Heathcotes Care Limited

Heathcotes (Whitley)

Inspection report

Whitley Farm Cottages
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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

This inspection took place on 23 and 24 May 2016.

The service is a residential home for people with autism and learning disabilities. The service can accommodate up to nine people. The building is a converted farmhouse in a rural location on the outskirts of the village of Whitley. Bedrooms are on the ground floor or upstairs, and each bedroom has ensuite facilities. The service has communal areas and a secure garden for people to use. At the front of the service there is a courtyard which people access, it had a locked gate then a driveway with another locked gate.

At the last inspection in August 2015 the service was rated good overall and was found to be meeting the regulations.

The service had a registered manager however, they had applied to deregister. Another manager within the organisation, who had been registered at another service, had applied to register at Heathcotes (Whitley). They had been working at the service for the last four weeks. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have 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 did not always have sufficient staff to meet people's needs. There were times when people who required specific support were not provided with this due to staff shortages. As the service did not employ ancillary staff this meant care staff were not always available to provide one to one care. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people who used the service were not always adequately managed. For example, one person who used the service had managed to run out of the service and onto a busy road. The service had implemented stricter security since the incidents. However, these should have been in place to prevent the incidents occurring. Environmental risks were identified during the inspection, for example, a broken trampoline and a chair at the top of a set of stairs which was a trip hazard. Not all areas of the service were clean. Some door handles were sticky and paintwork was dusty and stained. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care did not always meet their needs. For example, one person's care plan referred to a specialist communication method which should be used to enable them to express their needs and preferences. We did not see staff using this to communicate with the person. In addition another person was not supported to have a nutritious diet. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Record keeping was not adequate. There were gaps in key documents which meant we could not be certain people received the care they required. Gaps in the handover book meant, on some days, there was no

record of staff on duty or who they were providing support to. This was a breach of Regulation 17 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 the report.

Staff demonstrated a good understanding of how to safeguard people who used the service. They told us they would raise concerns with the manager and they were confident these would be investigated appropriately.

We saw evidence of detailed risk assessments and risk management plans. Where restraint or medicines were used to alleviate people's distress, staff told us this was always a last resort and risk management plans contained detailed guidance to ensure staff used the least restrictive intervention to keep the person safe. Medicines were safely managed.

The service had safe systems in place to recruit staff and the required checks were carried out to ensure staff were suitable to support people who used the service.

Staff had access to regular support, training and supervision to enable them to effectively meet people's needs.

The service adhered to the principles of the Mental Capacity Act (2005). Staff sought consent where possible and we saw records within people's care plans of mental capacity assessments and best interest decisions were recorded when required.

Annual health checks took place and the service referred people to health care professionals when additional support was needed.

People had positive relationships with support staff. People told us about the progress their relatives had made since living at the service and how happy they were. Where appropriate, detailed care plans had been developed to ensure the service was aware about how people wanted their needs to be met at the end of their life. People were supported to maintain relationships with their families and relatives told us they could visit anytime. People had access to support from advocates to ensure their voices were heard.

Although we saw some good evidence of activity for people there were times when the service had a chaotic feel. This centred on people and support staff congregating in the main lounge waiting for planned activities to begin.

We saw some good evidence of care planning being based on what was important to the person who used the service. Care plans contained information about people's like and dislikes. People had the opportunity to review their care and support with their key worker on a regular basis. The service had regular meetings where people could give their views and make suggestions about the service. Alongside this there was a clear complaints policy in place.

There had been a number of changes to managers at the service since we last inspected, this along with the turnover of support staff had resulted in a some challenges within the service. The registered provider had ensured additional support was available in order to address these. Although staff we spoke with told us morale was good we were concerned about staff approaching CQC directly to blow the whistle on what they alleged to be poor practice. The registered provider investigated these concerns and found them to be

unfounded. We were concerned this demonstrated a culture of mistrust of managers within the service. Despite this we received consistently positive feedback from everyone we spoke with about the new manager and staff told us they were confident improvements would be made under their leadership.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The service did not always have sufficient staff available to meet people's needs. The lack of ancillary staff meant support staff, who should have been providing one to one support, were undertaking other tasks within the home.

Risk assessments, although detailed, were not always followed by staff. Restraint was used as a last resort and the service had systems in place to analyse incidents, however more detail was required to ensure any areas of concern could be identified.

Staff understood how to protect people from avoidable harm. They were confident about the safeguarding reporting procedures.

No all areas of the service were clean and there were some environmental risks which posed a risk of harm to people who used the service.

