Care Quality Commission

Care UK Learning Disabilities Services Limited

Whitwood Grange

Inspection report

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Date of inspection visit: 8 & 13 April 2015
Date of publication: 26/06/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place over two days on 8 and 13 April 2015. The first day of the inspection was unannounced and the second day was announced. At the last inspection in January 2014 we found the provider was meeting the regulations we looked at.

Whitwood Grange is registered to provide accommodation and personal care for up to 17 people with a learning disability. They provide a service to people with complex needs and behaviours that challenge. The service is divided into three units. The service had a registered manager. 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.

Although people told us they felt safe we found this service was not providing consistently safe care. The provider did not have effective systems in place to manage risk so people were safe and also had the most freedom possible. Medicines were not always managed

Summary of findings

consistently and safely. Staffing levels were adequate but a high turnover of staff impacted on care delivery. The provider had effective recruitment and selection procedures in place. Staff had a good understanding of safeguarding people from abuse.

Staff were not always provided with training and support to ensure they were able to meet people's needs effectively. People enjoyed the food and had plenty to eat and drink but involvement in the meal planning process was limited. A range of healthcare professionals were involved in people's care although some health professionals raised concerns with us about the service provided at Whitwood Grange.

People we spoke with told us staff were caring and could make decisions about their care. However, we saw examples where people had not been consulted and the service could not demonstrate they had been made in the person's best interest. Staff understood how to provide care that respected people's privacy and dignity.

Aspects of people's care was not assessed, planned and delivered appropriately. There was not always enough information to guide staff on people's care and support. They engaged in social activities which were person centred.

The provider's systems to monitor and assess the quality of service provision were not effective. Actions that had been identified to improve the service were not implemented. Most of the management team were new and were focussing on allocating key responsibilities. The registered manager was confident once they were established improvements would be made to the service provision.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the end of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

There was a lack of consistency in how risk was managed. Some systems helped keep people safe but other systems were not effective which meant people were not protected.

Overall, there were enough staff to keep people safe but a high turnover of staff meant continuity of care was not always achieved.

Medicines were not managed safely.

Inadequate

Is the service effective?
The service was not always effective.

Staff were not always provided with training and support to ensure they were able to meet people's needs effectively.

People enjoyed the food and had plenty to eat and drink but involvement in the meal planning process was limited.

People attended regular healthcare appointments but did not have up to date health action plans which meant their health needs could be overlooked.

Requires improvement

Is the service caring?
The service was not always caring.

People who used the service told us the staff who supported them were caring. Staff were able to explain and give examples of how they maintained people's dignity, privacy and independence.

People were not always involved in making decisions about their care and some decisions had been made without appropriate consultation.

Requires improvement

Is the service responsive?
The service was not always responsive to people's needs.

People did not always receive care that was planned to meet their individual needs and preferences. Care records did not sufficiently guide staff on people's care.

People were encouraged to engage in various activities which were planned around their individual wishes. People spent time in the local and wider community.

Requires improvement

Is the service well-led?
The service was not always well led.

People who used the service said they saw the manager on a regular basis.

Requires improvement

Summary of findings

Health professionals told us the service was not always well managed.

Regular staff meetings were held and it was evident from the meeting minutes that topics relating to the quality of care and safety were discussed.

The systems in place to monitor the quality of service provision were not effective. Action was not always taken even though shortfalls were sometimes identified.

Whitwood Grange

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place over two days on 8 and 13 April 2015. The first day of the inspection was unannounced and the second day was announced. An adult social care inspector and an expert-by-experience visited on the first day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had experience in learning disability services. On the second day two adult social care inspectors visited.

Before this inspection we reviewed all the information we held about the service. This included any statutory notifications that had been sent to us. We contacted health and social care professionals and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

At the time of this inspection there were sixteen people living at Whitwood Grange. We spoke with six people who used the service, a relative, eight staff, two deputy managers and the registered manager. We observed how care and support was provided to people. We looked at documents and records that related to people's care, and the management of the home such as staff recruitment and training records, policies and procedures, and quality audits. We looked at seven people's care records. After the inspection we received feedback from three health professional teams, a social care professional and an advocate.

Inadequate

Is the service safe?

