Achieve Together Limited

Ashton

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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**

Summary of findings

Overall summary

About the service
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Ashton is a supported living service which provides support to people living in their own home. The service can support up to six people with a learning disability. CQC only inspects services where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time of our inspection six people were receiving personal care and support.

People's experience of using this service and what we found

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right Support: The model of care and setting did not always maximise people's choice, control and independence. For some people, living in a remote setting meant it was more difficult to access the community as their needs changed. The management team had plans to mitigate these concerns by looking at different transport options. However, these plans had not yet been embedded into practice which meant some people's options were limited. Some people living at Ashton were able to make use of the local bus service and enjoyed the rural location.

Right Care: People's care was not always person-centred and did not always promote people's dignity and privacy. Staff did not always support people in a warm and respectful way. People were not always offered comfort when they were upset. Staff did not always show regard for people's comfort or enjoyment and some of the ways staff described people's support did not show respect. At other times we found staff treated people with kindness and took time to make sure they were comfortable and were enjoying what they were doing. People had access to healthcare professionals and were supported by staff to attend appointments.

Right Culture: The ethos, values, attitudes and behaviours of care staff did not always ensure people led confident, inclusive and empowered lives. The positive values and attitudes of the management team were not consistently embedded into the culture of the staff team. This meant people's care was not always personalised and centred around the individual.

Risks to people's safety were not always robustly assessed, monitored and managed. People were not

always supported when anxious which put them and others at risk of harm. Assessments were not robustly completed and the provider had not ensured that information was shared between services. This meant they were unable to assure themselves people's needs could be safely met.

People had allocated one to one hours although it was not always clear how these hours were used and how this benefitted the individuals. People's records showed they enjoyed going out to places such as eating out, going to the cinema or bowling. Staff were unable to tell us about people's preferred options and people did not have the opportunity to access the things they enjoyed doing on a regular basis. People's sensory needs were not always supported and communication plans were not followed to enable people to be more involved in planning their care. Although people were supported to eat and drink, they were not always offered meaningful choices or options.

There was a lack of management oversight of the service. Quality assurance processes were not always effective in developing the service to make sure people had choices and were fully involved in making decisions regarding what they wanted to do and who they would like to live with. Records were not personalised and lacked detailed information in relation to the care provided to people.

Lessons were learnt from incidents and accidents which helped to keep people safe. Where concerns regarding medicines management were identified measures were taken and the issues addressed. Safeguarding concerns were taken seriously, reported and investigated in line with the guidance. People appeared comfortable in the company of staff and went to members of the management team if they had any concerns. Relatives and professionals who visited the service regularly were positive about the staff and described them as caring and kind.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This was the first inspection since the service registered with us on 1 December 2020. This is an established service which registered under a new provider on this date.

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support right care right culture.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to people safe care and treatment, person-centred care and the governance of the service. We issued Warning Notices to the provider in relation to Person-centred care and Good governance.

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.

Details are in our responsive findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Ashton

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
Two inspectors carried out the inspection. Following the first day of our inspection an Expert by Experience contacted relatives to gain their views of the service their loved ones received. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service provides care and support to people living in a 'supported living' setting, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave 24 hours' notice of the inspection to request consent from people to visit their home.

Inspection activity started on 18 January 2022 and ended on 31 January 202. We visited the office location on 18 January 2022 and 26 January 2022.

What we did before inspection
We reviewed information we had received about the service since the last inspection. This included safeguarding information and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service throughout our inspection visits to gain their views. Where people were unable to unable to talk to us, we observed their body language, interactions with staff and viewed things they wanted to show us which were important to them. We spoke with three relatives about their experience of the care provided to their loved ones. We spoke with seven members of staff including the registered manager and regional manager.

We reviewed a range of records. This included four people's care records and two people's medication records. We looked at three staff files in relation to recruitment and training records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visited the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● We received mixed responses from relatives in relation to staff understanding risks to their loved ones. One relative told us, "They understand (person) can fall easily and needs help with that. I know they do all they can." A second relative indicated they did not feel staff were fully aware of potential risks.

● People did not always live safely because staff and the management team did not always assess, monitor and manage safety well. One person's needs in relation to their anxieties and how these impacted on others were not fully known to staff and limited guidance was available to support them. The risk assessment and guidance in place did not give detailed direction of how staff should identify the persons anxiety levels were increasing. There were no strategies for supporting them to manage their distress or information regarding how to respond to behaviours which put the person and others at risk. Following the inspection, the registered manager put measures in place to reduce the risk to the person and others.