Medicines were managed safely. Staff recruitment was robust and people could be assured staff were safely recruited.

Is the service effective?

Good

The service was effective.

Staff told us they felt well supported by the new manager. We saw staff had access to an effective induction, ongoing training and development and regular supervision.

Meals were often convenience foods. However, the service had arranged a nutritionist to provide support to develop a healthy menu plan and to offer education about healthy food choices to the staff team.

People had access to a range of healthcare professionals. Where specialist support was required, the service liaised with the relevant health care teams.

Is the service caring?

Good

The service was caring.

Support staff spoke with warmth about the people they supported. People's dignity and privacy were respected and the service encouraged staff to think about these issues.

People were supported to maintain relationships with important people in their lives. Relatives were able to visit the service when they wanted to.

Relatives told us they thought staff understood the needs of people they supported and spoke about the progress people had made whilst living at the service.

Where appropriate, end of life care planning had taken place which meant the service had supported people to express their wishes about their care and treatment.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care was not consistently responsive to their needs. For example, where concerns had been identified and care plans developed to meet this need we did not always see care was delivered in line with this. Despite this, we also saw detailed care plans which staff adhered to and met people's needs.

Activities were variable, although we saw some good evidence of activity, there were times when the service had a chaotic feel and people were waiting to start their planned activity.

People knew how to make complaints and the service had a regular meeting with people. People also had regular meetings with their keyworkers so that they had an opportunity to give feedback about the service.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There had been a number of changes to the management at the service and a significant turnover of staff which had created a period of instability. However, a new manager had been brought in and the staff team were confident they would improve the service.

We were concerned about the culture within the service, CQC had received a number of whistleblowing concerns and it appeared there was an element within the staff team of mistrust in the management.

However, the provider had recognised the challenges within the service and had provided additional resources at a senior level to address some of the issues and to work with the staff team to make improvements. This demonstrated a commitment to service improvement.

Heathcotes (Whitley)

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. The 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.

The first day of the inspection took place on 23 May 2016 and was unannounced. The inspection team consisted of two inspectors and two specialist advisors; one of whom was a learning disability nurse and the other was an occupational therapist with a background in learning disability and autism care. We made the service aware we would return for a second day on 24 May 2016. On the second day one inspector returned to the service.

Before the inspection we reviewed all of the information we held about the service; this included reviewing notifications we had received. A notification is information about important events which the service is required to send to the Care Quality Commission by law.

We contacted the local authority's commissioning and contracts officer for the service, they had not undertaken a formal assessment visit recently and therefore could not provide any specific feedback. We took into account the views of the local authority social work team.

During the inspection we spoke with 12 members of staff; this included the current manager, previous registered manager, who is also the regional manager, a compliance manager, a manager from another service who had been offering support to the service, the deputy manager and care staff.

We were unable to speak with people who used the service. Because people were not able to tell us their views we spent time observing interaction between people and care staff. During the inspection we spoke with a visiting advocate. An advocate is an independent person who supports people to ensure their views are heard.

Following the inspection we spoke, on the telephone, with two relatives. We tried to contact a further two

relatives but we did not receive a response. We also spoke with another advocate who visited someone who lived at the service on a regular basis.

We carried out a tour of the premises, which included communal areas and people's bedrooms. We reviewed four people's care plans and associated records. We looked at medicine administration records.

We looked at management records associated with running the service such as quality assurance audits and staff meeting minutes.

Following the inspection we spoke with three health and social care professionals. These included a learning disability nurse, nutritionist and a social worker. We tried to contact a further two social workers and psychiatrist, but we did not receive a response.

Requires Improvement

Is the service safe?

Our findings

Both of the relatives and advocates we spoke with told us they thought the service was safe. One relative said, "I think [name] is safe there. The staff know [name] well, and [name] is never upset about going back there." Another said, "Yes [name] is safe there. If [name] wasn't happy about something we would know about it and [name] would let the staff know."

However, before the inspection we had received a number of whistleblowing concerns related to inadequate staffing levels within the service. A Whistleblower is someone who raises concerns about poor practice within an organisation. The organisation investigated the concerns and although some of the issues were unfounded some areas of concern had been identified and the provider had produced an action plan to support improvement.

Since our last inspection 21 staff had left the service and 18 staff had been recruited. Additional staff had also been providing cover from other Heathcotes services. The regional manager explained that staff who worked at other services were given time to read people's care plans and supported people with less complex needs.

