FitzRoy Support

Whitegates & The Cottage

Inspection report

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Date of inspection visit:
20 September 2016
22 September 2016

Date of publication:
02 November 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Whitegates and the Cottage on 20 and 22 September 2016. Whitegates and the Cottage consists of three adjoined houses and a separate cottage providing accommodation and support for 20 people with learning disabilities, some of whom also have physical disabilities. Each of the houses and the cottage accommodates five people. Whitegates and the Cottage is set in the village of Liss in Hampshire.

Whitegates and the Cottage had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service is required by a condition of its registration to have a registered manager.

People can be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA) 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). During this inspection we found where people lacked the capacity to agree to the restrictions placed on them to keep them safe, the provider made sure people would have the protection of a legal authorisation and had made the appropriate DoLS applications to the local authority.

Where the provision of people's care required restrictions upon their movements, the provider was able to demonstrate following the inspection that legal requirements had been met.

We found that the registered manager had not consistently followed the requirements of their registration to notify CQC of specific incidents relating to the service. We had not been notified of all injuries to people so that we could check that the provider had taken appropriate action to keep them safe. We also had not been notified of the outcomes of the service's applications to deprive people of their liberty so that we could monitor whether the service met the DoLS requirements.

There were sufficient staff to meet people's care needs at Whitegates and the Cottage. When there were absences, for example due to sickness, the provider managed these internally by deploying staff flexibly across the houses. They also used regular agency staff in order to ensure staffing levels were maintained to keep people safe. Recruitment procedures were in place to ensure that people were protected from the risk of employment of unsuitable staff.

Staff understood their role in relation to keeping people safe from the risk of abuse. A safeguarding policy was in place and staff knew how to identify concerns and what action they would need to take to report any suspicions or allegations of abuse.

Staff received an appropriate induction and continued to receive regular supervision and relevant training in

their role. People were cared for by staff who had received appropriate training and support.

Risks to people had been assessed and measures were in place to manage them. Staff understood the risks to each person and ensured these were managed appropriately. There were systems and processes in place to ensure people's medicines were managed safely and that their administration was documented. Staff had undertaken training to enable them to administer people's daily medicines safely and their competence was regularly checked by registered manager or her deputy.

There were processes were in place to monitor the quality of the service and identify the risks to health and safety of people. Where systems had been effective in identifying any shortfalls or issues of concern, actions had been taken to ensure that recommendations were acted on to improve the quality of service provided and keep people safe.

People were supported to eat and drink enough to maintain a healthy balanced diet. They had access to freshly cooked food which looked and smelt appetising. People enjoyed their meals and had the freedom to choose when they wanted to eat meals and snacks.

People's records demonstrated they were supported by staff to see a range of health care professionals. Referrals were made to enable people to access healthcare services when they needed to.

Staff were kind and warm in the ways that they supported people to help ensure that people had a positive and personalised experience of care. They communicated with people in a way which made them feel included and that they mattered. Staff were knowledgeable about people and had the skills, understanding and motivation to deliver good quality care. Relatives spoke positively and enthusiastically about the quality of care provided to people by staff at Whitegates and the Cottage.

People were supported by staff to be involved in decisions about what they ate, what they wore and what they wanted to do each day. Staff had access to guidance about how to communicate with people, which they followed. Staff and relatives were able to describe to us how people's privacy was maintained when their care was provided. Staff treated people with respect when they were delivering care and support to them and encouraged them to be independent where they were able.

Staff had a good knowledge of each person's care needs, interests and characteristics and care plans were person centred. Staff supported people to attend activities which enabled them to lead stimulated and fulfilled lives wherever possible.

The service was responsive to feedback and put in place improvements where these were identified. Relatives told us they had little cause to complain, but would feel comfortable in approaching the staff who looked after their loved ones or the registered manager if they had any concerns.

