Heathcotes Care Limited

Heathcotes (Whitley House)

Inspection report

Garmsway
Doncaster Road, Whitley
Goole
North Humberside
DN14 0HY

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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**

Summary of findings

Overall summary

Heathcotes (Whitley House) is a residential care home for people living with autism, a learning disability and/or mental health needs. The home is situated in a rural location on the outskirts of the village of Whitley and is registered to provide care for up to six adults. Accommodation is provided across a five bedroom house and a one bedroom independent living flat on the same site.

The home was first registered in May 2015. We inspected this service on 23 May and 3 June 2016. This was our first inspection of this home. The inspection was unannounced. At the time of our inspection, there were three people using the service; two people living in the main house and one person living in the home's independent living flat.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC). However, the registered manager was in the process of de-registering and a new manager was in post and applying to become the home's registered manager. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During the inspection we found that risks were identified and assessed, but care and support provided did not always effectively manage these risks. For example, one person using the service had left the home on several occasions. However, new gates installed to manage this risk and prevent the person running into a busy road at the front of the property, were left open when we visited.

This was a breach of Regulation 12 (2) (b) of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

We found that the registered provider had not maintained a complete and contemporaneous record in respect of each person using the service or with regards to the management of the regulated activity.

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

You can see what action we told the registered provider to take in relation to these breaches of regulation at the back of the full version of this report.

Health and social care professionals told us the care and support provided was not always person centred and responsive to people's individual needs. Concerns were raised about inconsistencies in the staff team at Heathcotes (Whitley House). We identified concerns about how recommendations from health and social care professionals were recorded and shared with staff and concerns around the support provided to

engage in meaningful activities including access to transport. We have made a recommendation about developing person centred care in our report.

Staff we spoke with understood their role and responsibilities with regards to safeguarding vulnerable adults.

There were sufficient staff on duty to meet people's needs and medicines were managed safely and in line with guidance on best practice.

Staff received an induction, on-going training, supervision and yearly appraisals to support them to develop in their role.

Due to people's complex needs, people using the service did not always have a varied and nutritious diet. However, staff encouraged people using the service to eat and drink regularly. People's food and fluid intake were monitored.

People were visited by health and social care professionals, however, records of their visits and the outcomes or any recommendations made needed to be more clearly recorded to ensure more effective collaborative working.

Staff were described as kind and caring and we observed that people using the service were treated with dignity and respect. People were encouraged to make decisions and be involved in planning their care and support.

There were systems in place to manage and respond to complaints.

We received positive feedback about the new manager of the home. However, a number of health and social care professionals raised concerns about the lack of coordination and management response to issues or concerns.

The registered provider had a system in place to monitor the quality of the service provided.

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.

Staff completed training to support them to identify and appropriately respond to safeguarding concerns.

People's needs were assessed and risks identified, but risk assessments were not always followed to effectively manage risks.

There were enough staff on duty to meet people's needs.

Medicines were managed safely and in line with guidance on best practice.

Is the service effective?

Good

The service was effective

Staff received regular training, supervision and annual appraisals to support them to develop in their role.

People were encouraged to make decisions. Mental capacity assessments were completed and best interest decisions made where necessary.

People's food and fluid intake was monitored and, where concerns identified, further advice and guidance sought from health and social care professionals.

Is the service caring?

Good

The service was caring.

We received positive feedback about the caring attitude of staff.

People were encouraged to make decisions and be involved in choices about their daily routines.

Staff respected the privacy and dignity of people using the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were assessed and personalised care plans were put in place to support staff to provide responsive care.

However, care and support provided was not always person centred and responsive to people's individual needs.

There was a system in place to manage and respond to complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

We received positive feedback from staff about the new management of the service.

However, we found that records were not always well-maintained.

There were systems in place to monitor the quality of the care and support provided.

Heathcotes (Whitley House)

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 registered 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 23 May and 3 June 2016 and was unannounced. There were three people using the service on the day of our inspection. The inspection team was made up of two Adult Social Care (ASC) Inspectors and two Specialist Advisors (SPA). A SPA is someone who can provide advice to ensure that our judgements are informed by up to date clinical and professional knowledge and experience. The SPA's who assisted with this inspection were specialists in nursing care and occupational therapy.