All of the people who lived at the service required one to one support for various hours within a 24 hour period and two people required two to one support. The regional manager told us the core staffing hours at the service were five waking night staff overnight and eleven support staff throughout the day. However, this needed to increase to twelve at certain times to enable one person to have two to one support when going out of the service.

The regional manager explained that the rota covered staffing levels at this service and another Heathcotes service, Whitley Park, which is on the opposite side of the road. However, they went on to say that at the end of June 2016, the rota would be separated and each service would have their own distinct staff team. 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 as staff required a notice period with regard to the change of working pattern.

Staff told us there had been shortages of staff within the service, but that this was improving. A member of staff told us, "There are times when we work short staffed. Staff ring in sick on the morning of their shift, this used to happen a lot but less now. That has improved. Before we used to have staff over from Whitley Park [service across the road]. We used to run backwards and forwards. We don't lose staff to Whitley Park now. In the last two to three weeks we have had staff at each house for the shift."

We reviewed the rota for May 2016 and saw some significant variances in staffing levels. For example, on some days the services had an additional three members of staff on duty throughout the day. However, there were four days when the service had less than the required core support staff. On these occasions the manager and deputy manager had to cover shifts to ensure the essential staffing levels were maintained. This meant that although people were provided the required one to one hours the manager was not

available to undertake management tasks within the service.

A member of staff said, "[Name] is left without proper cover quite often." Another member of staff told us that one person who required the support of two staff to keep them safe had, the day before we inspected, been supported by only one support worker for a four hour period. This meant the person and the member of staff were at risk of harm. We spoke with the manager about this, who initially told us they were not aware of this, however after investigating confirmed what we had been told was correct. This was because a member of staff undertaking an overtime shift had gone home early.
Another member of staff told us, "We are usually short staffed most days, two to ones don't get done. Most days we are running low." We asked they what impact this had on people using the service they said "They could get more anxious as they know staff are stressed and rushed off their feet. It impacts on timings of food, have had tea's late...staffing has a snowball effect on being able to clean, cook and support people."

Following the inspection we received a further concern about overnight staffing levels within the service. We discussed this with the regional manager who confirmed a member of staff had been taken home early by another member of staff during a night shift. This had left the service without the required number of staff. The regional manager had investigated this concern and had completed a formal supervision with the senior staff on duty to remind them this was not acceptable.

The service did not employ any ancillary staff. This meant that cleaning, cooking and laundry was completed by support staff. For some people this was part of their daily living skills and an advocate we spoke with was positive about the impact this had for the person they supported. However, the lack of ancillary staff this meant there were times when staff who were providing one to one support were in the kitchen. We were told other staff, "Kept their eye on people." A member of staff said, "We work as a team and watch out for each other, it works well."

During the first day of our inspection, we observed times throughout the morning where three people who used the service were in the lounge with one support worker. The regional manager explained there were only two people who used the service who needed 'constant supervision' by their support staff, despite this all of the people living at the service being funded for a minimum of one to one support for a number of hours each day.

The service did not have sufficient staff available to meet people's needs effectively. Staff providing one to one support to people also undertook other tasks and there were times when the service did not have the staff required to keep people safe. This was a breach of regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to the inspection CQC had been notified of two safeguarding incidents involving a person who used the service running out into the road. The person, who required one to one support, was not able to keep themselves safe or understand the risks associated with this. At the time of our inspection this matter was being investigated by the local authority safeguarding team.

Following the incidents the service had taken steps to increase the security within the service. We saw that new bike locks had been fitted to both gates and staff ensured these were secured at all times throughout our inspection. The regional manager explained the locks were a temporary measure and new secure gates would be fitted in the future. In addition to this the person had been referred, by the service, to the community learning disability team and had seen the organisation's in house psychologist to look at strategies to mitigate the risk, which was linked to deterioration in their behaviour and autism. The person had a detailed risk assessment in place which provided staff with guidance about how to reduce the risk

associated with the person's current behaviour.

Despite these measures to mitigate risk, we were concerned about the risk to the person due to inadequate supervision. On the morning of the first day of our inspection we observed two occasions when this person was unsupervised. We heard the member of staff, who was meant to be providing one to one support say, "Where has [name] gone?" This meant the person's safety was compromised, because they were not being adequately supervised. We spoke with the regional manager who told us this was a one off and the member of staff was distracted due to a 'personal problem'. The regional manager arranged for another member of staff to take over the support and on the second day of the inspection, the staff member providing this person support ensured they had the supervision they required to keep them safe.