The registered manager was supportive of staff and ran a well-managed supervision and appraisal system. Policies and procedures were in place and available to staff. Staff applied the provider's values in their work with people, which included ensuring that people were treated as equals and had choice in their lives. The culture of the service was person centred, and it was clear that people's experience of care was a priority for staff.

We found one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this 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?

Good

The service was safe.

Staff had completed pre-employment checks to ensure their suitability to work with people living at the home.

People were protected from abuse and avoidable harm by staff who knew how to recognise signs of abuse and how to report any concerns.

Risks were effectively identified, documented and managed, to enable people to lead fulfilled lives safely. Guidance was provided to staff to enable them to manage risks to people safely.

People were supported by sufficient numbers of staff to meet their needs.

People were protected from the risks associated with medicines by trained staff who administered their prescribed medicines safely.

Is the service effective?

Good

The service was effective.

Decisions about people's care were made in accordance with the legal requirements of the Mental Capacity Act 2005.

People's needs were met by staff who had received an induction, training and supervision to develop the required skills and knowledge they needed to support people effectively.

People were supported to eat and drink enough to meet their nutrition and hydration needs.

People were supported to maintain good health and had access to healthcare professionals whenever needed.

Is the service caring?

Good

The service was caring.

People received care and support from staff who knew them well, were kind and encouraging and delivered a caring experience.

People were encouraged to express their views and make choices, which staff respected. Staff encouraged people's independence where possible.

People received care which was respectful of their right to privacy and which maintained their dignity.

Is the service responsive?

Good

The service was responsive.

People received care that was personalised to their needs and the service was responsive when people's needs changed.

People were supported to pursue their interests and given opportunities to remain socially active.

There were processes in place to enable people to raise an issue or concern they had about the service. Issues raised had been recorded, investigated, and responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had not always notified us of specific incidents, such as injuries to people, or the outcomes of applications to deprive people of their liberty, to enable us to monitor these and take follow up action if required.

Staff told us that the registered manager was supportive. The registered manager had put plans in place in response to feedback to implement improvements to the service.

Quality assurance processes and procedures were in place.

The culture of the service was person centred. Staff practiced the provider's values in the delivery of people's care.

Whitegates & The Cottage

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 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.

The inspection took place on 20 and 22 September 2016 and was unannounced. The inspection team consisted of one adult social care inspector.

Before the inspection we reviewed the information we held about the home. This included previous inspection reports and any statutory notifications. A notification is information about important events which providers are required to notify to us by law. We did not request a Provider Information Return (PIR) to be provided before our visit, although this has since been submitted. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We gathered information relating to the PIR during our inspection and reviewed the information submitted after the inspection.

We spoke with the registered manager, two senior support workers, six support workers, three people, five relatives and two healthcare professionals. We reviewed care records for five people and medicine administration records (MAR) for seven people. We also reviewed recruitment and personnel files for six members of staff, staff rotas and other records relevant to the management of the service such as health and safety checks and quality assurance audits. Not many people were able to talk to us during the inspection, so we spent time observing staff interacting with them. This helped us see how caring staff were when they were engaging with and supporting people.

The last inspection of this home was completed on 21 March 2014 where no concerns were identified.

Good

Is the service safe?

Our findings

Relatives told us that they felt that their loved ones were safe at Whitegates and the Cottage. One relative told us "They absolutely keep her safe". The home had safeguarding and whistleblowing polices in place and staff had received training in safeguarding. People were protected from the risk of abuse because staff knew the signs of abuse and were able to describe how they would recognise changes in a person's behaviours. They were confident in what action they would take to protect people if they identified these.

The provider followed appropriate recruitment procedures to ensure that people were assisted by staff with the appropriate skills and experience and who were of suitable character. New staff had undergone the required recruitment checks as part of their application process. These included a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care services. We found that the employment histories for some staff contained gaps or were unclear; however the registered manager was able to provide further information in relation to these which confirmed that there were no concerns in relation to their suitability for employment.