● Risks to people's health and well-being were not always closely monitored. Due to a health condition two people's fluid intake required careful monitoring. One person's records did not clearly state any limit on their fluid intake and staff were not aware what the limit should be. Staff did not always record people's fluid intake and when it was completed, it was not always calculated through the day. This meant staff were unable to assure themselves people were not drinking more than recommended in order to monitor risks to their health.

● People's risk management plans were not always followed in relation to their health needs. One person's epilepsy plan stated they required rescue medicines to be administered should they experience a seizure lasting more than three minutes and an ambulance should be called. Training records showed not all staff had received training in the administration of rescue medicines. We asked the registered manager how this was managed. They told us staff had been informed to call an ambulance immediately as it was so long since the person had experienced a seizure it would be advisable for them to be reviewed by a health professional. However, this did not take into account the likelihood the ambulance would take longer to arrive than the three minute recommended period prior to rescue medicines being administered. The registered manager assured us this would be addressed.

The failure to ensure risks to people's safety were robustly assessed and monitored was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● In other areas we found risks to people's safety were managed well. Staff recognised signs when some people experienced emotional distress and knew how to support them to minimise this. One person showed signs of anxiety when particular topics of conversation were raised. Staff worked around these

conversations and moved on to topics they knew the person enjoyed. Staff were able to describe how they supported the person to reduce their anxiety by supporting them with different things they enjoyed doing.
● Staff managed the safety of the living environment and equipment through regular safety checks to minimise risk. Regular fire checks and drills were completed to ensure people and staff were aware of how to respond in the event of a fire. Personal emergency evacuation plans were in place to guide emergency services of the support people would require leaving the building.

Systems and processes to safeguard people from the risk of abuse
● Staff received safeguarding training. They knew how they would recognise and report abuse. Staff members were able to describe the types of potential abuse to be aware of, signs of concern and reporting procedures. One staff member told us, "It's stressed in team meetings what we should do should we see or suspect any abuse. We talk through the whistle blowing procedure and we have been empowered to know we can speak to any manager."
● People and those who matter to them had safeguarding information available in pictorial information and relatives confirmed they would be able to raise concerns with the management team and local authority. People appeared relaxed in the company of staff and approached the registered manager or regional manager to tell them about what was happening with their day and how they were feeling.
● Where safeguarding concerns were identified these were reported to the local authority in line with guidance. Records showed that where medicines errors had occurred these had been reported as required. Where the local authority requested additional information, this was provided to ensure any concerns could be investigated and the relevant action taken.

Learning lessons when things go wrong
● Staff raised concerns and recorded incidents and near misses and this helped keep people safe. Staff completed accident and incident forms when they found concerns. These were then reviewed by the registered manager and action taken to minimise risks of concerns happening again. This information was then shared on the central system and reviewed by senior managers looking at safety and quality. Any additional recommendations were then actioned by the management team.
● Action taken following concerns being identified led to a reduction in incidents. An analysis of incidents showed a number of medicines errors had occurred. The registered manager and regional manager organised enhanced training for staff and a full audit of medicines systems from an external professional. The learning from these actions had been implemented, since which time there had been no medicines errors.

Staffing and recruitment
● There were sufficient staff on each shift to meet people assessed hours of support, including one to one hours. However, schedules and records did not always reflect how people's one to one hours were used or how they benefitted from this support. The regional manager had identified this within their recent audit and the registered manager told us they were in the process of discussing this with people and staff to develop the use of one to one hours and how this would be recorded.
● There were a number of staff vacancies which meant agency staff were frequently employed. The registered manager told us they tried to mitigate the impact of this by ensuring regular agency staff were used so people got to know them. People appeared comfortable with all staff present during our inspection.
● Staff recruitment and induction training processes promoted safety, including those for agency staff. Prior to being employed, a range of checks were completed to help ensure staff were suitable for their roles. These included a face to face interview, a review of previous employment and references, health screening and a Disclosure and Barring Service (DBS) check. Profiles of safety checks completed for agency staff were reviewed by the registered manager prior to them working at the service.