We saw some environmental risks within the service which posed a risk of harm to people and staff. In the garden there was a trampoline, which had been installed to be level with the ground. This had broken and there was a gap between the grass and the trampoline which meant people could fall and injure themselves. Although we were told the trampoline was not being used and was due to be repaired, we were concerned about one person who spent a lot of their day running around the service and into the garden. We were concerned the person could slip and get their foot or leg trapped in the gap. We spoke with the manager who confirmed they were aware of this and had requested a repair. Following the inspection we received confirmation this had been fixed.

A chair had been left in the upstairs landing area near the top of the stairs, again we were concerned this posed a trip hazard for people and in particular the person who spent time running around the service.

We conducted a tour of the service and noted several communal areas which were not clean. In the lounge area the carpets were stained and the dining room flooring was scuffed. The regional manager told us these were due to be replaced in the next two weeks and we saw this was on their audit. We also saw skirting boards were dusty, doors and door handles were sticky and stained. The manager told us that staff should clean overnight. They accepted this was not a clean environment for people.

These examples showed that the service was not always proactive in managing risks and meant people were at risk of harm. This was a breach of regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service used a system called Non-abusive Psychological and Physical Intervention (NAPPI) to assess, prevent and manage behaviour which posed a risk of harm to people or those around them. NAPPI is accredited with the British Institute of Learning Disabilities for training in physical interventions. All of the staff we spoke with told us that the use of physical restraint was a last resort. Risk assessments provided information for staff about behaviour to observe and how they should respond, by for example redirecting the person, distraction, use of as prescribed medicines and then restraint as a last resort. NAPPI risk assessments provided information about how holds should be completed and what risks incorrect holding could cause. Risk assessments highlighted the risk of breathing complications in seated and supine positions (on their back lay down with staff holding), however, due to these high risk holds being used regularly in Whitley, good practice would be to highlight the dangers in the care plan also.

Restraint forms, which had been provided by NAPPI, completed by staff were not detailed enough to be able to track incidents, for example although staff names were included the forms did not say what part of the body the staff member was holding. This could lead to issues if any injuries occurred and also managers were not be able to establish which staff needed further training if injuries occurred. The registered provider may wish to explore this issue with NAPPI and look at the robustness of the documentation.

Accidents and incidents were recorded and monitored. For example, the manager analysed restraint forms after each incident. This was then sent to head office and if concerns were raised in relation to an individual, the behaviour therapist and NAPPI advisor could review this and offer additional advice and support to staff. This was also done in relation to medicines which were given as required to support people to alleviate distress or agitation. This meant the service was monitoring people's behaviour and if concerns were noted additional specialist advice and guidance was provided.

Staff demonstrated a good understanding of how to safeguard people who used the service, they were aware of the types of abuse and how to report concerns. Staff told us they would always share any concerns with the manager. They told us they were confident that the manager would take their concerns seriously and take the action required to keep people safe. The service had made appropriate safeguarding referrals to the local authority and had notified the CQC.

We observed two people being supported to take their medicine. Staff washed their hands and approached the person in a friendly manner, whilst explaining they had their medicines for them. The service had an up to date medicines policy which staff followed. All of the medicine records had the person's photo at the front. The medication administration records (MARs) had a box for allergies, however this was sometimes filled out as 'none known' when the person's profile clearly had allergies highlighted in red. We spoke with the regional manager who agreed to ensure this was corrected.

MARs were completed correctly and we did not find any missing signatures against medicines; however there were several missing signatures for prescribed creams and ointments. The regional manager agreed to look into this.

Some people who used the service had medicine as required to alleviate their distress or agitation. The service had protocols in place and it was clearly documented why 'as required' medicines had been given. The service had controlled drugs in stock. Controlled drugs are medicines which are liable to misuse and have specific legislative requirements attached to them. Controlled drugs were stored safely and in line with the legislative requirements.

A stock check, of boxed medicines, was completed after each person received their medicine and a nightly audit of stock was also completed. The manager explained to us if an error had occurred, the staff member would normally be suspended from administering medication and given further training. They would then have a competency check to ensure they were safe to administer medicines. This meant the service had safe systems in place to identify any potential medicines errors in a timely manner to ensure the required action could be taken

The service had effective recruitment and selection processes in place. We looked at four staff files and saw completed application forms and interview records. Appropriate checks had been undertaken before staff began work; each had two references recorded and checks through the Disclosure and Barring Service (DBS). The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people. We saw records of probationary reviews. These were completed at the one, three and six month stage. The records contained detailed information about staff's practice and included positive feedback as well as identifying ongoing development needs. Staff were subject to a six month probationary period. This meant the service could ensure staff were suitable for the role before offering them a permanent contract.