Before the inspection we looked at information we held about the service, which included notifications sent to us by the registered provider. Notifications are when registered providers send us information about certain changes, events or incidents that occur within the service. We asked the registered provider to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the local authority's quality assurance and adult safeguarding team to ask for their feedback about the service. We used this information to plan our inspection.

During the inspection we spoke with one person using the service and spent time observing interactions between staff and people living at Heathcotes (Whitley House). We spoke with the regional manager, registered manager and five members of care staff. We also carried out a tour of the premises, which included communal areas and people's bedrooms.

We looked at two care files and reviewed records relating to the management of medicines, staff rotas, meeting minutes and records used to monitor the service, which included health and safety, maintenance records and quality assurance checks.

Following our visit we received feedback about the home from five health or social care professionals and tried to contact four more, but did not receive a response.

Requires Improvement

Is the service safe?

Our findings

During our inspection we observed that people using the service acted in a way that indicated that they felt safe living at the home and with the care and support provided by staff. We saw that people using the service appeared comfortable and at home in their surroundings. Despite this, we were aware that one person using the service could become anxious and unsettled and had asked to leave the home on numerous occasions. At the time of our inspection, work was on-going to explore the option of supporting this person to live elsewhere.

A health and social care professional told us "From what I have seen at Whitley Park, [Name] is doing well. [Name] is kept safe and well by the service providers."

Before our inspection, we received information raising concerns about several incidents where a person who used the service had left the home and run out into the main road. There was a high risk of harm associated with this behaviour as the person using the service was not able to understand or independently manage the risks of running into the road. We were concerned that this person had been able to leave the home on more than one occasion. The local authority adult safeguarding team had been notified of these incidents. The regional manager explained how secure gates had been installed at the front of the home to prevent further incidents of people using the service running across the busy road unescorted.

We reviewed two people's care plans and saw that their needs were assessed and detailed risk assessments developed to guide staff on how to manage risks to keep that person safe. However, we were concerned that risk assessments were not always followed. Where there had been previous incidents of a person using the service running into the road, the person's care plan and risk assessments recorded "The main gates at Whitley Park should remain locked via the padlock at all times." However, on the first day of our inspection we found that this gate was left unlocked and ajar when we approached the home during the day. There was not a visible staff presence at this time. This meant the person using the service was at increased risk of harm as staff were not following their risk assessment, which had been implemented to avoid situations where they unsafely accessed the main road.

We noted that one person's care plan and risk assessment around them using the kitchen recorded "Staff must ensure all sharp items are locked away at all times." We found that the kitchen drawer contained a sharp knife and a cupboard, which staff identified as the 'sharps cupboard' and which contained a number of sharp knives was also left unlocked. We raised this concern with a member of staff; despite highlighting the concern to a member of staff, we found that this cupboard remained unlocked for the remainder of the day. On the second day of our inspection, we saw that the sharp knives had been removed, however, we were concerned that these risks had not been appropriately managed and addressed prior to our visit.

These examples showed us that identified risks were not always effectively managed in line with the plans in place to reduce risk and, as a result of this, people were at increased risk of harm.

This was a breach of Regulation 12 (2) (b) of the Health and Social Care Act 2008 Regulated Activities)

Regulations 2014.

The registered provider had a safeguarding vulnerable adult's policy in place to guide staff on how to identify and appropriately respond to safeguarding concerns. We saw that staff completed 'principles of safeguarding' training as part of their induction and staff we spoke with showed that they understood their role and responsibilities with regards to safeguarding vulnerable adults. Staff gave examples of the types of abuse they might see, what signs or symptoms they would look out for which may indicate someone was experiencing abuse and appropriately described how they would respond to safeguarding concerns to keep people safe. One member of staff told us "I would pass concerns on to the team leader, unless concerns were about them and then I would go to the manager." This showed us that there were systems in place to identify and respond to safeguarding concerns to keep people using the service safe.

We asked staff if there were sufficient staff on duty to meet people's needs; comments included "Staffing levels are fine, we've always got the staff we need on the day" and "We are struggling a little bit with staff, we've had a high turnover, but they have been trying to replace staff."