Using medicines safely

● The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured that people's medicines were reviewed by prescribers in line with these principles. People had been supported to reduce the use of anti-psychotic medicines they had been prescribed many years previously.

● Careful monitoring to gauge the impact of the changes meant regular adjustments were able to be made to get the right balance for people. The registered manager told us the changes had had a positive impact on people's general health and well-being.

● People received their medicines safely as robust medicines systems were in place. Each person had a medicines administration record which contained the information required regarding people's prescribed medicines. Staff signed the record and completed a stock balance following each administration. Where people were prescribed 'as and when required' medicines (PRN), guidance on when and how these should be offered and administered were in place.

● People could take their medicines in private should they wish. We observed staff asking people where they would prefer to take their medicines and offered to support them to their rooms for privacy.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

● The provider had ensured people were able to receive visitors in line with government guidance. People were also supported to maintain contact with their loved ones on the telephone. One person and their family told us staff frequently helped them to phone their family which was important to them.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Comprehensive assessments of people's physical and mental health were not always completed prior to someone moving into Ashton and receiving support. This meant staff were not fully aware of people's needs. They were not able to anticipate potential behaviours towards others and provide safe and appropriate support should people become distressed.
- The provider had not ensured different departments and services worked together to ensure detailed and robust information was shared when people moved. The registered manager told us they had received limited information in relation to the persons needs when a person moved to Ashton from another Achieve Together service. They said they had made attempts to contact the manager of the other service but had received no response. They described the information provided on the day the person moved in as limited.
- Care plans did not always reflect an accurate picture of people's needs and information was not always known to staff. Parts of one person's care plan referred to another person living at Ashton. Despite this, staff had signed to say they had read and understood the information. This error had not been raised with the registered manager. Information in people's care plans included where they liked to go when they went out. However, staff we spoke were not aware of this information.

The failure to ensure people's needs were robustly assessed and care plans contained detailed information was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- For some people we found care plans were detailed and contained information regarding how they liked to be supported and their aspirations. The registered manager told they were in the process of reviewing people's care records. We found care plans they had completed contained more personalised information and were more reflective of people's preferences and personalities.

Supporting people to eat and drink enough to maintain a balanced diet

- Staff were aware of people's likes and dislikes although people were not always offered choices in relation to their meals. One person was known to prefer a different menu to other people and had a pictorial file to aid them in making choices. This file was not used to support other people in making decisions.
- A menu was on display covering a four-week cycle. Staff told us this was followed but if people wanted anything different this was provided. However, people were not always consulted about the different options available to them. For example, at lunchtime on the first day of our inspection one person was asked if they would like pizza. This was then made for two other people without a choice being offered. A

third person who needed their food to be of a soft consistently was not offered a choice.

The failure to ensure people were consistently offered a choice of food was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● People received support to eat and drink enough to maintain a balanced diet. Staff were mindful that people had enough to eat and drink. Encouragement and support was offered to people when needed. One person chose not to eat with everyone else. Staff did not pressure the person into eating in the dining room. They understood the person did not always like to eat in the dining room and supported them to eat in their room if this was their preference.
● People could have a drink or snack at any time. One staff member told us, "They can help themselves to anything. We always make sure fruit is left out to encourage them or they can see what is in their cupboards." People who required support to make a drink or get a snack told staff when they wanted something and staff responded to them promptly.

Adapting service, design, decoration to meet people's needs
● Staff were supporting people to make their rooms more personalised, to better reflect their tastes and interests. One person's room contained very few personal items and was in need of decoration. A second persons room had no specific storage to keep their personal belongings tidy, this meant it was difficult to find what they wanted in their room. The registered manager told us people were being supported to look at ideas to make their rooms more personalised. They were able to describe plans such as the colours and themes people had chosen. The registered manager was confident these changes would be completed soon although no timescales had been set for when the improvements would be actioned.
● One person was known to enjoy sensory stimulation. There were no specific areas within the home to support this. The regional manager told us there were plans for adaptations to be made to an external building to create a sensory area although this had yet to be confirmed.
● The layout of the lounge and dining areas meant people were able to move around easily. The open plan design meant people were able to access the kitchen freely. The separate dining area also allowed people to sit quietly should they choose to do so. Where people required specific equipment to be fitted to aid their mobility or movement this was in place.
● People received support to maintain their home. The registered manager had submitted regular requests to the landlord for decoration as this had not been completed for a number of years.