The service undertook essential safety checks such as water, electric and fire to ensure people were supported in a safe environment. Personal emergency evacuation plans were in place and assessable for

the emergency services should this be required.

Good

Is the service effective?

Our findings

One person we spoke with told us they were confident that staff knew how to support their relative, "This is the best home [Name] has lived in, staff have supported [Name] well." Another relative said, "Staff are supporting [Name] as best they can, it's hard sometimes but when they need more specialist support they ask for it." They went onto say the service was working with healthcare professionals to support them.

Staff were provided with a comprehensive induction programme which involved five days of classroom based learning. Following this, they spent time in the service shadowing experienced members of staff. New staff completed the Care Certificate. The Care Certificate is a recognised qualification which aims to provide new workers with the introductory skills, knowledge and behaviours they need to provide compassionate, safe and high quality care. This meant
people could be assured the staff who supported them were appropriately trained and understood the importance of compassionate and effective care.

Staff told us they were encouraged to undertake a variety of training events to ensure they had the skills required to provide effective support. One member of staff said, "We can go on any training which is offered by the company. There is a lot on offer. The last training I did was about epilepsy."

Staff had access to regular supervision. Supervision is an opportunity for staff to discuss any training and development needs, any concerns they have about the people they support, and for their manager to give feedback on their practice. Supervision records were detailed and included information about individual staff member's ongoing development. A member of staff said, "I talk to the manager and ask to see them if there are issues in between supervisions. There has never been a problem."

Annual appraisals took place. The appraisal forms we saw were detailed and contained information about the staff member's performance and areas for ongoing development. The manager and regional manager had identified some staff where improvements were required and this was being managed via personal improvement plans. Again the issues were captured and goals were set to monitor progress.

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 are called the Deprivation of Liberty Safeguards (DoLS). All of the people who used the service were subject to a DoLS and these had been authorised by the local authority.

Throughout the inspection we saw staff offer people choices. Care plans contained relevant mental capacity

assessments which were decision specific. When it had been assessed that people were unable to make an informed decision, the service had liaised with relevant people and had made a best interest decision, which took into account the person's preferences. The service adhered to the principles of the MCA and we saw different areas of care were assessed. For example, one person lacked capacity to consent to their medicines, but had the capacity to understand the risks related to smoking. They had a detailed plan in place and the person had signed to agree to this. This showed the service respected people's ability to make unwise decisions.

The service had challenged a social care professional about the lack of a best interest decision in relation to a change of placement. This showed they understood the principles of the act and how this legislation was designed to protect people's rights.

Support staff made meals for people, as the service did not employ a chef. We reviewed the menu plans and records of people's dietary intake and found the majority of meals on offer to people were convenience or processed foods. For example, one person's food intake recorded vegetables on two occasions over a month. The majority of meals were pasta bake, fish fingers, chicken curry and there was repeated deserts such as angel delight. Staff told us they tried to encourage people to eat healthier options, but they said they found this difficult. One member of staff said, "No one is hungry, if anything they get too much. Do they need a pudding every night? But if you change routines people can react badly." Some people were fixed on certain foods, due to their autism, and we saw specific care plans in place regarding this.

People were weighed monthly and we saw two people who used the service had gained a significant amount of weight. The service had recently employed a nutritionist to look at healthy meal planning across the service.

We spoke with the nutritionist who explained they had visited the service and met with the manager and regional manager to review the current menu plans. They had not reviewed people's individual weight management, but said this was something they intended to do along with developing new menu plans. They also explained they would be offering some education and training to staff to ensure people were given 'structured choices' for example the choice of two types of fruit as a snack as opposed to fruit or cake. This was particularly important for people who lacked the capacity to make an informed choice about their diet.

The main dining area was in a busy part of the service. However, we saw one person ate their meal in the recently adapted lounge space which was quieter. The manager explained that one person liked to make a lot of noise whilst eating so they were supported to have their meals at a different time to ensure their needs and those around them were met. We saw some people enjoyed having their lunch outside and sat and ate with support staff. This was a relaxed experience for people.

Bedrooms at the service had been personalised based on people's individual needs. Staff told us if people wished to change from the standard furniture they could do. This meant people were able to have their personal environmental preferences respected. The general décor within the service was a neutral colour and lighting was appropriate. This demonstrated the service had taken account of the needs of people living with autism when planning the décor.

People had 'Health Action Plans' in place which included specific details of their mental and physical health needs and what support they needed to maintain their well-being. In addition to this, we saw the service sought support from relevant health professionals when it was required, for example the community learning disability nurse, psychiatrist and occupational therapy. Health professional we spoke with said,

"Staff are always pleasant and are open to working with me."