Our findings

We looked at how risk was managed for people who used the service and found there was a lack of consistency in how this was done. Some systems were in place to help keep people safe; however, other systems were not effective so people were not protected. Risks to people's safety had been assessed but staff were not following the home's own guidance. For example, one person's risk assessment clearly stated that staff must receive specific training to keep the person safe but we found most staff had not received this. Another person had been identified as needing a high calorie diet due to unexplained weight loss. A health professional had recommended fortification of milk drinks, encouragement to have a pudding with each main meal, fortified hot chocolate at least once a day and an accurate record of daily intake including refusals. **Fortified foods** are **foods** which extra nutrients have been added. The person's daily diet sheet showed none of the dietician's recommendations were implemented. This placed the person at significant risk of continuing declining weight loss. The registered manager assured us the recommendations would be implemented immediately. This meant risk was not being managed appropriately when care was being delivered.

The provider did not have effective systems in place to manage risk so people felt safe and also had the most freedom possible. We saw several examples where risk was managed in a way that compromised people's rights. One person's risk assessment stated they should have limited access to their clothing to help reduce risk. We looked at their support plan but this did not contain any information about how to support the person with this. We checked the person's wardrobes and drawers on both days of the inspection and found these were locked. Staff confirmed they were always locked. The registered manager said these should not have been locked and acknowledged this practice was not appropriate and did not meet the person's needs. An incident occurred a few months before the inspection and a decision was made to limit another person's right to answer the telephone. This was not formally assessed and the decision which had been made months earlier had not been reviewed.

Some people had specific risk assessments relating to their behaviour. These identified potential risks and provided guidance for staff to follow when behaviours were challenging. These helped reduce the likelihood of harm to both the person concerned and those around them. The provider's restraint policy and guidance was used in conjunction with the risk management strategies.

The registered manager told us checks were carried out on the premises to make sure they met safety requirements and this included internal checks and servicing from external contractors. We saw a number of service records and certificates that confirmed this. However, when we looked at fire records we found the last 'in-house' checks on fire equipment had been carried out over six weeks ago and these should have been completed weekly. We noted that fire drills had been carried out in September 2014 then February 2015. The home had in place personal emergency evacuation plans for each person living at the home. These identified how to support people to move in the event of an emergency. One person's clearly stated that they should be involved in monthly fire drills so they could become familiar with the process. This guidance was not followed. We concluded the provider was not doing what was reasonably practicable to reduce risks to people. This was in breach of regulation 12 (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we found people were not always protected because risk was not well managed, we did see some good systems were in place to check safety. Each day staff were allocated key roles, such as fire marshall and first aider. All staff had alarms so they could call for assistance in the event of an emergency. We looked at staff check sheets which showed staff were carrying out daily checks around the home. This included cleanliness, monitoring sheets, fridge and freezer temperatures, food charts and incident records. A senior member of staff was allocated to lead the shift and they were responsible for ensuring all tasks were completed. Staff we spoke with said these arrangements worked well. The environment helped ensure people could live safely. Each person had a risk assessment for accessing the kitchen and these ranged from no access to having access to make their own drinks and snacks. Some people had been identified as being at risk of falling from upstairs windows. We saw all upstairs windows were prevented from opening by tamperproof restrictors. An advocate told us, "Documentation including risk assessments, health and safety, training records, Medication Administration sheets have always been in place, up to date and reflective of the needs of the client. They appear to have a policy of ongoing reviews of risk which I have found positive. I believe this has

Inadequate

Is the service safe?

at times ensured safety of the resident whilst also striving for the least restrictive approach." A professional who supported a person who used the service told us, "Whitwood Grange has so far provided a safe environment."

We looked at risk assessments that showed risks in the environment had been assessed. These included use of sharps, use of gardening tools, gas appliances, visitors and use of company vehicle. A number of policies were in place to help manage risk. We asked to look at the medicines policy but were told this was not available on site. We asked how staff would access this information and were informed that a member of the management team would print it off if requested. This meant information was not readily available should staff who were administering medicines have a query.