During our inspection, we observed that there was enough staff on duty. Care and support was provided in a relaxed and unrushed manner. On the first day of our inspection, there were two care workers and one team leader on duty at Heathcotes (Whitley House). Staff told us that there was always a minimum of two care workers on duty during the day and that an additional member of staff came from another of the registered provider's homes across the road, if additional support was needed. Staff told us that there was either two members of staff on duty at night or one member of staff and another working a sleeping night. A sleeping night is when a member of staff sleeps within the home and gets up to provide additional assistance only when needed. We reviewed staff rotas, which confirmed these staffing levels.

Visiting health and social care professionals told us "Generally there does seem to be enough staff" and "It always seems that the numbers are there."

Where people could become anxious or distressed and staff needed to respond in a specific way to maintain their safety, information was recorded in people's care plan. We saw that all staff completed 'Non-Abusive Psychological and Physical Intervention' (NAPPI) training to equip them with the skills needed to respond if people were anxious or distressed. Staff we spoke with explained "We aim to use verbal reassurance techniques; restraint is a last resort using minimal impact and releasing as soon as we can." Staff explained situations where they might need to use restraint, for example, "If someone is very agitated and going to attack staff or service users", but told us "If we can avoid it [restraint] we do."

We saw that care plans and risk assessment around the use of NAPPI techniques contained information about how different people may react in certain situations, details about triggers for unsettled or challenging behaviours, guidance around distraction techniques and information about any medicines prescribed to reduce anxiety or distress. We saw that NAPPI risk assessments contained guidance for staff about how restraint should be completed safely and the risks associated with using incorrect techniques.

Where restraint was used, staff told us that restraint forms were completed. These forms included a section to review what had happened and to explore anything that could be learnt or done differently next time. However, we found that this section was not always completed. We also suggested that staff record more information on restraint forms, as documents that had been completed did not detail what part of the body each staff member was holding during the restraint. This could lead to issues if any injuries occurred, as it would be more difficult to establish which member of staff had caused that injury and identify where further training may be needed.

At the time of our inspection we were told there had been no accidents within the service. However, we were shown incident reports that had been completed, for example following periods of unsettled behaviours or near misses. These recorded details about what had happened leading up to the incident, details of the incident and any actions taken to diffuse the situation. Whilst this provided good insight into how staff managed incidents, we identified three occasions in the past six months where the manager follow-up section for these reports had not been completed. This section required that the manager considered whether the person's risk assessments or support plan needed to be amended or whether anything could have been done differently. On the second day of our inspection, the regional manager showed us that these gaps in recording had been addressed.

We concluded that whilst the majority of restraint forms and incident reports were completed correctly, more robust management oversight was needed to ensure that the manager review section of restraint forms and of incidents reports were consistently completed in a timely manner.

We looked around the home and saw that communal areas and people's individual rooms were generally clean, tidy and well maintained. We saw that checks of the building and the home environment were carried out to minimise health and safety risks.

We saw that a fire risk assessment was in place and checks of the fire alarm system, fire extinguishers, fire doors and emergency lighting were carried out to ensure that these were in safe working order. Personal Emergency Evacuation Plans (PEEPs) were in place documenting individual evacuation plans for people who may require support to leave the home in the event of a fire. This showed that the registered provider had taken appropriate steps to protect people who used the service against risks associated with a fire in the home environment.

The registered provider had a business continuity plan, which provided information about how they would continue to meet people's needs in the event that an emergency, such as a fire forced the closure of the home. This showed us that contingencies were in place to keep people safe in the event of an emergency.

Staff were recruited safely. We reviewed records relating to four staff and saw that interviews were completed, references obtained and Disclosure and Barring Service (DBS) checks completed before they started work. DBS checks return information from the Police National Database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups. This showed us that there were systems in place to ensure that only people considered suitable to work with vulnerable adults had been employed. We saw that new staff completed a six month probationary period to ensure that they were suitable for the role before being offered a permanent contract.

Medicines were managed so that people received them safely. The registered provider had a policy and procedure in place to guide staff on how to safely administer medicine. Records showed that staff received medicine training and competency checks were completed to ensure training had equipped staff with the necessary skills.

Where people using the service required support to take their prescribed medicines, this was documented in their care plan. One person using the service managed their own medicine and we saw that an assessment had been completed to check that they were able to do this safely.

We observed that medicines were securely stored in a locked treatment room. A daily record was kept of the temperature inside the treatment room and records for May 2016 showed that medicines were stored within

safe limits.