Good

Is the service caring?

Our findings

During our inspection we saw positive interaction between support staff and people. One member of staff sat and read through a catalogue with the person they were supporting. It was clear the person enjoyed this. We saw, in the person's care plan, this was an activity which they liked. Another staff member was mirroring the non-verbal communication of the person they were supporting and the person responded well to this. However, this communication was not consistently replicated by other staff members.

Staff spoke warmly and positively about the people they supported. One member of staff said, "I love working here and supporting people. I couldn't see myself doing anything else. We have a good bunch of people and we support people to do as much as they can for themselves." Another member of staff spoke with a sense of pride about the support they had given to one person in particular and the progress the person had made whilst living at the service.

The service had a presentation on the wall titled 'Dignity and Respect'. There were drawings and statements written about what these words meant and how they affected people who lived at the service. This demonstrated the staff team were actively encouraged to think about these topics.

An advocate, who had provided support to someone at the service for the last two years told us, "[Name] has made significant progress since they have moved in. When [Name] first arrived staff regularly used physical restraint due to [Name's] behaviour, this has reduced and [Name] is less anxious and really settled." They told us support staff and the management team understood the person's needs and knew them well and they went on to say whenever they visited, staff provided a detailed picture of how the person had been.

People were supported to maintain relationships with their families. One person was supported to speak with their family member every day. Relatives told us they were able to visit when they wanted and some people went to stay with relatives overnight or for the weekend.

One person explained their relative had to go into hospital for planned surgery and they were very concerned about how they would tolerate this. They said, "The support staff were great, two staff went with [Name] to the hospital and stayed there. The staff did a really good job at keeping him safe in the hospital and they really were concerned and wanted to be there with [Name]."

A relative told us, "[Name] has improved greatly since moving in. We've been very impressed with the care and support provided and we have seen [Name] spend time in lots of other services. This is the happiest they have been. [Name's] confidence is growing when out in the local community and we're happy with the care."

We spoke with an advocate who told us, "[Name] has a good relationship with staff and has a happy and positive relationship with their keyworker, who is very well informed about [Name's] needs. I have no concerns about the care and support which is provided to [Name]."

Where appropriate the service had completed care plans with people which highlighted the preferences they had for their care at the end of their life. This meant the service had started to work with people, where appropriate, to ensure they understood their preferences.

Requires Improvement

Is the service responsive?

Our findings

People did not consistently receive support that was responsive to their needs. Concerns about one person's weight gain had been highlighted by their doctor at an annual health check in January 2016. Their care plan had been updated and stated, 'Reduce unhealthy snacks and focus on healthy food. Set goals for [name]: Lose four pounds over four weeks.' It also contained a suggestion of thirty minutes exercise each day. The person lacked capacity in relation to their care needs and as a result they needed support staff to assist them to make healthy choices, for example choices between fruit for snacks and limited intake of sweets and processed foods.

We reviewed the person's food record for the last month and noted it contained repeated references to processed foods, sweets and deserts. The chart did not contain information about the quantity of food eaten so it was difficult to track how much the person was eating. In addition to this, we saw that although they were taking part in some activities which involved a degree of exercise, they also ate out at a local pub or MacDonald's on average three times a week.

Despite the concern regarding weight gain being identified in January 2016, they had gained a further ten pounds since then. The weight records showed a gradual weight gain each month and although a nutritionist had been employed to look at the dietary needs for people in the service as a whole, this person had not been referred to a dietician. This meant the service was not responding to the person's needs in relation to their weight management because they were not ensuring their diet was nutritious and they had not taken action to seek specific support about the continued weight gain.

We observed the staff team used verbal communication in engagement with people and we saw this this caused frustration for some people. For example, one person asked for the television to be changed and the staff member asked the person three times what they said.
One person's care plan stated they required 'simple and basic' language for communication or picture exchange communication system (PECS), which is an alternative communication system to verbal communication. We did not see staff use PECS during our inspection. A recent internal audit completed on 16 May 2016 highlighted this issue and the quality assurance auditor had recorded, 'Unable to find PECS at the service. Staff on shift couldn't find [Name's] PECS'. This meant the staff were not following the agreed support plans in place and did not promote preferred communication styles.

Support plans did not indicate any alterations or considerations to sensory processing requirements of people with Autism.