We looked at the systems in place for managing medicines in the home and found that appropriate arrangements were not in place for the safe handling of medicines. People were prescribed medicines to be taken only 'when required' e.g. painkillers that needed to be given with regard to the individual needs and preferences of the person. Clear information was available for staff to follow to allow them to support some people to take these medicines correctly and consistently, however, there was no information available to support other people. We saw some people had been given paracetamol medication but staff had not completed a medication administration record (MAR) because this was not available. Staff had only recorded the administration on a stock sheet which was not stored in the medication file. The deputy manager said they were introducing protocols for each person in relation to pain relief. One person was prescribed medication that must be taken before food. There was no information regarding this in the person's care plan. Another person was prescribed medication to treat anxiety. However, there was no information to help staff understand why the person required the medicine or decide when they should take it. The MAR was hand written and stated 'take when required for agitation'. It did not include how many tablets or how often the medicine could be taken.

One person was prescribed ointment for a skin condition but records indicated this was not applied as prescribed. The ointment should have been applied once or twice daily but there were gaps which indicated it had not been applied for eight days. Failing to administer medicines safely and in a way that meets individual needs placed the health and wellbeing of people living in the home at serious risk of harm.

It was not possible to account for all medicines, as medicines stock had not always been accurately recorded. When new MARs commenced stock balances were not always recorded. We counted one person's stock of tablets and found they did not correspond with the tablets administered. We noted this was because an incorrect amount was recorded after the last administration. Two checks had been completed by staff and stated the number remaining was correct even though it was evident this was not the case. We found that people using the service were not safe because they were not protected against the risks associated with use and management of medicines. This was in breach of regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Daily and weekly audits were carried out and had picked up some medication issues. For example, one person had been given an additional dose of medicine; this was picked up though the auditing systems, an error report was completed and action was taken to help prevent repeat events. However, there were a number of issues that had not been identified through the auditing systems so we concluded these were not effective. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager said before the inspection they had identified that management of medicines needed to improve and a newly appointed deputy manager was taking the lead on this. They had already started making improvements. For example, they had arranged to have medication administration directions more specific to ensure staff were clear about what and when to administer. We saw some of the new MARs which were printed by the dispensing pharmacist and were more specific. For example, one person's MAR had previously stated one or two tablets three times daily but the new MAR stated the specific times of administration and number of tablets.

People were protected against potential abuse. People we spoke with told us they felt safe in the home and did not have any concerns. A family member also told us their

Inadequate

Is the service safe?

relative was safe and well looked after. The registered manager told us they had no on-going safeguarding cases. We saw previous referrals to the local authority had been appropriately made.

We spoke with members of staff about their understanding of protecting vulnerable adults. They had a good understanding of safeguarding vulnerable adults, could identify types of abuse people could be at risk of experiencing in a residential care setting. All the staff we spoke with told us they had received safeguarding training. Staff said the training had provided them with enough information to understand the safeguarding processes that were relevant to them. Staff records confirmed staff had received safeguarding training. This helped ensure staff had the necessary knowledge and information to help them make sure people were protected from abuse.

We received a mixed response when we asked people if there were enough staff. Three people who used the service and a relative discussed staffing with us. One person said, "There aren't enough staff, they go off sick, it's boring when they're short-staffed." Another person said, "There aren't enough staff; with more I could go out more." One person told us they had to wait sometimes because staff were busy with others. Another person said, "They always seem to be short staffed."

Some staff told us there were sufficient staff to meet people's needs; others told us there were not and staff often had to work excessive hours. One member of staff said, "It's a good team but there are not enough staff." Another member of staff said, "We call reserves if we're short staffed and usually get cover." One member of staff told us they had to work too many days without a day off and long shifts. They said, "I'm exhausted." Another member of staff said, "It's very hectic when we are short staffed and it happens on a weekly basis. The management are aware and taking action but there are obstacles."

The registered manager told us they had experienced some difficulties which had impacted on the staff team but felt action had been taken to ensure there were adequate staffing numbers. They had experienced a high turnover of staff which included four staff leaving in one month. They had recruited staff and were nearly up to capacity. They had a new management team with three of the five seniors and one of the deputy managers relatively new to post. A health professional team said, "The staff try to do their best however there seems to be a large transition of staff and due to the complex care needs of some of the residents it is difficult to achieve continuity of care."

