. This limits their ability to be fully included in their home life. We have made a recommendation to the provider to address this.

We have also recommended that the provider review their complaints process to make it easy to see what complaints have been made and how they have dealt with them.

Children were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of Effective and Well Led key questions, the service was able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support:
• The provider used positive behaviour support plans and there was careful transition planning when children moved into the home. Children know what they can ask for help with and this maximised their opportunities for support and independence.

Right care:
• Care planning and communication to all staff promoted people's dignity, privacy and human rights.

Right culture:
• Leaders and care staff were open and honest. People knew they could raise concerns, and this was important to support inclusion.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection (and update)
At the last inspection of this service (published 17 December 2020) there was one breach of regulation (regulation 10). The provider completed an action plan after the last inspection to show what they would do and by when to improve. We reviewed this breach (published 16 September 2021) and found that the provider had made improvements and were no longer in breach of this regulation.

Why we inspected

We received concerns in relation to staffing and the impact on patient care. As a result, we undertook a focused inspection to review the key questions of effective and well-led only.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them.
We have found evidence that the provider needs to make improvement. Please see the well led sections of this report.

You can see what action we have asked the provider to take at the end of this report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for <Heaton House on our website at www.cqc.org.uk.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified breaches in relation to good governance at this inspection. This was due to a lack of effective systems to assess and monitor improvement at this location.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan to address the concerns that we have identified at this inspection. We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service effective? The service was effective. Details are in our effective findings below.	**Inspected but not rated**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Inspected but not rated**

Heaton House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors from the Children's Services Inspection Team.

Service and service type
Heaton House is a residential children's home that provides care and treatment to children and young people under the age of 18 who are experiencing poor emotional and mental health. Three children were living there and receiving care and treatment at the time of our inspection.

There was no registered manager. There was a new manager who planned to make a registered manager application. We have referred to them throughout this report as the manager. The provider is legally responsible for how the service is run and for the quality and safety of the care and treatment provided. We have referred to them throughout this report as the provider.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed all the information we held in our systems about the location and the provider. This included information the provider had sent to us as part of their legal responsibility to notify us of certain types of incidents and events, such as serious incidents and injuries involving the police.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection-
We spoke with two of the three children living there about their experience of their care and treatment. We also spoke with ten members of staff, including residential support workers, managers, members of the mental health team and executive team.

We reviewed a range of records. This included parts of all three children's records that were relevant to our focus for this inspection. We looked at records in relation to staffing, training and supervision, incident reporting and debriefs following episodes of restraint. We also looked at risk management recording, recording of auditing processes and documents that relate to the management of the service and service issues.

After the inspection –
Following our visit, we spoke with all three of the children's social workers, the independent mental health advocate and the district nursing team.

We continued to seek clarification from the provider to validate evidence found. We looked at terms of reference and minutes for staff support groups and management monitoring.

Inspected but not rated

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

Children's outcomes were consistently good, and children's feedback confirmed this.

Assessing children's needs and choices; delivering care in line with standards, guidance and the law
- Care and support is planned and delivered in line with current evidence-based guidance. Care plans are regularly reviewed, and changes are effectively shared with staff through the weekly case presentation. Children we spoke with were aware of their care plans and how this informed the support they received.
- Staff sought advice from multi-agency professionals to ensure that they were responding appropriately to emerging needs. Children knew the multi-agency team that supported them to meet their needs.

Staff support: induction, training, skills and experience
- Staff have the right knowledge, qualifications and experience to deliver safe care to children. They are subject to the right recruitment processes and induction and training when they join the provider. However, staff induction processes were not accurately recorded. This limits management oversight.
- Supervision was used regularly to support staff. However, it was less clear what the purpose of the supervision was. This made it difficult to evidence how supervision was supporting staff to deliver improved experiences and outcomes for children. We saw that some intervention debriefs used standard phrases. This meant that measures to respond and reduce risk to the child were not always personalised. The manager recognised these shortfalls and had plans to develop this area of practice.

