Heathcotes Care Limited

Heathcotes (Whitley)

Inspection report

Whitley Farm Cottages
Doncaster Road
Whitley Bridge
North Yorkshire
DN14 0HZ

Tel: 01977663476
Website: www.heathcotes.net

Date of inspection visit:
01 August 2017

Date of publication:
11 September 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection of Heathcotes (Whitley) took place on 1 August 2017 and was unannounced.

Heathcotes (Whitley) is a residential home for people with autism, learning disabilities, mental health needs, physical disability or sensory impairment. The service can accommodate up to nine people, but at the time we inspected there were seven people using the service. The building is a converted farmhouse in a rural location on the outskirts of the village of Whitley. Bedrooms are on the ground and upper floor, each with en-suite 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 and which is secured by a locked gate. A driveway, also secured by a locked gate, runs from the courtyard to the main road. Up to four cars can be parked on this driveway.

At the last inspection on 23 and 24 May 2016 the provider did not meet all of the regulations we assessed. This was with regard to safe care and treatment, staffing numbers, person-centred care and good governance. The provider had not ensured that people's risk assessments were followed, sufficient support workers were on duty to meet people's needs for one-to-one care, support was delivered in line with support plans and record keeping was accurately maintained. At that inspection the service was rated 'Requires Improvement'.

At this inspection we also found the overall rating for the service to be 'Good'. The rating is based on an aggregation of the ratings awarded for all five key questions. Improvements were made in the provision of safe care and treatment, as risks were managed, reduced and followed on an individual and group basis so that people avoided injury or harm wherever possible. Improvements in staffing numbers meant there were sufficient support workers to meet people's needs and we saw that rosters accurately cross referenced with the support workers that were on duty. People's support plans were followed more closely and so they were provided with person-centred care. However, although support workers maintained certain records more accurately than at the last inspection, some were still not detailed enough. This meant that while the requirements made against breaches in regulations at the last inspection, were now met, there were still some recommendations made with regard to best interest and physical intervention records.

The provider was required to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. On the day of the inspection there was no registered manager in post as they had left their position unexpectedly three days before we inspected. The provider was required to inform us of this via a formal notification. The acting area manager explained how the service was being managed in the interim period between having no registered manager and recruiting a new manager. They told us who would be managing the service from 7 August 2017 and that a new registered manager application would be made as quickly as possible. However, a service that does not have a registered manager in place cannot receive a higher rating than

'Requires Improvement' in the well-led domain as the registered provider is in breach of the conditions of their registration.

People were protected from the risk of harm because the provider had systems in place to detect, monitor and report potential or actual safeguarding concerns. Staff were appropriately trained in safeguarding adults from abuse and understood their responsibilities in respect of managing potential and actual safeguarding concerns.

The premises were safely maintained and there was evidence in the form of maintenance certificates, contracts and records to show this. Recruitment policies, procedures and practices were carefully followed to ensure support workers were suitable to carry out their roles and responsibilities with vulnerable people. We found that the management of medicines was safely carried out, but support worker knowledge regarding effects of some specialist medicines was lacking.

People were supported by qualified and competent support workers who were regularly supervised and had their personal performance annually appraised. Communication with people was effectively managed. People's mental capacity was appropriately assessed and their rights were protected. Support workers had knowledge and understanding of their roles and responsibilities with regard to the Mental Capacity Act (MCA) 2005 and they understood the importance of people being supported to make decisions for themselves. The management team explained how they worked with other health and social care professionals and family members to ensure decisions were made in people's best interests where they lacked capacity, but this was not always fully recorded.

People's nutrition and hydration needs were met. The premises were suitable for providing support to people with a learning disability and the environment was comfortable.

We found that support workers were kind and considerate and knew about people's needs and preferences. People were involved in all aspects of their care and support and were always asked for their consent before any support tasks were carried out.

People's wellbeing, privacy, dignity and independence were monitored and respected. This ensured people felt satisfied and were enabled to take control of their lives.

There was ample opportunity for people to engage in occupation, pastimes and activities if they wished to and these often related to helping people learn about or maintain daily living skills and acquire social skills. People had good family connections and support networks.

We found that the complaint procedure in place was effective and people had their complaints and concerns investigated without bias. People that used the service, relatives and friends were encouraged to maintain relationships through frequent visits and telephone conversations.