Medicines were supplied by the pharmacy along with printed Medication Administration Records (MARs). MARs are used to document medication given to people who used the service. MARs we checked were filled in correctly to record that people using the service had received their medicine as prescribed. Where medicine had been refused, this was appropriately recorded. We observed that stock checks were completed after medicine was administered and an audit of stock was also completed by the night staff.

The manager explained that if a medicine error occurred, the staff member would normally be suspended from administering medicine, given further training and further competency checks would be completed. This showed us that there were systems in place to ensure that any issues or concerns around medicine management would be addressed.

Good

Is the service effective?

Our findings

We reviewed the registered provider's induction and training programme. We saw that all new staff completed five days of induction training, which the registered provider considered to be mandatory. This included three days of training on topics such as fire safety, safe moving and handling, basic first aid, infection control, equality and inclusion, duty of care, principles of safeguarding and person centred support. All new staff also completed a two day course on non-abusive psychological and physical interventions (NAPPI).

Staff we spoke with told us that alongside induction training, they were required to shadow more experienced workers to gain confidence and experience in their role. One member of staff told us "I had four shadow shifts to get a feel for it – you don't get chucked in the deep end." They explained that a one month, three month and six month probationary review meeting was also held to monitor their progress and make sure they were happy and settled in their role. We saw records of completed probationary reviews, which contained detailed feedback about staff's practice with positive comments and areas where staff could improve or develop. This showed us that there was a system in place to support new staff to develop in their roles.

In addition to mandatory training, we saw that a range of non-mandatory training was also available for staff to broaden their knowledge and skills. Staff told us "There's always on-going training if they think you need to update something" and "I seem to have done loads of training...I find it quite interesting. I do rate the training sessions, it is important for this type of work."

Records showed that staff had regular supervision and yearly appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to its staff. It is important that staff have regular supervision as this provides an opportunity to discuss people's care needs, identify any training or development opportunities and address any concerns or issues regarding practice. Appraisals are used to assess staff's performance and set targets for the coming year. We saw that records of supervisions and appraisals completed were detailed and showed us that staff were supported and encouraged to develop in their role. Staff we spoke with told us they felt supported with comments including "I do feel supported, I do feel like they [the managers] are approachable and get things sorted if needed" and "[Name of manager] and [Name of other manager] are very open to progression, supporting and giving people chances."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the registered provider was

working within the principles of the MCA and DoLS. At the time of our inspection, two people using the service were subject to DoLS. One person using the service was supported by an Independent Mental Capacity Advocate (IMCA). An IMCA is someone who supports a person so that their views are heard and their rights are upheld.

Staff we spoke with had an understanding of the MCA and their role in supporting people to make decisions. Where there were concerns about people's ability to make an informed decision, we saw that mental capacity assessments had been completed and, where necessary, best interest decisions made. Best interest decisions are decisions made on a person's behalf where they have been assessed as lacking capacity.

Staff supported people using the service to buy food and prepare meals and drinks where necessary. A number of people using the service had complex needs around their food and fluid intake and often refused to eat or became fixated on certain types of food and drink. We observed that because of this, people using the service did not always have a varied and nutritious diet despite encouragement and prompting from staff to promote a more balanced diet. Staff we spoke with said it was often difficult to change people's eating habits and that they prompted and encouraged people to eat healthy options wherever possible.

A visiting health and social care professional told us "[Name's] diet is improving and he is no longer requesting cola or chocolate when he goes to the shop. This has resulted in a positive loss of weight." Other health and social care professionals raised concerns about the limited diet and lack of variety of food that one person using the service ate.

We observed that there was a range of food available in the home, including fresh fruit and vegetables from which staff or people using the service could prepare meals and snacks. Care plans contained nutritional assessments detailing the level of support people needed to ensure they ate and drank enough. Care plans also recorded important information about people's food likes and dislikes. Staff we spoke with showed us that they understood people's nutritional needs and their role in encouraging and prompting people to eat and drink enough, whilst trying to maintain a varied and balance diet.

We saw that where there were concerns about a person's nutritional intake, healthcare professionals were involved to provide advice, guidance and support. We saw that food and fluid monitoring charts were also used. These recorded what people ate and when they refused to eat or drink. Records showed that people using the service were weighed regularly. Where people refused to be weighed, staff described how they looked for visual clues to identify significant concerns regarding weight loss or weight gain. This showed us that the staff were monitoring people's food and fluid intake.