Staff support: induction, training, skills and experience
● Staff told us they felt the training they received was useful and relevant to their roles. One staff member told us, "The webinars and courses helped and had tests of your knowledge which was useful. I shadowed (staff member) for a while when I started. It's a nice team so that also helps to feel welcome."
● The management team and staff told us adjustments to training had been made quickly to account for COVID-19 lockdown measures. Staff completed both eLearning and face to face training. Courses covered areas including learning disability and autism, medicines, health and safety and safeguarding. Where refresher training was required, records showed this was scheduled within the next two months. The registered manager told us they had worked hard to ensure staff completed their training and were now looking to ensure this was embedded through mentoring and observations of staff practice.
● People's care was adjusted when their needs changed as staff had the training required to support them. One person's mobility needs changed which required staff to provide additional support for them to move and transfer. Staff had received training in this area and were able to support the person to adjust.
● Staff told us they felt supported in their roles and received regular supervisions. The regional and registered manager were able to describe conversations held with individual staff members to support them

in developing their practice. This included discussions on how staff could further personalise their approach in the way they supported people as part of the overall development plan for the service.

Supporting people to live healthier lives, access healthcare services and support

● People had health action plans which detailed the support they needed to remain healthy. This included areas such as foot and nail care, oral health care, male/female health and other health issues specific to the person. Plans included details from healthcare professional's advice. One person had been assessed as requiring their diet to be of a modified consistency and to have a dysphagia cup to help them drink more safely. We saw both of these things were in place and known to staff.

● People were registered with a GP and referred to health care professionals to support their wellbeing. One person's health needs and mobility had changed. Referrals had been made both directly and through the GP to specialist healthcare professionals. Where long waiting times presented concerns the registered manager ensured referrals were regularly chased up. People were supported to attend appointments both online and in person. Outcomes of appointments were recorded and any recommendations such as blood tests or medicines changes were followed up.

● People were supported to attend annual health checks, screening and primary care services. This meant people and staff had the opportunity to discuss any changes and have a full review of people's health and well-being.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

● People's capacity to make and consent to decisions about specific aspects of their care and support had been assessed and recorded. This included decisions regarding having 24-hour support and medical interventions such as the COVID-19 vaccine. Where people were found not to have the capacity to consent to certain decisions these were made in their best interests and their preferences taken into account.

● Processes took into account that people's capacity may fluctuate. One person's records reflected staff should wait until the person was well before assessing their capacity in making specific decisions.

● Staff we spoke with understood the principles of the MCA. One staff member told us, "We must respect people's choices regarding what they want. We must be flexible with how we approach people. The MCA is there for big decisions to assess their capacity and if they do not have capacity, we review what is in their best interests."

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People were not always supported with warmth and staff were not always attentive to their emotions. We observed a situation where one person appeared anxious and raised their voice at another person who began to cry. Once the person crying returned to the lounge a staff member placed a drink in front of them and said, "Drink your tea" before walking away. Staff did not offer either person any comfort or help people communicate what the issue was. We asked one staff member about the incident. They told us, "This is how it always is because they have known each other for years." Another staff member said, "That's how they are but the next minute they will be best friends." This approach did not take into account people's feelings at the time of the upset and did not follow care plans which instructed staff to intervene to support both people.
- Staff did not always show an interest in people's quality of life. On the first day of our inspection we observed one person spent the day watching films in the lounge. The person alerted us to the television flicking on and off making it very difficult to watch. We approached staff about this. They told us they were aware but there was nothing they could do as it was a problem with the aerial. They did not engage with the person to tell them what the issue was or how they could support them to rectify this. We informed the regional manager who immediately organised for new equipment to be collected so the problem could be addressed.
- Staff did not always demonstrate a respectful approach to people's privacy. One person informed staff they wanted to use the toilet. Staff shared this information between them in the lounge and agreed how and where they would support the person. They then relayed this to the person, again in the lounge, in front of other people. On other occasions we observed staff supported people with their personal care discreetly and helped them to adjust their clothing and fasten buttons to maintain their dignity.
- People did not always have the opportunity to try new experiences and widen their social network. We asked staff what different things people had tried or if people went out in the evenings. Staff told us people had routines they enjoyed and they rarely went out in the evenings and they did not believe this would be their preference. They were unable to tell us when people had last been offered the opportunity to try something new or to go out in the evening.
- People's records were not always written in a respectful way. For example, information about people's personal care support was regularly recorded within how people had chosen to spend their day. This demonstrated the approach of some staff was more functional than person-centred.
- People were not always consulted about decisions affecting their home. People had not been consulted when it was proposed a person moved into their home. Neither party had been given the opportunity to

meet or given information regarding each other.