While there had been recent disruptions in the management of the service an acting area manager was supporting another registered manager to ensure the service was well-led. This registered manager was posted at a sister service close by, but they were on holiday at the time of our inspection. The culture and the management style of the service were positive. There was an effective system in place for checking the quality of care delivery using audits, satisfaction surveys and meetings. However, this had failed to identify that some records were lacking detail. A recommendation has been made for this. People had opportunities to make their views known using these methods. People were assured that recording systems used in the service protected their privacy and confidentiality. Records were held securely on the premises.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from the risk of harm because there were systems in place to detect, monitor and report potential or actual safeguarding concerns.

Other risks were managed and reduced so that people avoided injury or harm wherever possible. Physical interventions were appropriately carried out but recording was insufficient.

The premises were safely maintained. Support worker numbers were sufficient to meet people's needs and recruitment practices were carefully followed.

People's medicines were safely managed, but support workers relied on health care workers' support for monitoring the effects of certain medicines.

Is the service effective?

Good

The service was effective.

People were supported by qualified and competent staff that were regularly supervised and received an annual appraisal of their performance.

People's mental capacity was appropriately assessed and their rights were protected, but records did not always support this.

Adequate nutrition and hydration was provided to maintain people's health and wellbeing.

The premises were suitable for providing support to people with learning disabilities and the environment was comfortable.

Is the service caring?

Good

The service was caring.

Support workers were kind and considerate. People were involved in all aspects of their care and support.

People's wellbeing, privacy, dignity and independence were monitored and respected.

Is the service responsive?

Good

The service was responsive.

People were supported according to their person-centred support plans, which were regularly reviewed. They had the opportunity to engage in occupation and some pastimes and activities of their choosing.

People had their complaints investigated without bias and they were encouraged to maintain relationships with family and friends.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service was without a registered manager, but interim arrangements were in place and the service was being appropriately managed. However, a service that does not have a registered manager in place cannot receive a higher rating than 'requires improvement' in the well-led domain as the registered provider is in breach of the conditions of their registration.

The culture and the management style of the service were positive. Quality monitoring was in-depth and while effective in most areas, had omitted to identify some minor issues with records.

People were assured that recording systems in use protected their confidentiality of information, because records were securely held.

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. 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.

The inspection of Heathcotes (Whitley) took place on 1 August 2017 and was unannounced. One Adult Social Care inspector and a Specialist Professional Advisor (SPA) carried out the inspection. An SPA is a person who has specialist knowledge and experience of working with people who use this type of care service. Their area of specialism was in learning disability and Autistic Spectrum Disorder support and care.

Information had been gathered before the inspection from notifications that had been sent to the Care Quality Commission (CQC). Notifications are when providers send us information about certain changes, events or incidents that occur. We also requested feedback from local authorities that contracted services with Heathcotes (Whitley) and reviewed information from people who had contacted CQC to make their views known about the service. We had also received a 'provider information return' (PIR) from the provider. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We met with three people that used the service and spoke with one at length. We spoke with the acting area manager, the operations manager and four support workers. We looked at care files belonging to four people that used the service and at recruitment files and training records for four support workers. We viewed records and documentation relating to the running of the service, including the quality assurance and monitoring, medication management and premises safety systems. We also looked at equipment maintenance records and records held in respect of complaints/compliments, accidents/incidents and physical intervention.

We observed staff providing support to people in communal areas of the premises and we observed the interactions between people that used the service and their support workers. We looked around the premises and saw communal areas and people's bedrooms, after asking their permission to do so.

Good

Is the service safe?

Our findings

People told us they felt safe living at Heathcotes (Whitley). One person explained to us that they found staff to be "Great, they are always there and look after me."

At the last inspection the provider was in breach of Regulation 12: Safe care and treatment, because people's risk assessments did not protect them from harm. One person had run out of the service and onto the road when they were unsupervised because of insufficient staffing and was at high risk of harm.

At this inspection people's risk assessments were followed more carefully and everyone was being supervised according to their individual staffing needs. Risk assessments included information on how best to monitor and support people to reduce the risks of harm or worse from, for example, obesity, choking, exploitation when in the community and accidents in the service or when in the community. Not all support workers had signed the risk assessment acknowledgement sheets to show they had read them. This was passed to the acting area manager to address, who assured us they would make sure staff signed on reading.

The staffing rosters corresponded with the numbers of support workers on duty during our inspection and showed that the use of agency workers was minimal. In some instances support workers were noted to be in relationships or related and we were advised that boundaries were maintained through supervision. Similarly, as a result of the service's geographical isolation, many support workers lived locally and knew each other from the local community.