Care files documented information about people's medical history, current health needs and prescribed medicine. This information was incorporated into care plans detailing the support required from staff to promote and maintain people's health and wellbeing. We saw that hospital assessments were in place in order to ensure that important information about people's needs and preferences would be shared if that person needed to be admitted to hospital.

The regional manager provided us with contact details of numerous health and social care professionals who regularly visited people using the service to promote and maintain their health and wellbeing. However, we found that records about these visits were poor with often limited or no information recorded about what had happened during this visit, what had been discussed and any recommendations made. The regional manager showed us a new form they planned to introduce to better record health and social care professional's visits, the outcomes and any recommendations made to ensure more effective collaborative

working.

Whitley Park was bright, airy and had a calm atmosphere. There were three people using the service at the time of our inspection, but space to accommodate up to six people. This meant there was ample space for people to move around the home.

Good

Is the service caring?

Our findings

During our inspection we observed that staff spoke with people using the service in a caring manner and tone. A visiting health and social care professional told us "Staff seem caring, I don't doubt that."

Some people using the service had complex needs and were often reluctant to engage in conversation or refused staffs attempts to interact with them. Because of this, we observed that meaningful interactions between staff and people using the service were often based around fixed routines. Despite this, we saw that staff regularly tried to engage people using the service in conversation and encourage meaningful interaction outside of these routines. Staff we spoke with talked about how they tried to encourage people to speak about or engage in activities to explore shared interests.

We reviewed the systems in place to support staff to get to know people using the service and develop meaningful caring relationships. A member of staff told us "New starters read through the care plan and every now and again staff read them to update yourself." They explained how this along with shadowing enabled them to get to know the person using the service. We saw that care files contained information about the person's interests to support staff to get to know them and develop meaningful relationships with people using the service.

Staff we spoke with explained that some people using the service were more responsive to certain members of staff. On the second day of our inspection, we saw a positive example of this. We observed how one person using the service responded more positively towards a member of staff showing us that they had developed a level of trust and a relationship meaningful to them with this person. The regional manager told us how they were developing a 'core team' of staff so that people using the service could be more consistently supported by people they knew and had developed a meaningful caring relationship with.

We asked staff if the people they worked with cared for people using the service; comments included "Staff are caring, they've got a very good rapport with service users" whilst one member of staff explained "They [staff] are always making sure wherever possible that they are listening, always making sure that the home's neat and tidy and making sure that people look presentable." Our conversations with staff showed us that they did care for people using the service; staff spoke about wanting to improve people's quality of life and promote wellbeing. This showed us that staff had a caring attitude and approach to supporting people using the service.

We observed that easy ready guides were available to explain the Deprivation of Liberty Safeguards, the Mental Capacity Act 2005 and about voting. Easy read information is designed for people with a learning disability and is a way of presenting plain English information along with pictures or symbols to make it more accessible. We saw that pictorial information was available regarding food choices and possible activities that people using the service might like to do. Staff told us this information was available to try and support people using the service to express their wishes and views and to support them to make decisions. We saw that staff did encourage and prompt people using the service to make decisions throughout our inspection.

We asked staff how they supported people using the service to maintain their privacy and dignity, one member of staff told us "[Staff] talk to people as equals and want to do the best by them...staff do go above and beyond in their approach." Other staff we spoke with showed that they understood the importance of maintaining people's privacy and dignity by explaining how they made sure people's doors were closed and prompted with personal care from outside the bathroom wherever possible to maintain people's privacy. We observed that conversations and support provided in communal areas was appropriate and respectful and that staff knocked on people's doors rather than walking straight into people's rooms.

Health and social care professionals told us "I think their [staff's] attitude is good, they are respectful. I have never witnessed anything of concern" and "I have not seen anything on my visits to make me believe they are not maintaining [Name's] privacy or dignity."

We observed that there was a presentation board about 'Dignity and Respect' in the dining room of the home. This had drawings and statements written by staff about what these words mean and how they affected people living at the service. This showed us that staff were actively encouraged to think about these topics when providing care and support.

During our inspection we saw no evidence to suggest that anyone using the service was discriminated against in respect of the seven protected characteristics of the Equality Act 2010; age, disability, gender, marital status, race, religion and sexual orientation.