The registered manager was confident the staffing arrangements were appropriate. We looked at staffing rotas for March and April 2015 which showed there had been a high level of sickness. Management were often finding additional cover for multiple shifts each day. Although we concluded there were sufficient staff to keep people safe it was evident that the service had struggled to respond to unforeseen events due to staff vacancies and sickness absences.

The home followed safe recruitment practices. We spoke with three staff about their recent recruitment process. They had attended a group interview and then an individual interview. They told us they had filled in an application form and relevant checks had been completed before they had started working at the home. We looked at the recruitment records for three members of staff and found relevant checks had been completed before staff had worked unsupervised at the home. We saw completed application forms, interview assessments, references and Disclosure and Barring Service (DBS) checks. The DBS is a national agency that holds information about criminal records and persons who are barred from working with vulnerable people.

Requires improvement

Is the service effective?

Our findings

Staff did not always receive appropriate support to enable them to carry out their duties safely and effectively. We got a mixed response when we spoke with staff about training and appraisal. All the staff we spoke with said they received regular supervision where they discussed their performance with a supervisor. The registered manager said they did not have a supervision and appraisal matrix but information was held in staff files. We asked to look at four staff's appraisals for last year; only two of these were available and we were informed this was because the other two had not been completed.

Some staff said they received good training; others said this needed to improve. One member of staff said, "Training is pretty good, we get supervision monthly but I've not had an appraisal for a while." Another member of staff said, "We get refresher training so everything is kept up to date." One member of staff told us they thought some members of staff were not adequately trained to work at Whitwood Grange which put others at risk of harm, they said, "Staff go through induction but are not ready. I'm not sure if it's the quality of staff they are recruiting or the lack of induction and support when they start." Another member of staff said, "I wasn't prepared. When I started I didn't get chance to shadow other staff or read people's care plans properly." Two members of staff said they had experienced difficulties when providing support to people because they felt they were not equipped to work with the individuals they had supported. We spoke with the registered manager about the induction of new staff who acknowledged that the amount of shadowing time with experienced staff was inconsistent. They had identified this as an area to improve so deputy managers were arranging coaching sessions. We received feedback from a team of health professionals. They said, "People appear to be accepted at Whitwood Grange with complex care needs before staff are trained and competent to deal with them."

We asked to look at some recent induction records to show staff had completed an effective induction. These were not available. The registered manager said these were held centrally and a copy should have been held in staff files on site. The registered manager had a training matrix which showed staff received a range of training including safeguarding, epilepsy, autism, food safety, health and safety, fire, moving and handling and first aid. There were some gaps which indicated staff had not received the relevant training. The registered manager said this because the main matrix needed updating. We also looked at other documents that showed other training was also provided. Staff had completed 'positive behaviour support' which covered 'proactive working practices, keeping safe strategies and person specific interventions. Staff should have completed ligature cutting training but most staff had not received this. We asked to look at this training matrix which showed 15 staff had received it; 34 had not; ten were recorded as not applicable and three were on long term absence. The registered manager said they were aware staff needed to receive this training and were planning additional training sessions. We concluded that staff did not always receive appropriate support, training and appraisal to enable them to carry out their duties they are employed to perform. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Training records showed staff had received Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. DoLS protect the rights of people by ensuring that if there are restrictions in place they are appropriate and the least restrictive. The Care Quality Commission (CQC) monitors the operation of DoLS which applies to care homes. We were told that six people using the service were subject to authorised deprivation of liberty and a further ten standard authorisation applications had recently been made. We saw two people's DoLS were subject to conditions which had been included in their planning and delivery of care. This helped ensure people's rights are protected.

We looked at the provider's physical intervention and restraint policy. The policy gave clear advice to staff about how restraint could be lawfully used to protect people from harm. The policy described the use of physical restraint and defined four broad categories of physical intervention - restraint, holding, touching and presence. Care plans and incident records showed that physical intervention was only used as a last resort where harm may come to the person concerned or to those close by. All incidents were clearly documented. Information recorded included the contributing factors to behaviours, staff's interpretation of triggers to the behaviour and method of restraint, for example, blocking an intended assault. The length of time the restraint was in place was recorded as was the names of staff involved. The incident records showed the event

Is the service effective?

was subject to senior staff review with any lessons learned translated into care plans. Staff completed a form which reminded them they needed, in some circumstances, to make a safeguarding referral to the local authority and/or a notification to the CQC. Staff we spoke with were able to describe de-escalation techniques and how they minimised the use of restraint.