There was adequate cover for additional support to enable people to access a good range of community based activities and pastimes. People told us they thought there were enough support workers to support them with their needs. One person that lived at Heathcotes (Whitley) said, "Whenever I need to go out there is always someone (support worker) able to go with me." Support workers confirmed that staffing levels were sufficient.

There were systems in place to manage safeguarding incidents and support workers were trained in safeguarding people from abuse. Support workers demonstrated knowledge of their safeguarding responsibilities and knew how to report suspected or actual incidents to their seniors in charge so they could refer these to the local authority safeguarding team. Support workers gave us some accounts of incidents that had taken place and required referral. Records were held in respect of handling incidents and the referrals that had been made to the local authority.

There had been a high number of referrals in the last 12 months; 18, but all of these had been appropriately investigated by North Yorkshire County Council safeguarding team or internally within the organisation when instructed to do so by the safeguarding team. Formal notifications were sent to the Commission regarding incidents, accidents and events that affect the running of the service, which meant the provider was meeting the requirements of the regulations.

Physical interventions took place but only where a person was at high risk of harming themselves or others, when being in a heightened state of anxiety. Support workers were trained in Non-Abusive Psychological and Physical Intervention (NAPPI), which was British Institute of Learning Disability (BILD) accredited. Interventions were documented and there was a separate interventions record book. Together these provided a full account of interventions. However, they failed to record the time that interventions took and so we discussed this with the registered manager who assured us this information would be recorded in future. This was so that senior managers in the organisation could check that physical intervention was not used any longer than necessary.

The strategies used in NAPPI techniques were linked to the risk assessments that had been compiled for people with regard to their positive behaviour plans. These risk assessments and plans were compiled by the organisation's NAPPI trainers and not the service employees, as they involved the use of high risk techniques. This ensured support workers only used the safest techniques.

Accident and incident policies and records were in place for the management of these events. Records showed that these were recorded thoroughly and action was taken to ensure injured persons received the medical treatment they needed. Systems used helped to prevent accidents and incidents from re-occurring.

Maintenance safety certificates were in place for utilities and equipment used in the service, and these were all up-to-date. People had personal emergency evacuation plans in place to instruct support workers on how to assist them to leave the building safely in the event of any emergency. The service had utility and other service maintenance contracts in place to ensure the premises and equipment were safe. Any medical devices held for use by the visiting district nurses were maintained and in working order. These safety measures and checks meant that people were kept safe from the risks of harm or injury should any aspect of the premises or equipment used be found to be unsafe.

Recruitment procedures were safe and ensured support workers were suitable for their roles. Job applications were completed, references requested and Disclosure and Barring Service (DBS) checks were carried out before support workers started working. A DBS check is a legal requirement for anyone applying for a job or to work voluntarily with children or vulnerable adults. It checks if they have a criminal record that would bar them from working with these people. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

Support workers confirmed they had been recruited according to procedures. We were told one person who used the service had recently been involved in interviews of new workers.

Medicines were safely managed within the service and a selection of medication administration record (MAR) charts we looked at were accurately completed. Medicines were obtained in a timely way so that people did not run out of them. They were stored safely and administered on time, recorded correctly and disposed of appropriately. A daily audit was carried out to check medicine stocks. The purpose of some medicines was not always recorded accurately in people's support plans and this was discussed with the area manager who agreed to check the reasons for medicines and ensure the information was correct.

Support workers were required to be vigilant to potential adverse effects of medicines, although in some instances workers did not appear to understand the potentially hazardous nature of specific medicines (especially with regard to medicines that people took to help them manage their mental health needs or anxieties). Support workers were reliant on local specialist health services for assistance with regard to people's clinical needs and complexities and despite making referrals did not always receive a timely

response. However, support workers continued to ensure people's clinical needs were appropriately referred and that specialist services were reminded of these referrals until information or support was obtained. People were supported to access regular medicine reviews.

Controlled drugs held in the service (those required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001) were also safely managed at the time of the inspection.

All of this ensured that people who used the service were protected from the risk of harm and abuse.

Good

Is the service effective?

Our findings

One person told us their support worker helped them with daily tasks, activities and decisions. They said, "I like having [Name] work with me. Together we get things done and we go places." They told us that they trusted support workers to be there whenever they were required.

Support workers received the training and experience they required to carry out their roles competently. Training completed was evidenced in support workers files and in discussion with workers who confirmed the courses they had attended and qualifications they had achieved.

Support workers completed an induction programme, received regular one-to-one supervision and took part in a staff appraisal scheme. Induction, supervision and appraisal were all evidenced from the documentation seen in support workers' files and via discussion with them. Training included, for example, mental health, diabetes, safeguarding adults and non-abusive intervention.