During the inspection, we saw that there were enough staff on duty to meet people's needs safely. Staffing levels were based on how each person was funded according to their specific needs, for example some people had one to one support for all or part of the day. The registered manager told us that a minimum of two members of staff worked in each of the three houses and the cottage during the day and we saw from rotas that there was often more than this according to people's funding. There was one waking staff member rostered during the night at each of the three houses and a sleep-in staff member at the cottage. At the time of our inspection there were four staff vacancies, one of which was filled during the inspection. Vacancies were covered by the flexible use of staff across the houses and cottage. The provider told us that they also used agency staff, however these were regular and knew people well. One agency staff member we spoke with had worked at the home for three years. The provider ensured that using regular agency staff enabled people to have consistency of care from staff they were familiar with.

People's relatives told us that there were happy that there were enough staff. Although busy at times, staff we spoke with thought that there were enough staff; one told us "If ever there is a problem, they (the registered manager) will call on agency staff" and another said "If someone is off sick, they (registered manager) will first look to see if they can get the shift covered from within the staff team".

Detailed and personalised risk assessments were in place for people. Staff were required to read people's risk assessments and support plans and sign to say they had read them. Staff we spoke with were knowledgeable about the risks to people. For example, one person had recently been visited by the speech and language therapist to assess their risk of choking. Staff were able to describe what this meant for the person and the action they needed to take to ensure that the risks to the person was minimised. We saw staff supporting the person to eat in accordance with the guidance that had been provided by the speech and language therapist.

Appropriate risk assessments and support plans were in place for people who suffered from epilepsy. These included individual risk profiles for each person which incorporated guidance to staff on how to recognise the onset of a seizure and the action they needed to take to support the person and keep them safe.

Accident and incident reporting protocols and procedures were in place. We viewed records from the start of 2016 and saw that accidents and incidents had been recorded and investigated appropriately. The registered manager told us that since June, the provider had implemented a new system where accidents or incidents coded Red or Amber were reported immediately to the provider who checked the action taken and looked for any trends or patterns.

People had Personal Emergency Evacuation Plans in place to ensure that they could be kept safe during an emergency. There was a weekly test of the fire alarm and other fire safety checks. There was an annual fire risk assessment in place and we saw that there were two evacuation practices a year. Records confirmed that fire drill evacuations had been carried out twice a year for each of the houses and the cottage. The provider employed a maintenance person to work across each of the houses two days a week to ensure that people had a safe environment to live in. Moving and handling equipment such as hoists were being regularly serviced. The registered manager carried out quarterly health and safety checks across all the houses and the cottage.

People were protected from environmental risks around the home because regular checks were completed to keep the environment and equipment safe for people.

There were processes and procedures in place to ensure the safe storage, administration and disposal of medicines. Medicines stocks were appropriately checked and signed in by the registered manager and their deputy. We checked people's Medicines Administration Records (MARs) for seven people for the current month and found staff had correctly signed them following the administration of people's medicines. MARs were colour coded to help staff ensure that they were administering medicines at the right time of day. We saw that MARs included body maps to guide staff on the application of prescribed topical creams and also a rotation record to ensure that medicines patches were administered appropriately.

Medicines were kept in locked cabinets in each person's room and in a secure storage area. Opened by dates were recorded on the medicines we checked. This ensured that medicines were used within appropriate timescales and were therefore safe for people. We saw that procedures were in place for when medicines were taken out of the home if people were going on a trip and that medicines had been signed out and signed back in appropriately.

Staff told us, and we observed, that they were confident in administering medicine to people because they had received training and were subject to annual observations to ensure their competence to administer medicines. We saw that medicines administration was always witnessed by two staff in accordance with the provider's medicines policy. Staff were aware of the procedures for reporting medicines errors. Medicines incidents that had occurred in 2016 had been recorded appropriately and the local authority safeguarding team had been notified and GP advice sought.