The failure to ensure people's feelings and dignity were consistently respected was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● At other times we observed staff approached people with kindness and listened to their views. One person asked staff for specific puzzles from their room. Staff asked questions to clarify and ensure they got the right one. When another person became upset, staff supported them with kindness and tried to understand what had upset them. One person was excited about the new DVD equipment and wanted to set this up whilst others were watching television. Staff supported the person to focus on other things until there was a good time to do this.
● Staff knew people's routines and when they needed their space and privacy and this was respected. We saw people had the opportunity to spend time in their rooms or have company in the lounge if they wished. Staff told us on occasions one person preferred to spend their time in bed if they were not feeling well and this was respected.

Supporting people to express their views and be involved in making decisions about their care
● Support plans were written by staff members who had knowledge of people's routines, likes and dislikes. However, plans did not demonstrate how people were involved in developing their support plans or how they wished to use their support hours. Support plans were mainly in a written format which the majority of people living at Ashton would find difficult to understand. No photographs or creative ways of presenting people's support plans had been used to make them more personalised and accessible to people. Relatives told us that they were invited to reviews of their loved one's care and felt able to contribute but had not seen their support plans.
● Staff supported people to maintain links with those that were important to them. One person told us they liked to make a call to their family twice each week and staff supported them to do this. The person's relative confirmed this was the case and told us staff were always supporting when they called.
● People were enabled to make day to day choices for themselves such as where to spend their time in the house, what clothes to wear, films they would like to watch and what drinks they would prefer. However, the range of options for how people spent their time was limited. The registered manager acknowledged this was the case and assured us this was something they were looking to address.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them; Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People were not supported to participate in their chosen social and leisure interests on a regular basis. People's care plans contained information about the things they enjoyed doing such as going to the cinema, bowling, going out to eat or to have a beer. However, records of how people had spent their time did not show people were supported to do these things regularly. We asked staff members when people last went out to do the things they enjoyed. Staff told us it had been a long time since these things had been planned. One staff member told us, "To be honest I don't know why we don't do these things more. We should make more of an effort now lockdown is over. It needs to be planned more. If it's not planned in advance, we get busy with other things and it doesn't happen."
- Records for one person showed they enjoyed going out for meals and to the cinema. There was no information regarding the types of films they liked or where they liked to eat. Records for the first three weeks of January showed they had been for a walk on three occasions and once to a day service for people with a learning disability. Staff were not aware of the information in the persons support plan. One staff member told us, "(Person) likes going for a walk around the (site)." Another person's records also showed that with the exception of attending day services they had not been out in the first three weeks of January. This did not demonstrate a personalised approach to supporting people to do things they enjoyed.
- Where people's needs changed these were not responded to quickly to enable people to continue to do things they enjoyed. Due to changes in one person's mobility they were no longer able to access a standard taxi and adapted transport was too costly. Access to other community and voluntary transport had not been fully explored. This meant the person had not been able to access the day service or go to town for several months. During the inspection different types of transport were discussed. The registered manager followed up on this which resulted in the person being able to start accessing the things they enjoyed doing.
- How people spent their time when at home was not always planned or different options explored. On the first day of our inspection we found there were few options offered to people apart from watching television or doing puzzles. One person's support plan highlighted they enjoyed sensory activities, particularly things they could feel and smell. Our observations and records showed these areas were not regularly explored with the person with only one sensory item repeatedly offered.
- The regional manager told us the service promoted, 'Active Support' to encourage and enable people to be involved in day to day living tasks and promote independence. We observed this was the case for one person who was involved in meal preparation and cleaning. However, we did not see others being encouraged and supported in this same way when the management team were not present. Staff were observed to make people's drinks, clear tables, make meals and do the laundry without people's involvement.

● Staff did not always spend time with people or show an interest in what they were doing. During the first day of our inspection we observed little interaction with people. Staff did not sit and chat with people about what they were doing or offer opportunities to get involved with day to day household tasks. The registered manager told us they recognised this was an area which some staff needed support to develop.