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 interest 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 interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Where people were assessed as having no capacity to make their own decisions, the registered manager arranged for best interest decisions to be made, DoLS applications to be submitted and reviews to be carried out. This was managed within the requirements of the MCA legislation.

There were numerous examples of assessments of people's capacity to make decisions but in some instances there were no specific decisions required and the assessment was merely an assessment of the person's ability to understand information. Best interest decision records showed little consultation with advocates or other stakeholders external to the service, although we were told that advocacy services were available and used and stakeholders and families were consulted. The management team explained that doctors were reluctant to be involved in such decisions, but that family members and officers of the local authority were involved. The lack of recording this evidence is dealt with in the Well-led section of the report.

We heard and observed that people were asked by support workers for their consent to be helped and supported before it was given to them. Support workers were patient with people and respected their

responses. There were some indications in people's files that people and their family members had been consulted about consent.

People ate a largely nutritious diet. They were consulted about their dietary likes and dislikes, allergies and medical conditions. Information gleaned was recorded and informed the support plan. Staff sought the advice of a Speech and Language Therapist (SALT) when needed, but had not yet done so for one person who required their food cutting up due to an identified risk of choking from eating too quickly. When we asked about the risks associated with the sandwiches they ate, which was shown on their support plan as one of the foods they preferred, we were told that support workers always supervised their mealtimes to ensure they ate more slowly and all of their food was cut up to help with this. The acting area manager assured us they would make a referral to SALT to seek further support.

Support workers provided three meals a day plus snacks and drinks for anyone that requested them, including at supper time.

People's health care needs were appropriately monitored using annual health checks and one person was assisted in this by an advocate. Health action plans were in place and followed so that people's health needs were met. People, their families and healthcare professionals were consulted about medical conditions and all information was collated and reviewed with changes in people's conditions.

Support workers told us that people could see their doctor on request and the services of the district nurse, chiropodist, dentist and optician were accessed whenever necessary. People's health care records confirmed when they had seen a professional and the reason why. They contained guidance on how to manage identified health care needs and recorded the outcome of any consultations with professionals. Diary notes recorded when people were assisted with the health care that was suggested for them.

Communal space in the premises was suitable for the people that used the service. Floor coverings were non-permeable for easy clean. The kitchen was a focal point and domestic in style. The lounge, dining space and activity room were spacious, light and airy and a garden to the rear of the property was designed for easy maintenance and contained physical activity equipment, such as a trampoline and swing.

People's personal space was personalised with items and belongings of their own. They had their own bedrooms with access to shared communal lounges and dining room. Bedrooms were designed and furnished to suit people's individual needs, for example, sparse and with neutral colours for those with autism spectrum disorder. Other bedrooms had specifically placed furniture and belongings, which suited people diagnosed with learning disabilities and compulsive tendencies.

One person had an independent flat, attached to the main property, which had its own front door, living/dining room/kitchenette, bedroom and bathroom. It was furnished in a style of their choosing. We noticed the oven door in this flat had broken off and a support worker was made aware to request repair. The management team spoke about possible future changes to the premises that would bring the living arrangements in line with the national policy and the national plan on 'Building the right support' for people with learning disabilities.

Good

Is the service caring?

Our findings

People were seen to be getting on well with support workers who regularly offered them guidance in their daily routines and activities. Support workers told us there had been low morale among the team in the recent past but this had changed. They said that relationships between people and support workers were much better and the atmosphere was calmer, due to the fact that the use of physical interventions had reduced and people were receiving more positive attention. One support worker said they had developed different roles and relationships with different people, depending on people's needs.

People's general well-being was considered and monitored by the support workers who told us they were aware of the signs and triggers that usually made people anxious. Activity and occupation helped people to feel their lives were busy and fulfilled, which aided their overall wellbeing. Managers spoke passionately about ensuring people were supported with the best possible opportunities and use of resources, but explained that often delays in responses to requests for assistance from external providers meant that specialist insights were not always considered.

We observed support workers treated people with respect, kindness and compassion throughout all interactions. However, we overheard a support worker ask a person if they wanted to go to their room. When the person replied that they did not the support worker said, "Well don't swear then." We also heard a support worker counting out when waiting for a response from a person, but was told this was used in a fun way and not as an indication that a sanction would ensue. Some support plans noted that people should be 're-directed to their bedroom' where all else failed when managing concerning behaviour and others talked about people 'needing clear boundaries' – these euphemistic (understated) terms could easily be misconstrued. These ambiguities were discussed with the management team who told us they informed support workers in clear terms what was required regarding the guidance that each person needed. We saw that written best interest decision information supported this.