Some people were prescribed controlled drugs. These are prescription medicines controlled under the Misuse of Drugs Act 1971 and have additional safety precautions and storage requirements. Controlled drugs were stored and administered in accordance with legislation.

Good

Is the service effective?

Our findings

The relatives we spoke with were positive about the staff and their ability to meet their loved one's care needs. Relatives said that they felt staff were well trained and had sufficient knowledge and skills to deliver care.

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 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 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 service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's consent in relation to decisions about their daily care was sought by staff. We saw that staff explained the procedures they were about to carry out and asked people for their consent before providing care, for example whether they were happy to take their medicine. Support plans included guidance for staff on what to do if people refused their medicines and staff were familiar with this.

The registered manager had applied for and received DoLS authorisations for ten people living at the home and was awaiting the outcome of a further ten applications. Records showed that people had received assessments of their mental capacity to make decisions about their day to day care. These documents included who should be consulted when specific decisions were to be made as part of a best interest process.

However, we could not see from records that people's mental capacity had been assessed and their consent sought for some specific decisions, including around the use of wheelchair chest harnesses and lap belts, and bed rails. Although these measures were in often in place to protect people, providers are required to take account of the person's capacity to consent to their use. Where people lacked capacity to consent, we could not see from records that an appropriate best interest process had been applied. This meant that people might not have had the opportunity to take part in decisions which would restrict their movement.

The registered manager was able to describe what best interest decisions meant for people and was also able to give examples of when least restrictive options had been considered and implemented in the home. For example when someone had fallen on the stairs, a stair gate was considered and dismissed in favour of improved lighting on the stairs. A member of staff also described how bedrails had been removed for one person as they "didn't need them anymore".

However, as best interest processes had not been documented, we could not see how the provider had ensured that decisions taken on behalf of people who lacked capacity were necessary and proportionate, that less restrictive alternatives had been explored and that relatives had been consulted.

Following the inspection the provider submitted written evidence which demonstrated that people had been consulted about the use of these restraints and that where people lacked the capacity to consent to their use legal requirements had actually been met.

New staff undertook the Care Certificate when starting work. The Care Certificate is the industry standard which staff working in adult social care need to meet before they can safely work unsupervised. The provider's induction process also included e-learning modules which new staff completed before they took up their post and a two day training event incorporating medicines administration and moving and handling. New members of staff also undertook a two week period of job shadowing a more experienced member of staff before they worked alone with people. People were cared for by staff who had undergone a suitable induction to their role to ensure they could provide people with effective care.

The provider assessed staff competence in various aspect of the delivery of care, including moving and positioning people and supporting people at mealtimes. Observation assessments by the registered manager and senior staff were used effectively to assess whether staff were performing to a competent level and to highlight any areas for improvement. Observations were carried annually, and more often when a need had been identified, for example if there had been a medicines error.

The provider ran a programme of mandatory training which included Care and Control of Medication, First Aid, Safeguarding and Moving and Positioning. We saw that staff were up to date with their training and on the few occasions where training was overdue it had been scheduled for completion. People were supported by staff who were trained and therefore able to provide safe and effective care. Staff told us that they were happy with the training opportunities provided to them and the training was sufficient to support them to carry out their role. Some described courses they had recently attended. One explained how her moving and positioning training had taught her about the need to check the equipment before using it to move a person and talking to the person as they were moving them in order to reassure them.

Staff told us, and records confirmed, that support and development meetings took place approximately every month for new staff and every two months for other staff. These meetings also occurred on a more adhoc basis when required, for example if someone returned to work after a period of sickness or there had been a medicines error. These meetings included a discussion about staff progress and identified any performance issues which needed to be managed. Staff appraisal meetings took place annually. The appraisal process covered performance against objectives, development and training and how the provider could support staff to achieve their future aspirations.

People were assisted by staff who received guidance and support in their role through a thorough induction, training, and programme of supervision and appraisals. Relatives told us that they thought that staff were sufficiently skilled to meet their loved ones care needs.