The lack of opportunities for people to take part in things they enjoyed, develop interests and personalised support was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● In other instances, we found people were able to pursue their interests and take part in things they enjoyed. One person told us they liked to keep busy and did their housework everyday which they enjoyed. They told us they also enjoyed walking and horse-riding which they had been doing for many years and travelled by bus to get there. We saw the person was involved in preparing vegetables for the evening meal on both days of our inspection. Staff told us the person liked to write what they had done in the day alongside staff and we saw they were supported to do this.
● On the second day of our inspection staff were more proactive in the support and options they offered people. One staff member sat with people doing arts and crafts and then encouraged people to join in with singing for a short while which people seemed happy with.
● People had support from a visiting aromatherapist/reflexology and art therapist who came to their home. One person who did not always respond well to touch had shown they enjoyed having their hands massaged by smiling and holding their hands out when the aromatherapist approached them. The registered manager told us people had chosen which of their artwork they wanted displayed and where this was hung in the dining room. One person showed us their work and was clearly pleased to see it on display.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People's communication plans were not always adjusted and followed to ensure information was presented to them clearly. One person's communication plan stated, due to their hearing impairment, they communicated through lip reading, using pictures and gestures. No adjustments had been made to the persons plan or support as a result of staff wearing masks which meant the person could no longer lip read. Staff did not use any pictorial form of communication and did not know if the person had pictures available to them. We observed staff responding to the person verbally, not acknowledging the person would not be able to hear them or lip read. The person then repeated their exchange a few minutes later or went to another staff member. At times they demonstrated clear frustration but this was not identified by staff. The registered manager told us the person was very skilled at making themselves understood by using gestures, pointing and guiding staff to what they wanted. However, this did not acknowledge the person did not always receive a response they were able to understand.
● Another person's communication plan was very brief and did not guide staff as to the best way to offer the person choices or how to understand their response. This stated the person used a particular gesture which could mean a variety of different things but there was no guidance regarding what these may be. The plan went onto say the person responded well to the use of, 'now and next' but did not provide guidance on the context of how this should be used or if pictures should accompany this communication. Staff were not seen using this style of communication when supporting the person. There was no information within the

person's plan regarding how they were encouraged or supported to make requests or communicate their wishes. We observed the person responded to staff when asked a direct question such as if they wanted a drink but otherwise communication was very limited.
● The regional manager and registered manager told us they had researched a communications library they were looking to join. This gave access to different types of technology and communication aids which people could trial to see if they suited their needs.

The failure to ensure people had effective communication plans and that information was presented in a way they could understand was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● In other areas we found people's communication plans were known to staff and followed. Staff knelt or sat beside people when speaking to them and were heard to repeat what the person had communicated to check they had understood correctly. Staff understood how to present information to one person to ensure they did not make them anxious.

Improving care quality in response to complaints or concerns
● Relatives told us they felt the registered manager was open to discuss any concerns they may have. One relative told us, "I'd speak to the manager first. I'm sure I would be listened to. I have no complaints or concerns."
● The registered manager and regional manager spent time with people and knew them well. People appeared comfortable in their presence and were seen to approach them for support in sorting out problems on a day to day level.
● The provider had a complaints policy in place which set out how complaints could be made, timescales and how they would be responded to. The registered manager told us they had not received any complaints in the past year.

End of life care and support
● No one was receiving end of life care at the time of our inspection. Records showed that staff had started to discuss people's wishes with them and their relatives/advocates. The registered manager told us, "We have discussed this as a team. We need to be sensitive to people and ask them things gradually."

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;