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

Despite this, we also saw good evidence of more positive care planning and delivery of support. For example, one person had a detailed care plan in relation to their daily routine and the importance of adhering to this to reduce the person's anxiety. Staff adhered to this care plan and could explain to us the importance of this to support the person to remain well.

The regional manager explained they had access to psychology input and a NAPPI specialist and sought specific advice for people if this was needed. This advice was used to support staff to develop effective support plans. Care plans contained information about people's likes and dislikes and gave a sense of the person and the support they required to meet their needs.

Care plans were reviewed and updated on a regular basis. Relatives we spoke with told us they were involved in the initial development and review of support plans. People were supported to have regular meetings with their key worker to ensure they were given the opportunity to provide feedback on the support they received.

Both of the relatives we spoke with and the two advocates were positive about the range of activities on offer for people who used the service. One person said, "[Name] has an impressive weekly routine with trips out along with life skills work. Their keyworker has common interests and they take part in age appropriate activities." A relative told us, "[Name] goes out regularly and is looking into going on holiday abroad with support staff. They have a structured activity plan in place which is important to them."

During our inspection we saw three people were involved with domestic activities which included hoovering, laundry and mopping. This meant the service were supporting people in daily living skills.

Although there was some good evidence of activity this was not always consistent. There were times during our inspection when the service had a chaotic feel. The main lounge area was a central gathering point for people and staff, especially when waiting to go out on planned activities. On the first day of our inspection, during the morning, the lounge became overcrowded with people who used the service and their support staff. On the second day of our inspection we saw people were sat in the lounge ready to set off on a day trip to the coast, people were excited and the room was full of a noisy buzz. We observed this for 30 minutes. The delay was due to another member of staff being out with a person in one of the cars. Staff rang the member of staff who was out with another service user to find out when they would be back. However, people were waiting for some time. During this period there was minimal stimulation for people, one person was watching television but the environment was noisy. This meant people who required a quiet or calm environment as a result of their autism were not provided with this and this could result in distress. This could impact on people's safety because people may become distressed and display this by demonstrating behaviour which posed a risk to themselves or others.

Whitley shared their two vehicles, two seven seater cars, with the Whitley Park. Staff described the cars as being shared to ensure each person who wished to access them could do so.
A health care professional we spoke with raised concerns about the service only having two vehicles, which were shared with the service across the road where another three people lived. They expressed concern that this limited the activity people could take part in outside of the service.
Some people were supported to use public transport to access the community.

We recommend the provider review the range of activity on offer for people and consider how best activity can be planned to avoid long waiting periods in the main lounge.

We saw a recent copy of 'service user meeting minutes' which looked at areas such as nutrition, general activity and the environment. This meant people had a forum to provide their feedback on the service.

The service had an up to date complaints policy. However, the regional manager told us they had not received any formal complaints since we last inspected. People told us they knew how to raise concerns. One relative said, "[Name] has spoken to staff if they're not happy and staff have responded well." An

advocate we spoke with told us they had raised issues to staff and these had been dealt with appropriately, they were confident the service responded to feedback.

Requires Improvement

Is the service well-led?

Our findings

The service had experienced a number of management changes and significant staff turnover since our last inspection. During this time there have been two managers who had left the service. At the time of our inspection, the manager had been working at the service for four weeks. They were currently the registered manager at another service run by the registered provider and had been brought into offer some stability and leadership at Whitley. They had applied to deregister for the previous service and to be the registered manager at this service.

The CQC had received a number of whistleblowing concerns since our last inspection. These alleged concerns had been shared with the registered provider and they had been investigated, the majority of the concerns raised had been unsubstantiated by the registered provider. However, in March 2016 an independent manager had been brought into the service to investigate some specific concerns a member of staff raised when they left their employment. The member of staff had contacted the CQC and written to the managing director of the organisation. The regional manager had developed an action plan to address the issues identified within the investigation and shared this with the CQC and the local authority. This demonstrated a commitment to working in a transparent way and to addressing concerns which were raised.

During the inspection, staff we spoke with said morale was good. However, they told us there were two core staff teams and there was a competitive culture between them. One staff member said that there were 'different team dynamics.' This had been recognised by the managers within the service and they were working to address this.

Despite the fact we were told staff morale was good, we were concerned about the culture within the service. Following the inspection we received a further three whistleblowing concerns related to staffing levels within the service. We spoke with the regional manager about one of the whistleblowing concerns and shared the theme of the three reports. We were told that staff had been 'told what to say to CQC about the staffing levels within the service'. Our concern was that staff felt the need to contact the CQC instead of using the service's own whistleblowing policy. This demonstrated a culture or element of mistrust of the management team within the organisation. The regional manager explained they had previously held staff meetings to discuss the whistleblowing policy and to assure staff they wanted issues to be brought forward so they could be resolved in a timely manner. The regional manager told us they would reiterate this to the staff team.