We saw that people were supported to eat and drink enough to maintain a nutritious and balanced diet. People's dietary needs were catered for, for example, some people were on pureed diets and one person required a gluten free diet. We observed people who were able choosing and enjoying eating the meals that staff freshly prepared for them. Meals and snacks were prepared for people when they chose to eat. Those able to do so ate independently, while others were supported to eat in accordance with their support plans. Kitchens had bowls of fruit available for people to pick from as they pleased. Staff were able to explain to us

what fruit people liked, which was often soft fruit such as bananas, nectarines and grapes, all of which were available. People had access to appetising and nutritious food.

People had regular visits to healthcare professionals, both on a routine basis, and also when there were issues or concerns about their health. Care plans evidenced regular visits to the GP, dentist, and opticians. We saw that people had been seen by a speech and language therapist (SALT) and attended hospital appointments where appropriate. Records confirmed that that staff had sought advice about people's care from relevant healthcare professionals. Staff we spoke with were knowledgeable and able to discuss recent changes in people's needs and how to respond to them. This demonstrated that they understood people's medical conditions well.

Care plans included 'Hospital Passports' which contained facts about people if they needed to attend hospital. This ensured that information about people's needs and support was available to other healthcare professionals to ensure continuity of care.

Good

Is the service caring?

Our findings

Relatives we spoke with were positive about the care that their loved ones received at Whitegates and the Cottage. One relative told us "Yes, all very very good" and another said "They have been brilliant". Another relative described her loved one as "extremely happy" and that they "couldn't have got her in a better home".

One relative described how her loved one enjoyed coming home for visits but was "equally happy when it was time to go back again." Another relative described how whenever she visited, her loved one was "always beautifully turned out" and that "she does not want for anything".

We observed patient, caring and compassionate interactions between people and staff throughout our visit. A relative described her loved one as "very tactile and cuddly" and that "staff were good at responding to that". Staff chatted to people as they supported them, involving them in conversations, explaining what they were doing and asking for people's opinions.

The home had a strong person-centred culture, where staff knew each person well, and spoke with fondness about their personalities and interests. Staff were warm and jovial, engaging people in friendly conversation as they went about their daily tasks. In turn we saw that residents were relaxed and happy in their company. Bedrooms were personalised to people's individual taste. There was a real sense that each of the houses and the cottage were people's homes, where people could relax and be themselves.

People were supported to express their views and be involved in decision making as far as they were able. House meetings were held every month in each of the houses and the cottage which residents and staff attended. We saw from the minutes that people were involved in discussion and contributed to them where they were able, for example, activities people would like to do.

We saw that people were offered choice in planning the menus for each week. Staff told us of one resident who despite being involved in choosing their meal, often changed their mind when it came to eating it. Staff explained, and we saw, that this person had their own fridge which they then went and chose something from as an alternative. Mealtimes were flexible. We observed one person choosing their lunch and then wandering away from it into another room. The staff member said "That's ok, she will come back to it when she feels like it".

A member of staff explained how one person liked a choice of finger foods for their lunch so that they could just pick out what they felt like eating that day. We saw that condiments were offered to people and they chose whether they wanted them or not. One person chose to have tomato sauce with their meal and chose whether they wanted it "all over" or "just to the side".

Some people were supported to choose what they wanted to eat, or wear, or what activity they wanted to do by means of a communication book with photos. People found the picture of what they wanted and showed it to staff as a means of communicating their choice if they were not able to verbalise. People were

clearly familiar with this process as one person showed us the book and pictures within it.

People were treated with dignity and respect at Whitegates and the Cottage. Staff were able to explain to us how they maintained people's privacy and dignity by closing people's curtains and doors when they were delivering personal care. A staff member described how one person always left the door open when using the toilet, and that staff knew to shut it after her to protect her privacy. They described speaking to people "how we would like to be spoken to" and we observed this in practice during our visit. We observed that staff were patient, polite and respectful when communicating with people. Relatives we spoke with were happy that staff respected people's privacy and dignity. When we asked one relative about this they replied "Definitely they do".