Requires Improvement

Is the service responsive?

Our findings

Before our inspection we received concerns about the registered provider accepting people with more complex needs than those which could be met at the home. In one instance, this had led to a person having to move out of Heathcotes (Whitley House) a short time after arriving.

During the inspection, we spoke with the regional manager about how they decided if the home would be suitable to meet a new person's needs. We looked at assessments completed before people moved into the home and saw steps were taken to gather information before a decision was made about whether the home would be suitable for that person. The regional manager requested copies of other professional's assessments, daily records and accident and incident reports, but told us they did not always receive this information before people moved into the home. We spoke with the regional manager about ensuring they had all relevant information about people's needs before agreeing that a new person could move into the home. We were concerned that important information about people's needs could have been missed by not looking at this information and completing more robust preadmission assessments. The regional manager told us that they had learnt an important lesson about more robustly gathering their own information about people's needs before accepting new people to the home.

We reviewed two people's care plans and saw that these contained detailed information to guide staff on how people's needs should be met. We found that care plans recorded people's likes, dislikes and personal preferences with regards to how their needs should be met.

Although we saw that there were systems in place to support staff to provide person centred care, we received a number of negative comments from health and social care professional professionals.

At the time of our inspection, the regional manager explained that staff rotas were organised centrally for Heathcotes (Whitley House) and another of the registered provider's services, Heathcotes (Whitley), which was on the opposite side of the road. This meant staff worked flexibly across the two services, with staff from one service supporting the other service when necessary. Three health and social care professionals we spoke told us they felt this arrangement, and a high turnover of staff, affected the continuity of care for people living at Heathcotes (Whitley House). Comments included, "There's not really been a consistency of staff" and "They [staff] do not have the experience." Health and social care professionals told us that staff regularly said "I haven't been here so I don't know", "I don't know them" or "I don't know what his activities for the day are. I'm new" when they visited and asked for information about the people they were supporting. Health and social care professionals we spoke with emphasised the importance of staff knowing and understanding people's needs and explained how consistency of care and approach was needed particularly when supporting people with autism. Three staff we spoke with told us that there had been a high turnover of staff. One member of staff commented, "That security and predictability for the people who use the service is important, the units are so very different, it is difficult for staff to gain experience."

We identified that, across both services, 21 staff had left the service and 18 staff had been recruited since August 2015. During our inspection four of the five staff we spoke with told us that they did not normally

work at Heathcotes (Whitley House) and usually worked at another of the registered provider's homes across the road. We spoke with the regional manager who told us that each home would have its own distinct 'core team' of staff by the end of June 2016 and rotas would be organised separately to ensure greater continuity of care. The regional manager explained core staff were already working at each service, but they had been unable formally change the rota before the end of June 2016 as staff required a notice period before changing their working patterns.

During the inspection, we received a number of comments from health and social care professionals who told us they felt the lack of knowledge and experience of staff affected their ability to provide person centred care. Comments included "They are not implementing a basic autism friendly approach – being able to provide that structure...I feel if they [staff] were given more training they could implement it", "They [staff] do not have the experience" and "I do feel that their [staff's] knowledge of autism means that they are unknowingly or unwittingly not acting in the most caring way." A member of staff told us "Staff have done the best they can with the training they have offered...I certainly think it would be good if there was more mental health awareness."

The regional manager told us that staff completed autism training and this was provided by professionally qualified and experienced staff that each had over 10 years' experience of working with people with learning disabilities, autism or other complex mental health needs.

We looked at the systems in place to ensure staff had up-to-date information about people's changing needs. We saw that daily records were completed to record important information about any issues, concerns or updates regarding the care and support provided to each person using the service that day. The forms also recorded any safeguarding issues, accidents or incidents, appointments and details of any trips out. The home had a communication book which recorded similar information about things staff needed to be aware of or that staff needed to do. Staff told us they got up-to-date information about people's changing needs through reading the professional visits record, through handover records or information recorded in the home's communication book. This showed us that there were systems in place to share information.