People we spoke with said they could have drinks and snacks when they wanted. They told us they had enough to eat and mostly liked the food. We observed people being supported in the kitchen. People received different levels of support with meal and drink preparation, however, people's involvement in choosing what to eat and general meal planning was varied. One person told us they planned their meals day by day. Another person told us they were not asked what they liked and didn't get to choose. One person told us they did not choose the meals but said, "I do my own breakfast, drinks, crumpets and supper." They told us they didn't used to have a set menu. One person expressed to staff that they did not like the meal on offer so staff offered an alternative.

People talked to us about their meal time experiences. Some changes had been introduced and staff no longer ate with people who used the service. We were told this was because a decision was made that staff had to provide their own meals. One person who used the service told us they preferred it when they ate together, "Like a family."

Menus were provided for lunch and evening mealtimes. These offered people a selection of foods and promoted healthy eating. The registered manager explained that the deputy manager from one of the provider's sister homes devised the menu and ensured people were offered nutritionally balanced and varied meals. However, there was no information to show how people were involved in the planning of meals. The registered manager said they would look at including this topic in individual monthly meetings that were held with people to talk about their care and support.

None of the people who used the service that we spoke with had concerns about their healthcare. They said they visited a local GP and dentist. One person said they visited a psychiatrist. Another person said they had visits from a nurse. We saw staff had requested a longer appointment with a health professional so as to allow one person time to discuss their needs and have time to understand. This helped ensure the person received equal and fair treatment and promoted their independence.

Staff told us systems were in place to make sure people's healthcare needs were met. They said people attended healthcare appointments and we saw from people's care records that a range of health professionals were involved. People had accessed services in cases of emergency or when their needs had changed. This had included GP's, hospital consultants, community mental health nurses, speech and language therapists and dentists. We saw people had received winter 'flu vaccinations' and had been encouraged to participate in cancer screening and education programmes. For instance, one person had been shown how to self-examine to minimise the risk of undiagnosed testicular cancer.

People did not have up to date health action plans (HAP). A HAP should hold information about the person's health needs, the professionals who support those needs, and their various appointments. The plan is based on a full health check. The management team told us that people did have HAP but when we looked at the records we found people only had 'hospital passports' which are documents they would take if they needed to share information about their health. These were only partially completed.

We received feedback about the service from three teams of health professionals. One team told us they had, "No concerns regarding the care provided by Whitwood Grange." One team told us, "For certain individuals the staff team have worked proficiently and achieved good outcomes, there are some clients who appear to have more challenging behavioural needs which outcomes have not been as positive." Another health team told us appointments were made but then people would not attend. They said this was "frustrating because it resulted in wasted appointments" and "there could also be a potential unmet health need". It was not made clear at the inspection who had made the original appointments and who had responsibility for informing the health care professionals of any changes.

The same health team also told us things were not always "done in a timely manner". They said, "There has also been lack of follow up after discussions around certain health issues." We concluded care and treatment was not

Requires improvement

Is the service effective?

provided in a safe way to ensure people's health needs were met. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs were met by the design of the environment. It provided people with individual space but they could also access communal areas if wanting to spend time with others. We saw people could chose to spend time in their room. However, we found the decoration of the home was bland with no domestic feel to it. For example, in one lounge there was a settee, a television that was boxed in and wall mounted and some curtains at the window. There was nothing to suggest it was people's home or to reflect the personalities of the people living there. There were no pictures. The dining room was the same. The registered manager said this was people's choice. We asked to see how these choices were made but were told this was done on an informal basis. The registered manager said they would ensure future decisions were recorded.

Requires improvement

Is the service caring?

Our findings

We received positive feedback from people who used the service about the staff who supported them. Everyone we spoke with told us that staff treated them well. One person said, "Staff are OK, friendly and polite." Another person said, "Staff are kind." A relative said, "The staff are fine." People told us they could make day-to-day decisions about their care, such as when to get up and go to bed, what activities they wanted to do.