Supporting children to eat and drink enough to maintain a balanced diet
- Children are supported to plan their meals for the week. This includes planning shopping and cooking. They were encouraged to take responsibility for keeping the kitchen clean. This supports children's independence as they reach adulthood. Children told us that they were involved in all aspects of meal planning and that they enjoyed this. Staff and children told us they go to the shops to get additional food as and when they need it to ensure that needs are met. We saw that the food that had been bought reflected the meal planning.
- The kitchen and dining area were clean, and food was stored safely. Children had access to their own cupboards to store food that they liked. This was important to children with different cultural and nutritional needs or preferences.
- When needed, alternative nutrition was stored and prepared according to manufacturer's instructions. This ensured that the risk of infection was reduced.
- Children did not have access to healthy eating education. This is important especially because some children's medication affect their nutritional status.

Staff working with other agencies to provide consistent, effective, timely care
- There were processes for referring children to external services to ensure that needs are met in a timely way. We saw examples of this during our record review.

● There was limited evidence that referrals are followed up to ensure they have been received and understood. This means that in some cases, children and multi-agency partners were not clear of the status of a referral. For example, whether it had been made or accepted or whether the child had an appointment to meet an identified need.
● Relationships with social workers were largely positive. Although all external stakeholders reported that more timely communication would help them to support the provider in meeting the children's needs. For example, contacting family and social workers after a child had needed an intervention. Following a recent incident, the provider had identified that they needed to improve their multi-agency communication and recording of those contacts and outcomes.

We recommend that the provider ensures that all multi-agency communication is timely so that it has a positive outcome for children. This includes referrals to other organisations and how they are recorded and followed up.

Adapting service, design, decoration to meet children's needs
● There was a process to support maintenance and environmental improvements. Carpets had recently been replaced throughout the house. Spaces that children enjoyed spending time in had been made fit for purpose.
● Children told us that they are able to choose how they have their room decorated and how it is laid out. Staff worked with children to make sure that their rooms remained a safe space.

Supporting children to live healthier lives, access healthcare services and support
● Children that we spoke to knew what medication they were prescribed and its effect.
● Children were able to access community activities to support them.
● Where appropriate, staff acted as advocates for people in communicating with other services. This includes accessing the Independent Mental Health Advocate.
● We found that more could be done to educate and support children to make healthy choices.
● Education, Health and Care (EHC) plans were not part of the children's records. This limits the providers ability to support children to achieve good outcomes.

We checked whether the service was working within the principles of the Mental Capacity Act (MCA) and whether any conditions on authorisations from a Court of Protection had the appropriate legal authority and were being met.

● Staff understood the limitations of orders issued by the Court of Protection in respect of children aged 16 and 17 years. It was clear that when decisions were made about restricting children's liberty, efforts were always made to do so with the consent or co-operation of the child. Staff used children's positive behaviour plans to support them to use the least restrictive options.

Inspected but not rated

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

The service management and leadership was inconsistent. Leaders did not always use their systems smartly enough to be assured of high-quality, person-centred care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- We found that the recording of complaints and incidents was not always consistent. This limited the opportunity for the provider to identify themes and learn.
- People we spoke to told us that they were able to share concerns with the provider and they felt listened to. However, people did not experience change or plans to address issues from feedback.
- Children were not able to tell us what happened as a result of their feedback. This includes an example of a child not receiving an update or an outcome after they had raised a concern. Although all children told us they felt able to share with the provider what they would like changed.
- The provider had well established plans to set up a parents and carers group so that they could continually secure feedback and co-produce changes that were needed to secure good outcomes.