We saw from the observation assessment form for new staff providing support at mealtimes that one of the areas evaluated during the observation was whether the "inductee promotes the dignity of the individual at mealtimes" and ensured that "independence is promoted". We observed this in practice when we saw staff supporting people to eat, for example, by encouraging them to feed themselves where they were able. We saw from minutes that opportunities were taken at staff meetings to remind staff of people's capabilities and ensure that they encouraged people to do what they could for themselves, for example taking dirty plates and cups to the sink, and tying their own shoelaces.

Good

Is the service responsive?

Our findings

People's care needs were documented clearly in their care plans which were personalised to each individual. Documentation for each person consisted of a person centred plan, a support plan and a Health and Medication support plan. Relatives confirmed that they were invited to be involved in care plan reviews every six months. One relative told us that they attended review meetings when they could but if they couldn't make it the registered manager "always keeps us in the picture" and "asks if there is anything we would like to raise".

People's person-centred plans contained an "About me" section which included things that staff needed to be aware of, things the person enjoyed doing, people they liked to spend time with, their mealtime preferences and guidance for staff around communication. They also included "things that are important to me", these included for example, "not to be rushed, give me time to answer, to have access to things I enjoy". Another gave guidance to staff on employing a specific tactic to encourage a person to communicate and think about their answers to questions rather than just giving yes or no answers.

The documents helped new staff in particular to get to know the person and enabled them to provide personalised, safe and effective care for them. One member of staff described how when they first started working at the home they got to know people's likes, wishes and needs by reading their person centred plan and care plans, as well as spending time chatting to the person and learning about them from colleagues.

People's health and medication plans included information for staff around people's specific medical conditions such as epilepsy, and guidance to staff on how to support people with swallowing difficulties at mealtimes. They also included information for staff on what medicines were prescribed for the person and why, how the person preferred to take their medication and what to do if the person refused their medication. They provided guidelines for the administration of PRN medicines, which are medicines which are administered as and when the person needs them. We saw that one person had a PRN medicine for their anxiety, and their health and medication plan gave guidance to staff on how they would know if this was required.

This guidance enabled staff to understand how to care for each person individually and we saw that staff had signed people's care plans to confirm that they had read them.

Some people living at the home had behaviours which were sometimes challenging. We saw for one person that staff had kept a chart to detail their patterns of behaviour and sleep over the period of January through to May 2016. The registered manager explained to us that this information had then been collated for a meeting with clinical psychologists to help inform strategies to help manage the person's behaviours.

The registered manager told us that they had noticed that people's behaviour had sometimes changed when they had had a change in their life. We saw that staff had used behaviour charts to track any changes and had introduced a "learning log" system to monitor people's moods and behaviours whenever they tried anything new, for example a new activity. The log identified the support required and was adjusted for the

next time if anything was identified which might enhance the experience for the person or to correct anything which didn't work well.

People's support needs were regularly reviewed through monthly link worker reviews for each person. This is where each person's nominated key worker met with their senior support worker to review and update people's care and support needs. These meetings included review and discussion of any changes that were required to people's person centred plans, their support plans or their health and medication plans.

Because of staff's different working patterns, we saw that there were shift handovers at least three times a day. Each house also had a communications book, diary and shift handover file. We viewed the communications book in one of the houses for the period covering July to September and saw that this was used effectively. There were appropriate mechanisms in place to enable staff to communicate with each other and exchange up to date information about people's care needs.

Activities were provided for those that were able and wanted to take part. These were stimulating and personalised to people's preferences. For example, one person enjoyed water sports and therefore took part in kayaking and sailing. On the second day of the inspection, the person had travelled to Spain to go on a water sports activities holiday. Another person was a fan of cars and racing and regularly attended banger racing and days out at Goodwood. One person was a fan of West Ham United and had gone to London to see them play during the last football season. A member of staff told us that they were currently exploring whether they could arrange access to West Ham TV so that the person could watch it in his room.