We spoke with staff about the care that was provided. In the main, staff told us people were well cared for. One member of staff said, "People are well looked after. I have no concerns about the care." Another person said, "We support people to the best of our ability." Another member of staff said, "The quality of care is alright. They match staff to service users." Some staff raised concerns that inexperienced staff worked with people which sometimes resulted in inconsistencies in care provision.

Staff also told us systems were in place to make sure people's privacy and dignity were respected. Everyone had their own room with en-suite facilities. We saw a listening device in a communal area. The registered manager confirmed this was used to monitor one person who had epilepsy during the night. However, we noted it was switched on during the day and could hear the person chatting to staff whilst in their room. This meant the person did not have the privacy they needed. The registered manager said this should not happen in practice and would remind staff that the correct protocol must be followed.

We saw displayed in the staff room success stories; these contained information about how people had made progress and how they were supported to be more independent. For example, one person had progressed from never going out to often going out on their own. Another person planned their own day to day activity schedule. Another person had learned to clean their own room and bathroom.

People who used the service told us they were involved in making decisions about their care and reviewing this on a regular basis. They said that staff listened to them. One person said, "Sometimes they listen to me, but not always." Another person said, "Staff know what's important for me because they have a handover meeting every morning." A family member told us their relative had chosen their key worker and planned their holiday. A professional who supported a person who used the service told us, "I believe Whitwood Grange provide a caring environment for the person I work with. They have been keen to mark special days like their birthday and Christmas."

Although people told us they were involved in making decisions about their care, we saw examples where people had not been involved and decisions had been made without appropriate consultation. Six months before the inspection, a decision had been taken to change the approach when communicating with one person; this was because the person was displaying increased behaviours that challenge. Two staff said they were concerned that the decision was not in the person's best interest. The person's care records showed the decision had been taken following advice from two health professionals and there had been a noted reduction in anxieties and behaviours. However, the decision had been made without adhering to good practice guidance. A best interest meeting was not held and there was no evidence to show the person's own views had been considered or what they might have done had they been able to make the decision themselves. There was no evidence the person concerned had been involved in the decision, nor was there any evidence the person had been encouraged to participate and had refused. Family members or an advocate were not involved in the decision making process. We concluded that the registered person did not fulfil their duty by carrying out, collaboratively an assessment of the needs and preferences for care and treatment. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff explained that some people had, in their room, pictorial boards to help communication. This involved displaying pictures of the day's activities. One member of staff said, "We use the 'now, next, then' planners which are good." When we looked around the home we saw there was no signage, pictorial or easy read documentation displayed. In one area there was some easy read documentation but access by people who used the service was limited. A health professional had recommended the use of an electronic tablet for one person to help communication. The registered manager said this had

Requires improvement

Is the service caring?

been purchased and they were waiting for the health professional to help set up the recommended programme. At the time of the inspection people could not access the internet but we informed this was being reviewed.

We saw people had access to advocacy services. An advocate told us, “They have always been open to suggestions and discussion around their care needs and progressing forward with therapeutic input. Communication with me has always been timely and appropriate.”

Requires improvement

Is the service responsive?

Our findings

We found the service was not always responsive because people did not receive appropriate care to meet their needs. Before we carried out our inspection, we received information of concern that indicated people were not always receiving appropriate care, which included a lack of assessment before people moved into the service. The registered manager discussed a recent admission and transition process. They said there had been a clear assessment process which included involvement of senior managers and a designated staff team but felt if the service had not been working to a timescale the transition process could have been longer.

Professionals told us the service was not always responsive. One health professional team said, "The staff and managers do not inform our team consistently when safeguarding incidents occur even when we are actively involved with a servicer user who resides there, we will find out through social care direct often a few days after the incident or when the issues have escalated."

We looked at care plans and found that some people's care plans were out of date and inaccurate. This meant staff did not have had accurate and up to date information about people's care and support needs. One person's care plan did not contain important information about their dietary needs. In another person's care plan we saw a communications strategy had been designed to reduce anxiety and behaviour that challenges. From discussions with staff and the registered manager we established that the care plan was out of date and had not been reviewed. We also found that the communication strategy used in practice did not follow formal guidance. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst some elements of care delivery were not appropriate we also saw examples of good care planning and delivery. We observed staff supporting people in a positive and skilled way. Some people living at the home had Autistic Spectrum Disorders (ASD). We saw staff interacting with people with ASD with a structured and therapeutic approach. Staff were helping people to develop social skills and manage stress. Staff communicated in a way which helped them understand what others may be trying to communicate to them. We saw the service used schedules and timetables to give the necessary structure and visual cues to people with ASD. For example, one person required a clear timetable for carrying out cleaning of their room and clarity about when they would receive support with personal hygiene. Our observations indicated that this element of care was being delivered in accordance with the care plan.