- The culture of the service did not always value people's individuality and work towards positive outcomes for people. Staff did not always engage with people and work together to create a warm and welcoming atmosphere. There was a feeling of staff completing tasks and providing care rather than being encouraging and proactive. In contrast, when the management team were with people and staff in the lounge, the atmosphere was more positive and people engaged easily with them. The regional manager and registered manager told us they had also recognised this difference. They told us they knew staff cared about people and planned to spend more time with staff to mentor and develop a more positive culture.
- Quality audits were not effective in driving improvements to the support people received. The last full audit available to us was completed in July 2021. One area of concern identified was regarding people's opportunities to engage in activities both in their home and going out. The registered manager told us they had completed weekly calls with the quality assurance team to review the action plan. Although our inspection found these areas continued to be of concern, they were no longer listed on the service improvement plan. The regional manager informed us they had identified these issues during their audit the week prior to our visit although a copy of this audit was not provided to the CQC.
- We identified other on-going concerns identified during the July 2021 audit where improvements were not evidenced. This included areas such as how support plans were written and how risks were recorded and monitored.
- There was a lack of management oversight regarding people's support hours and how these were used in supporting them to live an ordinary life. People's records and plans did not account for how the one to one funded hours were utilised for their support. Daily records and shift planners did not contain evidence of the support people received, how staff engaged with them during this time or what benefit this had been to the person. This concern had been raised within the July 2021 audit. The regional manager told us they had recently completed an audit and found the same concern. Although the management team stated staff had been informed of how information should be recorded there was no evidence of regular checks being completed to monitor progress.
- The provider failed to ensure information was shared between services to ensure people moving had a smooth transition. The provider had not considered risks and shared appropriate information in relation to a person moving from another Achieve Together service to Ashton. Systems were not in place to review decisions and people's safety in order to assure themselves this was the best move for the person and

others living at Ashton. This meant people were put at risk of harm and the potential disruption of having to move again.
● Records were not completed in a comprehensive way to show the person was at the centre of their support. Daily records concentrated on people's personal care, meals and drinks. Preferences and choices were not clearly recorded to build a picture of what the person had enjoyed, what they spoke about or how they had been supported. For example, people's records regularly reflected, "Did not decline any activities offered." However, there was no information regarding what had been offered or how they had communicated what they wanted to do.
● People were not routinely involved in service development and planning their care. The registered manager told us people found tenants meetings difficult so staff reflected people's reviews individually during monthly meetings. However, records did not evidence these meetings took place regularly. Monthly meetings for one person had only been held on four occasions during 2021. These were very brief notes and did not reflect how the person had been involved.

The failure to ensure robust oversight, effective quality assurance systems and comprehensive records was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● In other areas we found quality audits had been effective in addressing concerns. Where it was identified that improvements were required for how medicines were managed, we found these systems were now working well. Action had also been taken in relation to people's health care plans. More detailed information was available to staff and positive relationships were being built with healthcare professionals.
● Relatives told us they felt the registered manager communicated well and had been pro-active at being in touch to share information. One relative told us, "When I speak to them they give me reports and are kind about it. (Loved one) is quite happy." The registered manager told us they were in the process of sending out quality surveys to families and others involved in the service to gain their views of the support their loved ones received. They told us any feedback would then be collated into an action plan.
● Staff told us they felt valued in their roles and felt listened to. Staff reflected the registered manager and regional manager had spoken about their vision how people's support would be provided . One staff member told us, "They really want to push and get the guys here as independent as possible and to do the things they want to do. I think (registered manager) is good, she says she's grateful for all we do and she will always listen."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others
● The provider had a duty of candour policy in place which provided information as to when an incident would be reviewed under this policy and how information would be communicated. The regional manager confirmed that whilst all incidents were shared with loved ones, there had been no incidents which met the duty of candour threshold.
● Relatives confirmed that they were informed of all incidents and any health concerns involving their loved ones. One relative told us, "I do get letters saying things about reviews from health professionals. If he falls, they ring and tell me what's happened."
● Professionals who visited the service told us they were updated on any changes to people's needs and were welcomed into the service. One professional told us, "I find Ashton to be very good. I see improvements wherever (regional manager) goes and (registered manager) seems to be the same." A second professional told us, "I feel it's a nice place and if someone needs their attention, staff are there for them."
● The registered manager was involved in engagement groups which aimed to help improve care services in the local area. For example, the registered manager attended local safeguarding forums.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure people's feelings and dignity were consistently respected

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to failure to ensure risks to people's safety were robustly assessed and monitored

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people's needs were robustly assessed and care plans contained detailed information The provider had failed to ensure people were consistently offered a choice of food The provider had failed to ensure people had opportunities to take part in things they enjoyed, develop interests and to receive personalised support The provider had failed to ensure people had effective communication plans and that information was presented in a way they could understand

The enforcement action we took:

We issued a Warning Notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure robust oversight, effective quality assurance systems and comprehensive records

The enforcement action we took:

We issued a Warning Notice