Staff meetings took place on a regular basis. We saw copies of meeting minutes which included general service issues such as training, record keeping and information about the needs of people who used the service. The minutes were signed and dated by staff who attended and staff who did not attend signed to say they had read them. This meant the staff team were provided with the opportunity to give their views on the running of the service.

The provider had arranged for additional support to be provided at the service, which showed they realised

there were challenges and had ensured they were supporting the team to make the required improvements. We spoke with the quality assurance auditor who had been spending two days a week at the service to provide support to the new manager and the staff team. In addition to this a registered manager from another service had also been spending time there each week to support the new manager.

The quality assurance auditor told us they were observing staff practice and giving feedback to the staff team and individuals where required. They said they thought some of the staff team had become complacent due to what they considered were previous issues concerning staffing levels within the service and that for some staff, "There was a lack of initiative." We saw evidence that issues with individual staff members were being addressed on an individual basis via performance development plans.

The manager was new to the service and was getting used to the team and getting to know the people who lived there. They explained the strength of the service was that the staff team worked together. They were keen to tackle individual staff issues to ensure people were providing the support expected of them and to improve staff morale.

All of the staff we spoke with described feeling supported by the new manager and were confident they would make improvements. One member of staff said, "We work well as a team and new manager has made a difference. We've got hope now. [Name of manager] leads and directs the shift. Weekend support is available on the telephone so you don't feel you are alone on shift. It feels safer." Another said, "The new manager is brilliant. Well organised and supportive. Things are on the up. They are approachable. I have the feeling they are going to be good." A member of staff said, "We are working towards the way forward, people here deserve it."

Daily notes contained key information about people's wellbeing. However, it was difficult to follow the records made following intervention from health care professionals. Although staff could provide detailed updates about the involvement and recommendations from professionals these were not always documented within the person's care plan. This meant it was difficult to establish whether the service was adhering to advice provided by health care professionals when meeting people's needs.

Other records we reviewed contained significant gaps which meant it was difficult to establish whether people had received the support they required. For example, activity records were not always completed. We reviewed one person's activity log for the last month and saw it contained 12 days where nothing was recorded and seven occasions when the only record was 'out'. Food charts were not completed robustly and we saw gaps throughout the charts we reviewed. This meant we could not be sure people had been provided with the support they required.

In addition to this, the daily handover book, which recorded staff that were on shift, who they were supporting and a summary of how each person had been during each shift, were not always completed. We looked back at the handover records for May 2016 and saw four days when the handover book had not been completed. This meant if there had been an incident on one of these days it would have been difficult to track which staff were on duty and who they were providing one to one support to.

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

The quality assurance auditor explained they were looking to streamline records to ensure key information was recorded and to avoid any repetition or duplication of records. Following the inspection we were told new forms had been implemented within the service and that the staff team had been positive about this. In addition to this they had completed a comprehensive audit of the service and had highlighted some of the

issues we had found during our inspection, for example issues with record keeping and communication. They explained they were due to meet with the regional manager and new manager of the service to develop a detailed action plan. This demonstrated the provider had recognised the challenges within the service and had provided additional resources to support the required improvements to take place.

The regional manager completed monthly quality assurance audits which highlighted areas for improvement along with positive practice. In addition to this audits of medicines and care plans took place on a regular basis. This meant the provider was assessing the quality of the service delivered.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care was not always delivered in line with people's care plans. For example, specialist communication methods were not adhered to and one person had a detailed support plan about healthy eating as a result of significant weight gain. The support plan was not followed and the person continued to gain weight. Support plans did not indicate any alterations or considerations to sensory processing requirements of people with Autism.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were identified however one person had managed to leave the service on two occasions, which left them at risk of harm. Action had been taken to mitigate the risk, however, the incident should not have occurred in the first place. Environmental risks were not identified and the service was not clean.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Record keeping was poor, there were gaps in people's individual records which meant we could not be sure people had been provided with the support required to meet their needs. Handover records were not always completed which meant we could not establish which

member of staff had provided one to one support to which person. This meant if there was an incident, it would be difficult to track who was involved. In addition to this restraint forms were not detailed enough.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient staff available to meet people's needs. At times one to one support was not provided in line with care plans and risk assessments. The service did not have any ancillary staff which meant support staff were completing household tasks as well as providing one to one support.