We recommend that the provider implements a clear and accessible system to monitor and manage feedback and complaints. This includes ensuring that they have communicated with people during and after feedback and a complaint.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- At the time of our inspection we had not received an application for a registered manager. The home had not had a registered manager for several months. Whilst there had been staff from other locations covering the functions of the role, we saw that this had not provided the stability in leadership that the home needed. As we mentioned at the start of this report, there was an experienced manager in post at the time of our visit. We were told they would be making the application to the Care Quality Commission to be the registered manager.
- There was a lack of documented direction for new management to support improvements. There was no prioritised or measurable plan to support the manager in leading this location. This is important because of the significant shortfall in staffing numbers that have been an issue for the home for over one year.
- All staff we spoke with shared that the managing director had recently visited the home. They described how this helped them feel connected with the leadership team and the providers vision and culture. Most staff described leaders as approachable. This is important to secure positive impact from changes that the home has recently made.
- Documentation was not always fully completed, for example provider templates. In addition, managers were limited in their ability to identify these shortfalls due to staffing challenges that we have mentioned previously and the lack of consistent management at the home. For example, in debrief paperwork and

induction paperwork that we reviewed, there were frequently empty fields. This meant that the record did not always provide the assurance that it needed to. The manager had plans to address this.

Continuous learning and improving care

● Managers completed a monthly audit cycle. This covered a broad range of subjects including maintenance and privacy and dignity. The effectiveness of the audits could be further strengthened by ensuring sufficient detail is recorded and learning is consistently shared at staff meetings.

● There was evidence of leaders and staff learning from incidents. Incident reports appropriately identified risks and plans were put in place to mitigate the risks. However, we found limited assurance that all actions had been completed.

We found no evidence that children had been harmed. However, audit and management systems were not detailed enough to provide the right measures of improvement. There was limited evidence that audit findings were shared through staff meetings. This means that the provider was not always able to monitor improvements to services. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving children using the service, the public and staff, fully considering their equality characteristics

● Children that we spoke to were aware of the care and support they could access and how they could get more help when they needed it. Children had opportunities to choose activities to enjoy outside of their home and staff were able to support children to enjoy those activities.

● As mentioned earlier, the provider had advanced plans to establish a parent forum. The aims of this included opportunities to regularly engage with parents and involve parents at the earliest opportunity in service re-design.

● We saw an example of how a staff member had communicated effectively with a parent following an incident. This allowed the parent to offer support to their child and they felt involved in their care.

● Everyone we spoke to as part of the inspection told us that they felt comfortable to raise concerns and give feedback. However, feedback was not always reported or acted on in a timely way. This means that people were not encouraged to share experiences because they could not see the changes that it resulted in. One child described an incident when she had raised a concern and not had any feedback. We were assured that the manager and staff took children's concerns seriously. This meant that concerns were always investigated. However, there wasn't assurance that young people were always made aware of the outcome of their concerns.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for children

● Most staff told us that there was a positive culture of openness and they felt supported by their immediate line manager. There were some differences in staff experience that was dependant on the support they had had through their probation. We saw evidence that recording of probation processes had improved recently. We have highlighted to the provider that inconsistencies in probationary periods and how they are recorded made it difficult to ensure that all staff and children had experienced an open and inclusive culture.

● Although there were early signs of recent improvements, some processes that support staff had not consistently happened as regularly as the provider intended. For example, team meetings and regular supervision and debriefs after interventions had been inconsistent.

This limits opportunities for managers to empower staff to strive for good outcomes for children and young people.

● Staff who had recently started at the provider told us that their training was of good quality and it supported them to deliver high quality care. This is positive and reflects the changes that the provider has made recently.

Working in partnership with others

● The service is collaborative and works with external stakeholders and agencies. This supports joined up care. It does not always share information in a timely way. External stakeholders had to request important updates, and this limits the timely support the multi-agency network can offer children.

● Stakeholders told us that they knew who to speak to and can share feedback and concerns. However, their experience was that they did not see changes or get updates as a result of their feedback. This limits the effectiveness of partnership working.

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
Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (2) (a) (b) (d) (e) Leaders did not have the right detail in plans to assess and monitor improvements. Changes in management meant that some challenges had not been fully understood and there was no prioritised plans to support the new manager. This meant that the timescale for improvements was not clear.