Care plans were personalised and recorded what people could do independently and where they required support. The care plans identified how people liked to spend their time and how they liked to be supported. They detailed what people said about their anxieties and behaviours. We saw family members had also been involved. One person's care planning had been developed through a multi-disciplinary team (MDT) approach. The outcome of this approach was recorded in the care plan and showed the person had benefitted from the care provided. A recent MDT review meeting acknowledged; 'Staff are implementing the O.T's recommendation'; 'The environment has been adapted to meet {x} needs which has reduced adverse behaviour' and 'PRN (as necessary) antipsychotic medicines are now rarely used'. These comments clearly demonstrated that health professional advice was being taken. An advocate told us, "The support provided to the gentleman that I work with has always appeared person centred and responsive to change, be that environmental or linked to changes within the client. Due to this I have seen a gradual improvement in his cognitive abilities and this has enabled him to have more input into decisions around his daily living and activities." A professional who supported a person who used the service told us, "Whitwood Grange has been effective in providing the stability in support and accommodation required by the young person I work with. I believe they have developed different methods in engaging with the young person and have put his wishes and interests in how they planned his support. Staff have been creative in working with the young person and have concentrated on his strengths. They have been able to accommodate the young person's interests."

Some people attended care reviews where they decided and agreed what they would like to do. These were held every few weeks and also attended by management and staff. This helped ensure people developed their care and support.

From discussions with people who used the service and records we concluded people engaged in a range of

Requires improvement

Is the service responsive?

activities within the home and the community. Each person had daily activity schedules and a daily diary. These showed activities were varied and related to their own interests and preferences. One person told us they enjoyed dog-walking, cycling, walking, trampolining, playing games and music on their computer. Another person said they enjoyed horse-riding, going on the train, to the cinema, walking, trampolining, buying a newspaper, shopping, going to the pub, playing pool, going to watch football and playing rugby. One person told us they had an allocated patch of garden. Staff told us most people accessed the community daily.

Three people told us they would like to move from Whitwood Grange to more independent accommodation. One person told us they felt frustrated by what they perceived to be slow progress. We discussed this person's comments with the registered manager and saw from care records that efforts had been made but with no success. Care records showed professionals and the person's family were involved.

People told us they would talk to staff or their family member if they had any concerns. None of the people we spoke with had ever made a complaint. A relative told us they had not made a formal complaint but had raised concerns in the past with the manager or deputy which then got resolved.

We looked at the record of complaints, which showed complaints were investigated and resolved where possible to the person's satisfaction. Staff we spoke with knew how to respond to complaints and understood the complaints procedure. The registered manager told us there were no ongoing complaints.

Requires improvement

Is the service well-led?

Our findings

The service had a registered manager who oversaw the care given. The management team were relatively new and the registered manager said they were focussing on allocating key responsibilities. The registered manager was confident once they were established improvements would be made to the service provision. People who used the service said they saw the manager on a regular basis. One person said, "[Name of manager] talks to me when I see her." They also said that senior managers visited on occasion.

We received mixed feedback from staff and visiting professionals about the management team. Before this inspection we received information of concern and were told that staff had tried to talk to management about some concerns but were not listened to. At the inspection, one member of staff said, "The manager is doing a good job." Another member of staff described the manager as "supportive." Staff told us the operations manager had worked alongside staff and helped develop care strategies for one individual. One member of staff said, "We talk everything through which helps." Another member of staff said they had seen the operations manager visit but had never had an opportunity to speak with them.