However, visiting health and social care professionals told us "I have tried to implement recommendations, but what I have been finding is that recommendations have not been passed down to the staff team" and "They need to make recommendations [from visiting health and social care professionals] more clear." We found that these comments were reflected by other health and social care professionals who felt that the advice given was not consistently followed and that this was impacting on the quality of the care and support provided. The regional manager told us that they often received conflicting advice about how to best meet people's needs and this made delivering a consistent person centred approach difficult. However, we were concerned that records of professional's visits were not always well maintained with details about visits, the outcomes and any recommendations made not consistently recorded. We concluded that work was needed to develop more effective collaborative working relationships with health and social care professionals and to better record and share information from visits with the staff team.

We spoke with staff about the support provided to people using the service to engage in meaningful activities. Staff explained that people using the service had one to one hours with staff available each day or across the week to support them to engage in activities and access the wider community. However, the regional manager and staff we spoke with told us about the difficulties they faced encouraging people to go out. Staff told us "Usually there are not a lot of activities in this house" and "We are trying to improve activities and get more activities done. In this house, unfortunately, there is no set activity routine." They explained that people using the service often refused to engage in activities despite regular prompting and

encouragement. A visiting health and social care professional told us "[Name] can be reluctant to engage with the staff there and myself when I visit at times, which can make delivery of that service difficult. However, I feel that this has improved while he has been living there...He was initially not going out and now has regular trips out to the shops."

We found that one support plan for activities, in place on the first day of our inspection, stated 'The person will refuse' in the opening statement. In this instance, we were concerned that the person's openness to engage in activities was prejudged. Activity encouragement sheets were in place to record when staff prompted people to engage in activities, we observed that support was provided to engage in activities as part of people's established routines and we observed staff offering or prompting people to initiate activities. However, this support appeared tokenistic at times and we saw that staff did not consistently make concerted or meaningful attempts to encourage people to engage in a range of activities.

People living at Heathcotes (Whitley House) had access to two cars which were available to take them out and to access the wider community. These vehicles were shared with another of the registered provider's home, Heathcotes (Whitley), on the opposite side of the road. Because there were 12 people, living across the two services, who may want to use the cars, they were not always immediately available. Some people could access public transport, however, others were reliant on the cars to take them out. The regional manager told us that people who used the service had daily use of the car, however, health and social care professionals we spoke with raised concerns about the impact of waiting for the cars to become available. One person who used the service had a history of self-isolating and spent long periods of time alone in their room. A member of staff explained how care and support had to be provided on "[Name's] terms" and they were often reluctant, despite encouragement, to engage with staff. On the day of our inspection, they told us that the morning routine had been a positive experience, because a car was immediately available. Health and social care professionals told us they felt it was important for a car to be readily available, when the person did want to go out, and thought that having to wait could increase their mistrust in staff and lead to further self-isolation. We were given a number of examples where this person had to wait to go out or we were told they had gone back to bed because transport was not readily available. The regional manager told us they had only recently been made aware of this issue, had not experienced any problems with this person waiting for the car and were taking steps to try and enable them to have access to their own vehicle.

We concluded that the work was needed to improve the level of person centred care and support provided at Heathcotes (Whitley House). Concerns were raised about the inconsistencies in the staff team and how this impacted on the knowledge and experience of the staff supporting people who used the service. Improved access to transport needed to be explored. Although at the time of our inspection work was on-going to address this, a more consistent and coordinated approach was needed to ensure that information and recommendations from health and social care professional's visits were recorded and shared to support staff to provide responsive person centred care.

We recommend the registered provider seek advice and guidance from a reputable source about continuing to develop person centred care.

The registered provider had a policy and procedure in place detailing how they managed and responded to complaints. We observed that a copy of the complaints policy was displayed in the entrance of the home for people using the service or visitors to access if needed. Staff showed us a complaints book, but this contained no entries. A complaints log kept in the homes office recorded that there had been three complaints made and we saw that these had been investigated and the issue resolved.

We saw minutes from a residents meeting held in April 2016. We saw that people using the service had been

reluctant to engage in this, but that topics discussed included activities, proposals for a holiday, any care or support issues and meal planning. This showed that the registered provider was trying to involve people using the service in decisions about the care and support provided.

Requires Improvement

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration for this home. There was a registered manager in post on the day of our inspection and, as such, the registered provider was meeting this condition of their registration. At the time of our inspection the registered manager was in the process of de-registering and a new manager was in post and registering to become the home's new registered manager.