Advocacy services provide independent support and encouragement that is impartial and therefore seeks the person's best interests in advising or representing them. There was minimal evidence of engagement with advocacy services, although the acting area manager told us that services were available through 'Cloverleaf' and another organisation in Wakefield, but there were local difficulties accessing these. We were told that one person had support from an Independent Mental Capacity Advisor (IMCA) and another was represented by a parent regarding finances.

People told us their privacy and dignity were respected. One person said, "I really like my own space [independence] and staff help me go out when I need to." We observed people being encouraged to make choices and given time to themselves when they needed it. Everyone received support with personal hygiene in the privacy of their own bedrooms or bathrooms and confidentiality of personal information was upheld.

One support worker told us, "I always knock on people's doors and wait to go in, I ensure curtains are closed and give people the choice of having bathroom doors closed or open. I always give people time in the

shower and say 'shout if you need me' and if necessary will sit outside people's bedroom to be close at hand, but still afford them time on their own." Another support worker was mindful of what they wanted to tell us and asked, "Is it alright to say who this information relates to?" before explaining their example of the support a person needed.

Good

Is the service responsive?

Our findings

At the last inspection the provider was in breach of regulation 9: Person-centred care. This was because support plans were not always followed regarding people's communication systems and nutritional needs.

At this inspection we found that people's support plans were being followed and support workers understood their responsibilities to ensure people's needs were met according to their plans. We found that people's communication and nutritional needs were met.

However, sometimes people made choices that deviated from agreed support plans. For example, one person who was encouraged by a dietician to eat a healthy weight reducing diet to aid their health conditions (diabetes, high blood pressure and asthma) had capacity to say what they liked and did not like, and so sometimes they chose to eat food that was not healthy. No amount of encouragement could persuade them otherwise, but support workers continued to look for alternative ways of encouraging them to eat healthily.

People had support plans that were person-centred and informed support workers on how best to meet people's needs. They contained information under several areas of need and personal risk assessments to show how risks to people were reduced or managed. For example, with nutrition, medicines, going out in the community, using public transport or the service's vehicle and when taking part in development of life skills. We noted that support plans did not have a date of completion and pointed this out to the management team, who explained the format had been altered and space for recording the date must have been missed. They assured us this would be amended.

Support plans also identified when increased agitation or anxiety might arise and included bespoke de-escalation strategies. Support workers were conversant with the plans, but not all of them had signed the plans to indicate they had read them. While support plans were person-centred and believed by managers and support workers to be reflective of positive behaviour support (PBS) theory and practice, we found that PBS was not inherent throughout the support plans. PBS was used only at times when people's behaviour was anxious or distressed. PBS could have been used more intensely to help people achieve improved lifestyles free from anxiety.

PBS is a person centred framework for providing long-term support to people with a learning disability, and/or autism, including those with mental health conditions, who have, or may be at risk of developing, behaviour that challenges support workers. It is a blend of person centred values and behavioural science and uses evidence to inform decision-making. Behaviour that challenges usually happens for a reason and maybe the person's only way of communicating an unmet need. PBS helps us understand the reason for the behaviour so we can better meet people's needs, enhance their quality of life and reduce the likelihood that the behaviour will happen.

Activities were held either in-house with support workers or mostly out in the community. These included karaoke, bingo, guessing games, swimming, walking and visiting parks. People told us about the pastimes

they engaged in, where and when. We saw items in place for electronic games and simple pastimes, including board games, jig-saws and books. People had their own electronic musical and computer equipment.

People sometimes watched television and on the day we visited one person was watching a DVD with their support worker. Another person completed a jig-saw and a third person played music on their personal headphones, while a fourth completed some drawing and colouring. We were told that a local sports event had been held recently for people, which was greatly enjoyed. Other events included trampoline, barbecues and firework displays.

Support workers recognised that it was important to provide people with as much choice of activity as possible, so that people continued to make decisions for themselves and stay in control of their lives. People chose the food they ate each day, where they relaxed, who with, when they got up or went to bed, what they wore each day and whether or not they went out or joined in with entertainment and activities. People's needs and choices were therefore respected.

People's relationships were respected and support workers assisted people to keep in touch with family and friends. Support workers encouraged people to receive visitors and to visit family wherever possible, as well as remember family birthdays and anniversaries.