A health professional team told us, "When we try to make appointments or contact senior staff and managers they are always 'unavailable in meetings or training; this seems to be a stock response. When we do eventually speak with the managers they are very defensive as if there is something wrong." Another health professional team said, "The biggest issue is around communication both within the service and also phoning through to the home as often there is no reply. Some individuals appear to be very knowledgeable about the residents and their needs however, there does not seem to be any effective mechanism for this information to be shared amongst colleagues. This can have an impact when certain members of staff are not on duty offering fragmented care. There is always willingness amongst staff to try and improve the lives of the people they care for." A professional who supported a person who used the service told us Whitwood Grange was "generally well-led". They said the home had responded well to incidents but felt day to day "communication could be more effective and quicker".

An advocate told us, "Management at Whitwood Grange have always appeared to have an up to date knowledge of the gentleman that I have worked with. This suggests to me that management are accessible to both residents and staff at Whitwood Grange and reinforces my view that the service is person centred and small enough to maintain a 'family feel'. I have witnessed that staff feel able to speak to the manager at Whitwood Grange for advice, information or guidance and that this interaction has been welcomed/ encouraged by management."

Staff we spoke with said they had clear roles and responsibilities. At the beginning of each shift they were allocated staff duties and informed who they would be working with on a one to one basis. We saw a number of check lists that staff completed which ensured daily tasks were completed. The senior member of staff leading the shift showed us their allocation sheet which was discussed with the registered manager or deputy at the beginning of the shift.

Regular staff meetings were held and it was evident from the meeting minutes that topics relating to the quality of care and safety were discussed. The management team had looked at how they could improve the service and asked the staff team for suggestions. They had covered what is working, what is not working, teamwork, communication, keyworkers and care files.

The team had a 'float your boat' project where team members and management recognised good practice and formally acknowledged this. A notice board contained recent examples of good practice.

We found there were gaps in the way the provider monitored the overall service. The registered manager said they had regular supervision with the operations manager where they discussed the service; however, visit reports were not completed. We could not establish what was checked and who was consulted. An annual provider quality assurance visit was carried out in June 2014. A report was written with several points to action. The quality assurance document stated that the operations manager should review these every three months but this had not been completed. One action point was to develop a service user guide. We asked to look at this but were told it was still being developed. The registered manager showed us a quality enhancement plan that referred to 'establishing measurable objectives based upon priorities'. This again had not been completed.

Requires improvement

Is the service well-led?

The provider had identified that some information in people's care records was difficult to locate and had recommended introducing a new more streamlined system. The registered manager explained that a new format had been introduced last year but this hadn't worked well so they had reverted back to the old system. At this inspection we also found it difficult locating information.

For example, we asked to look at one person's care records but were told this was held in four different files.

The home's management team provided some data to the provider such as staff training, accident and incidents, complaints, the number of person centred reviews out of date, the number of health action plans out of date and the number of environmental risk assessments out of date. We looked at the recent data that was shared and found this was not always accurate. For example, the data stated the number of appraisals out of date was zero but we identified that two out of the four we reviewed were out of date, we also saw that people did not have health action plans but the data stated that zero health action plans were out of date. We concluded the provider did not have systems that were effective to assess, monitor and improve the quality and safety of services. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked to look at feedback from people who used the service. No survey or questionnaire results were available. The registered manager told us the provider had sent out surveys at the beginning of the year but they had not yet received any feedback. The service did not hold service user meetings. The management team said they did this on an informal basis and did not generally record people's wishes. One member of staff said they had held a meeting to discuss purchasing an entertainment system but this was not documented. The registered manager said they would look at gathering people's views on a more regular basis to ensure people had opportunities to be involved and help drive improvement.

The registered manager had sent out staff surveys in March 2015 because they had identified that a high number of staff had left. We looked at some returned surveys, which identified a number of common themes and areas where the service could improve. The registered manager had already started taking action to address some of the key issues.

The homes statement of purpose outlined the aims and objectives, and nature of services provided. We noted it stated that 'survey results are available on request from your local care UK branch'. The registered manager said these were not available and agreed to ensure the statement of purpose accurately reflected the service provision.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 and treatment was not appropriate and did not meet people's needs. The registered person did not fulfil their duty by carrying out, collaboratively an assessment of the needs and preferences for care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and support was not provided in a safe way for service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not have systems that were effective to assess, monitor and improve the quality and safety of services.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff did not receive appropriate support, training and appraisal to enable them to carry out their duties they are employed to perform.