Other activities included use of the hydropool facilities in the community and attendance at local day centres. These were often session based, so that people could choose which sessions they wanted to be involved in. We saw that people regularly went bowling, on trips to the cinema and theatre, swimming and to the gym. When we asked how staff knew what people enjoyed, they explained that this was based on their knowledge of the person, the information provided in care plans, and by asking the person what they wanted to do at house meetings. They also used taster sessions so that people could try new activities and decide whether they liked them enough to continue or not.

One relative described how the home had organised for their loved one to try sailing which the person really enjoyed, and had also found a day centre for them to attend which they thought had been "going really well". They described how there was plenty for them to do inside the house as well, and that their loved one enjoyed music therapy and aromatherapy.

The home had a complaints policy in place. We viewed the complaints file from 2014 to the current date and saw that there were three complaints recorded. These had been investigated thoroughly and responded to appropriately. In one case the provider had identified improvements which could be implemented, such as improved team-working, and the registered manager had acted on these. This showed that the service was responsive to feedback.

Another of the complaints we viewed had been raised by the registered manager herself, on behalf of a person. The registered manager explained that this was as a result of some work which was ongoing at the moment to help people to "have a voice" to complain if they were unable to communicate this for themselves. The work included helping staff to recognise what constitutes a complaint.

Relatives we spoke with confirmed that they would know how to make a complaint if they ever had cause to, by talking to the staff or registered manager. They told us that they would be comfortable with raising any concerns or complaints, but most said that they've never had to, with one saying "because it is a

consistently brilliant place".

Requires Improvement

Is the service well-led?

Our findings

The registered manager had not always complied with the requirements of their registration to notify CQC of specific incidents relating to the service. In two instances, they had not notified us of serious injuries to residents where one had sustained a broken hip and another a broken ankle. The registered manager was able to talk to us about these incidents during inspection, however it is a legal requirement for such incidents to be notified to CQC when they occur to enable us to monitor all incidents which affect the health, safety and welfare of people and take follow up action if required.

We had also not received notifications for the DoLS application outcomes as required by law to support us to monitor whether the service was meeting their requirements relating to DoLS. As we had not been made aware of the outcomes of the applications, we were not able to assure ourselves that where people were being deprived of their liberty that this was being done lawfully. The provider had not notified CQC of the outcome of their applications to deprive people of their liberty.

The failure to notify these incidents amounted to breaches of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

There were systems and processes in place to ensure the quality of care received by people. The registered manager or her deputy observed staff competency annually across a range of areas including medicines administration and moving and positioning people. Health and Safety checks were carried out across all houses and the cottage every quarter. We viewed the checks that were carried out in March and June 2016 and saw that they were effective in identifying various actions for improvements. We saw that actions identified in the March 2016 check had been marked as complete in the June 2016 check, with any outstanding elements carried over to the next audit.

Annual medicines audits were conducted by the community pharmacy, monthly medication audits were completed by senior support staff for each house and quarterly medication audits were carried out by the registered manager or their deputy. There had been some identified areas for improvement from the last pharmacy visit in April 2016. We saw that changes had been implemented as a result of the recommendations. These included ensuring that medication stocks were entered on the MAR sheet with the date and quantity received, the use of body maps to identify where topical creams and patches were to be applied, and recording "opened by" dates on medicines. One of the other recommendations from the audit was that handwritten entries on MAR sheets required two signatures. The registered manager and her deputy had been assigned to monitor this. During inspection we saw that two handwritten entries on MAR sheets in August 2016 had not been double signed. The registered manager told us that she would speak to the member of staff responsible for this to remind them of this requirement.

The provider carried out quality assurance audits twice a year and interim desk top audits which were based around how the service was performing in relation to the CQC's five key questions. These checks included audits of support plans and staff files. We viewed a document relating to an audit completed in October 2015, which had been effective in identifying areas for improvement. During inspection, we saw that the

actions arising from the October 2015 audit had been completed.