A complaint policy and procedure was in place and the service had forms to complete whenever anyone had concerns about or was unhappy with the service. The provider used an on-line care home monitoring system where the public and other stakeholders could anonymously post concerns or compliments. Records showed that complaints and concerns were handled within timescales and that due regard was paid to issues people raised. People we spoke with told us they knew how to complain and named support workers they trusted and would tell their concerns to. We saw that complainants had been given written details of explanations and solutions following investigations. Compliments were held in the form of letters, cards and emails.

Requires Improvement

Is the service well-led?

Our findings

People told us they thought the service had a busy but pleasant atmosphere. Support workers described the culture of the service as "Challenging, cheerful, dedicated and rewarding."

At the last inspection the provider was in breach of regulation 17: Good governance. This was because records were not always accurately maintained.

At this inspection we found that much improvement had been made and records were up-to-date and relevant. However, further improvements were still needed as other minor issues were noted. For example, one or two documents (two support plans and some best interest records) were not dated or did not contain names and the views of all interested parties. These were discussed with the management team who undertook to rectify the issues. We recommend that the names of all stakeholders involved in best interest decisions and the contributions they make to those decisions, be recorded on the documentation as evidence of their involvement.

The management team and support workers accurately maintained other records regarding people that used the service, employees and the running of the service. These were in line with the requirements of regulation and we saw that they were up-to-date and appropriately and securely held.

At the time of our inspection there had been no registered manager in post for the past three days. A service that does not have a registered manager in place cannot receive a higher rating than 'requires improvement' in the well-led domain as the registered provider is in breach of the conditions of their registration. The management team (acting area manager and acting head of services) were managing the service in the interim. Management responsibility was to be passed to a registered manager of a sister service close by, on their imminent return from leave of absence.

The provider and the management team were fully aware of the need to maintain their 'duty of candour' (responsibility to be honest and to apologise for any mistakes made). The service fulfilled its responsibility to ensure any required notifications were passed to the Commission regarding accidents/incidents, interventions or untoward events.

The management style of the management team was open, inclusive and approachable. Staff told us they expressed concerns or ideas freely and felt these were positively considered.

People were supported to maintain links with the local community where possible, through social integration in the village and towns nearby. People visited shops, stores, cafes and places of entertainment. Relatives played an important role in helping people to keep in touch with the community by supporting them to visit places of entertainment as well as family homes.

We looked at documents relating to the service's system of monitoring and quality assuring the delivery of the service. We saw that there were quality audits completed on a regular basis and that satisfaction

surveys were issued to people that used the service, relatives and health care professionals.

Some of the quality audits were carried out by the management team and others by the organisation's appointed quality monitoring team at the end of each month. Audits were detailed and covered many aspects of the service delivery. Information was analysed and presented in visual format as well as a written report on the areas requiring improvement. An action plan was produced each time an audit was completed and information on action taken was carried forward to show how issues had been addressed. Information was also sent to the organisation's head office on a weekly basis about, for example, staffing figures, financial returns, incidents and accidents.

We found the audits completed by the management team on people's care records were insufficiently effective, because these had not picked up that 'best interest' records did not show evidence of who had been consulted regarding the decisions made. Nor had they picked up that 'physical intervention' records failed to show the length of time people were restrained.

People completed satisfaction surveys with the help of support workers or family members, but we were told that health care professionals hardly ever completed any.

Contact we made with placing local authority contractors and social workers before the inspection revealed positive comments. One social worker informed us 'I have had contact with the care provider and undertaken one multi-disciplinary team (MDT) meeting along with family members. I have not undertaken a reassessment of my client yet as this is not due until next year, although generally I would undertake an interim visit which will be due In August 2017.' They also informed us 'My contact with the care provider has to date been positive. I have established good contact with the placement manager and we have been able to work with my client's family to maintain a positive start to the placement. The support also appears to be positive and my client is settled and well supported. Some issues have arisen In placement and we are actively addressing these. I have requested that some therapeutic support is made available from within the provider's MDT as well as contact being made with the local Community Learning Disability Team as necessary. I found the manager responsive to suggestions around use of an advocate, for which a referral was made, and generally there seems to be a determination to offer the best and most appropriate support to my client.'

We did not see any completed support worker surveys. However, the management team explained that workshops were held for support workers where they discussed and explored, for example, personalising situations and were given opportunities to de-stress. Managers and senior support workers were trained to recognise when employees were stressed and were therefore offered guidance and opportunities to talk and de-brief.

Records were securely held on the premises and ensured confidentiality regarding people's information.