We asked staff whether they thought the home was well-led, comments included "Recently yes, since we have had the new manager. Previously there wasn't any leadership"; "This home gets managed very well, if you have any issues they get dealt with straight away. [Name] always thanks you and gives you positive feedback" and "There's been a recent change in manager – [Name] seems very nice and open, listens and seems approachable. I can go and ask her for help."

However, feedback about the management of the home was not consistently positive and a number of visiting health and social care professionals raised concerns about the lack of a consistent and coordinated approach. Comments included "Management haven't had the skills and experience to address concerns", "There does not seem to be a really coordinated approach, everybody does their own thing" and "There has been a few occasions when communication has not been the best, as visits from our team have not been known of by the staff at Whitley Park...but this appears to have improved recently." Another health and social care professional told us they felt that information was not acted upon and concerns not addressed, commenting "At this point, no, I would not recommend the home."

We asked for a variety of records and documents during our inspection. We found these were stored securely; however, we were concerned that records were not always well maintained.

We found that incident reports had not always been signed off by the manager or senior person to record that they were satisfied with the response to any incidents and that no further lessons could be learnt or action needed to keep people safe.

We found that dates of professional's visits were recorded, but there was not always a clear record of what had happened at that visit, what was discussed or details of any recommendations made. This made it difficult to establish whether staff were following advice provided by health and social care professionals.

We found that daily recording sheets in relation to people's 'personal hygiene encouragement' and 'activity encouragement sheets' had not always been completed. We also found that other records relating to the running of the home were not always completed. For example, we observed that the registered provider had a system in place requiring staff to complete daily temperature checks of the home's fridge and freezer. Records of these showed that they had not been consistently completed and there were a number of gaps in these records. We also found gaps in records relating to the testing of the fire alarm, checks of the fire fighting equipment and emergency lighting.

In addition to this, we saw that the daily handover book used to record which staff were on shift and who they were supporting had not always been completed. We reviewed handover records for May 2016 and saw three days when the handover book had not been completed. This made it difficult to track which staff were on duty and who they were providing one to one support to.

These examples showed us that the registered provider had not maintained a complete and contemporaneous record in respect of each person using the service or with regards to the management of the regulated activity.

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

We also spoke with the regional manager about duplication of information in care plans and daily records. For example, we observed that there were four records being used in relation to monitoring one person's food and fluid intake. We found other information duplicated across care plans and risk assessments and spoke with the regional manager about ensuring care files were accessible and easy to use. A visiting health and social care professional told us "When you look in [Name's] file there is form after form after form. It needs to be more concise, it needs to be more useful for staff to use." On the second day of our inspection we were shown an updated care file which contained more concise information and staff we spoke with told us "Now they have been updated, the care plans, for me, give you what you need to know. Before they were a bit vague...they are more structured now."

We reviewed the system in place to monitor the quality of the care and support provided at Heathcotes (Whitley House). We saw that the regional manager completed regular quality assurance audits to identify and address any areas of concerns. Records showed that care plan audit checklists and drug administration and storage audits were completed on a regular basis. The regional manager showed us a copy of a 'quality assurance home audit report' completed in April 2016. This covered all areas of the care and support provided and showed that the home had been scored 90% using the registered provider's own quality assurance tool. This showed us that there were systems in place to monitor and assess the quality of the service delivered.

Records showed that the registered provider held regional managers meetings to share information and discuss improvements. We saw minutes from a meeting in April 2016 in which training, quality assurance issues and CQC compliance were discussed. We saw that regular team meetings were held for staff at Heathcotes (Whitley House) to attend and minutes were produced so that staff unable to attend could keep up-to-date with what was discussed. Minutes showed that topics covered at team meetings included training, best practice with regards to record keeping and the people using the service. This showed us that team meetings were used to effectively share information and to discuss improvements within the home and with the care and support provided. At the time of our inspection team meetings were held amongst the whole staff team working across Heathcotes (Whitley House) and another of the registered provider's homes on the opposite side of the road. The regional manager explained, however, that when each home got its own distinct staff team, team meetings would be held separately for each home in future.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The CQC had been informed of significant events in a timely way. This meant we could check that appropriate action had been taken.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured that all reasonable and practicable steps had been taken to mitigate risks. Regulation 12 (2) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not maintained a complete and contemporaneous record in respect of each person using the service or with regards to the management of the regulated activity. Regulation 17 (2) (c) (d).