The registered manager was supported by a deputy manager who had been in post for around a year. We noted that the deputy manager was still awaiting some training from the provider around managing performance and conducting support and development meetings for staff. The deputy manager was covering these duties and was undertaking a separate management qualification. However, completion of the provider's training would help ensure they were effective and confident in supporting staff in accordance with the provider's procedures, particularly in the registered manager's absence.

Copies of the provider's policies and procedures were in place, these included policies for health and safety, medicines administration, safeguarding vulnerable adults, accidents and incidents, working with people who present challenging behaviour, equality and diversity, confidentiality and whistleblowing. Staff we spoke with were aware of the policies and were delivering care in accordance with them.

Whitegates and the Cottage had a large staff team with staff working all sorts of different shifts using full and part time working arrangements. As a result there were seldom opportunities to get the whole team together at once. Instead team meetings were held separately for members of staff working in each of the houses and cottage. The registered manager had been working on putting in place mechanisms to support staff in working well together and to build on relationships between management and the staff teams. They had introduced team profiles for each of the teams working in each of the houses and the cottage, including one for the management team. These profiled the personalities, characteristics, behaviours and values of each team member to help staff understand, value and respect one another and so aid team working. The registered manager had also organised a team building event earlier in the year which seemed to have been received positively by staff. They spoke of another being planned for before the end of the year. We observed team members getting on and working well together.

The provider's vision was for "a society where people were treated as equals regardless of their disability" and their mission was "to transform lives by supporting people with learning disabilities to lead the lives they choose". The provider had core values including the commitment to "see the person". Staff were observed to uphold the provider's values in their work with people. They spoke with and treated people as equals to themselves and ensured that choice was offered at every opportunity. People were involved in developing the service, for example, when new staff were recruited.

A relative described how the provider was "a great believer that these should be people's homes, not institutions". We saw during the inspection how this was enabled by staff and managers.

Relatives spoke well of the staff teams working at Whitegates and the Cottage and leadership of the service. Some relatives told us that they would usually go straight to the staff teams in the respective houses if they had any questions and concerns and were confident that these would be dealt with effectively. One relative described staff as "having a sense of professionalism" and "conscientious and dedicated". Another described the registered manager as "A wonderful manager, hands on, down to earth and knowledgeable".

Staff we spoke with described the registered manager as "approachable" and "easy to talk to". One staff member told us that she was "a good manager" and described how she would pitch in and help out and that "most staff have a good relationship with her". They described how she was "fair and flexible" and "willing to compromise" for example in respect of organising rotas. Staff told us that they felt supported in their role and it was "a nice working environment". Some told us how the registered manager had been particularly supportive of them, telling us "She is very good to me" while another described how the registered manager had supported them to improve their skills, for example writing up people's notes. Staff

described how the registered manager was open to ideas and suggestions for improvement, for example, a member of staff noted in a support team meeting that they thought that one person would benefit from using hydrotherapy, and this had been put in place.

We viewed the minutes of some staff support team meetings. These were held every month in each of the houses and the cottages and attended alternately by the registered manager or her deputy so that one was always present at each. Meetings discussed updates for each resident on changes in their health or support needs, any recent changes in behaviour, their community engagement and participation and any changes to their risk assessments. The meetings also covered health and safety issues, updates on recruitment, procedures around complaints, and training. From the minutes we could see how areas for improvement were identified, for example reflecting on any feedback and concerns from people's relatives and appraising staff of the need to keep relatives more informed of any changes. The minutes were signed as read by all members of each house team, which ensured that staff who were not present for the meeting were aware of its outcomes.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified CQC of an injury to a service user. This was a breach of Regulation 18(2)(b) The provider had not notified CQC of the outcome of their applications to deprive people of their liberty. This was a breach of Regulation 18(4B)