Milestones Trust

8 Chestnut Road

Inspection report

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29 April 2016

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

8 Chestnuts provides accommodation and personal care for up to five people who have a learning disability. There was one person accommodated at the time of the inspection. This was an announced inspection, which meant the staff and provider knew we would be visiting. This was because there were often times when there was no one at the service as they were out and about in the community. This inspection took place on the 26 and 29 April 2016.

There was a registered manager in post who also worked at another registered home which was part of Milestone Trust. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had delegated the day to day management responsibility to a team leader.

Due to the nature of the service and that only one person was living in the home at the time of the inspection. We have not included our evidence in the main body of the report to protect the confidentiality of the person. The full report has been shared with the provider.

The person benefited from a service that was tailored to their individual care and support needs. Staff supported the person throughout the day and night on a one to one basis. Staff felt isolated. External support systems that were provided were not as effective as they should have been in supporting the staff remotely. The person's behavioural care plan requires more information to guide staff to meet the person's needs consistently.

The person was protected from the risk of abuse because there were clear procedures in place to recognise and respond to abuse and staff had been trained in how to follow these procedures. Systems were in place to ensure the person was safe. These included risk management, checks on the environment and safe recruitment processes. Staff knew what to do to keep the person safe.

A care plan was in place that clearly described how the person wanted to be supported. This was tailored to the person. Care was effective and responsive to person's changing needs. The person had access to healthcare professionals when they became unwell or required specialist advice. The person received their medicines safely.

The person's rights were upheld and they were involved in decisions about their care and support. Where decisions were more complex these had been discussed with relatives and other health care professionals to ensure it was in the person's best interest. Staff were knowledgeable about legislation to protect people in relation to making decisions and safeguards in respect of deprivation of liberty safeguards. An appropriate application had been made in respect of these safeguards ensuring the person was protected.

Staff had received appropriate training to support the person living at the service. Staff were supported in their role and received regular supervisions. Supervisions are where a member of staff meets with a senior manager to discuss their role, performance and training needs.

Systems were in place to ensure that any complaints were responded to. The person's views were sought through an annual survey and through monthly meetings.

The staff, the team leader and a representative from Milestones Trust completed regular checks on the systems that were in operation in the home to ensure they were effective.

The person was provided with an effective, caring and responsive service that was well led. The organisation's values and philosophy were clearly explained to staff.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. This was because there was risks that had not been fully assessed and guidance made available to staff. Staff did not always feel safe and felt isolated.

Systems were in place to protect people from the risk of abuse. This was because there were clear procedures in place to recognise and respond to any abuse. Staff were trained in how to follow the procedures.
The environment was clean. Risks had been identified with guidance in place to minimise an occurrence. The person was receiving their medicines as prescribed.

Is the service effective?

Good

The service was effective in meeting the needs of the person. They were clearly involved in making decisions about their care and support. Staff were aware of the legislation to protect the rights of the person and applied this to their everyday practice.

The person was involved in the planning of their menu and supported to make healthy choices. The person had access to health and social care professionals.

The person was supported by staff who knew them well and had received the appropriate training.

Is the service caring?

Good

The service was caring.

The person and their relative thought the staff were approachable and kind. The person was supported in an individualised way and was involved in their plans of care to ensure their wishes were taken into account.

We observed there was a good interaction between staff and person who used the service.

Is the service responsive?

Good

The service was responsive.

Care was based around the person's needs and aspirations. Staff were creative in ways of ensuring the person led an active and fulfilling live. Activities were planned with the person both in the community and within their home. This included keeping in contact with friends and family.

Staff were knowledgeable about how to support the person. Care plans clearly described how the person should be supported. The person was very much involved in developing and reviewing their plan of care. Staff actively listened to the person and responded appropriately to any concerns or suggestions.

There were systems in place to raise concerns.

Is the service well-led?

Good

The service was well led.

Staff were clear on their roles and aims and objectives of the service and supporting people in an individualised way and encouraging them to take control over how they wanted to live. People's views were sought in driving improvement to the service.

Staff described a cohesive team with the team leader working alongside them. Staff told us they felt supported both by the management of the service and the team. The registered manager was manager for another service and had delegated the majority of the responsibilities to the team leader.

The quality of the service was regularly reviewed by the provider/registered manager and staff.

8 Chestnut Road

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 was an announced inspection which was completed on 26 and 29 April 2016. The inspection was completed by one adult social care inspector. The previous inspection was completed in February 2013 there were no breaches of regulation at that time. This service had been dormant for over 12 months in 2014 until the present person moved to the home in June 2015.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they planned to make.

We reviewed the information included in the PIR along with information we held about the home. This included notifications, which is information about important events which the service is required to send us by law.

We contacted four health and social care professionals to obtain their views on the service and how it was being managed. This included professionals from the local community learning disability team and a consultant psychiatrist.

During the inspection we looked at the care records for the one person living at the service and records relating to the running of the home. This included staffing rotas, policies and procedures, quality checks that had been completed, supervision and training information for staff. We spoke with two members of staff and the operations manager and the registered manager in person, and two members of staff by telephone. We also contacted another service to speak with staff there that provided support to the staff by telephone

We spent time speaking with the person living at 8 Chestnut Road. Records relating to the recruitment of staff were held at the main Milestone Trust office so we were unable to check on this occasion. Before the

inspection we contacted a relative by telephone to ask about their experience of the care and support the person received.

Requires Improvement

Is the service safe?

Our findings

8 Chestnut Road supports one person. We inspected all areas of this question and found there were some areas that required improvement to ensure the safety of the person. As there is only one person it was not in the best interest of the person to publish the full report of our evidence. This was because we could be infringing on this person's right to confidentiality. A full report has been sent to the provider so they had the full information on how we reached our judgements.

There were two breaches in respect safety.

We found that the registered person had not ensured there were suitable numbers of staff. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

During the inspection we contacted the provider who had put in interim measures to make sure the person was safe.

We found that the registered person had not ensured there was sufficient information to guide staff in supporting the person safely in the community in the event of an incident escalating. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

Good

Is the service effective?

Our findings

8 Chestnut Road supports one person. We inspected all areas of this question and found the person was being provided with a service that was effective in meeting their needs. As there is only one person it was not in the best interest of the person to publish the full report of our evidence. This was because we could be infringing on this person's right to confidentiality. A full report has been sent to the provider so they had the full information on how we reached our judgements.

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Is the service caring?

Our findings

8 Chestnut Road supports one person. We inspected all areas of this question and found the person was being provided with a service that was responsive in meeting their needs. As there is only one person it was not in the best interest of the person to publish the full report of our evidence. This was because we could be infringing on this person's right to confidentiality. A full report has been sent to the provider so they had the full information on how we reached our judgements.

Good

Is the service responsive?

Our findings

8 Chestnut Road supports one person. We inspected all areas of this question and found the person was being provided with a service that was responsive in meeting the person's needs. As there is only one person it was not in the best interest of the person to publish the full report of our evidence. This was because we could be infringing on this person's right to confidentiality. A full report has been sent to the provider so they had the full information on how we reached our judgements.

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Is the service well-led?

Our findings

8 Chestnut Road supports one person. We inspected all areas of this question and found the person was being provided with a service that was well led. As there is only one person it was not in the best interest of the person to publish the full report of our evidence. This was because we could be infringing on this person's right to confidentiality. A full report has been sent to the provider so they had the full information on how we reached our judgements.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 12 HSCA RA Regulations 2014 Safe care and treatment We found that the registered person had not ensured there was sufficient information to guide staff in supporting the person safely in the community in the event of an incident escalating. Regulation 12 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing We found that the registered person had not ensured there were suitable numbers of staff ensuring the welfare of the person and the safety of the staff. Regulation 18 (1)