Avenues London

Avenues London (South)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 08, 09 and 10 November 2017 and was announced. Avenues London (South) provides personal care and support to over 100 people with learning disabilities across south London. The service primarily focuses on providing support to people living in 'supported living' services, but also includes some domiciliary care and outreach service provision.

The service had a registered manager in post. 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.

At this inspection we found that a number of improvements were required because, whilst the provider had taken appropriate action in response to any safeguarding concerns, one staff member had not followed safeguarding procedures and had failed to report an allegation of abuse. People were supported by trained staff to take medicines, but details about the support people required was not always clear in their support plans, and records showed staff provided medicines support to one person which was not part of their assessed needs or in line with the provider's medicines management policy. Planned staffing levels have been determined based on an assessment of people's needs, but sufficient staff had not always been consistently deployed as planned. The provider had systems in place to identify issues and drive improvements, but these were not always used effectively.

Whilst we received positive feedback about the management of the service from people we spoke with, two staff told us they did not feel they received adequate support from the management team and commented negatively about the culture of the service. We followed up on these concerns with the management team and noted that attempts had been made to offer support to staff through supervision and team meetings, and that where appropriate staff performance was being managed in line with the provider's procedures. Staff had also taken action to make changes to the support they provided in response to the issues raised by the relative.

People's needs had been assessed in line with their views and preferences. Risk management plans were in place where risks to people had been identified and staff were aware of the action to take to manage identified risks safely. The provider reviewed information regarding any accidents and incidents that had occurred and took action to reduce the risk of future occurrence. They followed safe recruitment practices and supported staff through regular training and supervision.

People were protected from the risk of infections because staff had received training in infection control and food hygiene, and were aware of the steps to take to reduce the risk of the spread of infections. We observed staff following safe infection control practices. People were supported to maintain a balanced diet and were involved in decisions about what they ate. Staff were aware of the support people required to prepare and eat their meals, and supported them accordingly.

Staff were aware of the importance of seeking consent from the people they supported and demonstrated an understanding of the Mental Capacity Act 2005 and how it applied to the support they gave people to make decisions. People were supported to have maximum choice and control of their lives, and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice. People were also supported to maintain good health. They had access to a range of healthcare services, and healthcare professionals we spoke with told us staff worked well with them to deliver effective care and treatment.

Staff treated people with care and compassion. People were involved in making decisions about their care and treatment and had access to advocacy services where appropriate. People told us staff treated them with dignity and respected their privacy, and we observed staff treating people respectfully during our inspection. The provider had a complaints policy and procedure in place and people told us they knew how to complain.

People received personalised care that reflected their individual needs and preferences. They were involved in the planning of their support and had meetings with their keyworkers on a regular basis to ensure their needs were being met and support plans were up to date. Staff supported people to maintain relationships with family and friends, and to take part in a range of activities in support of their interests and need for social stimulation.

The provider also sought people's views on the service through meetings and regular surveys. The outcome of the last service indicated the people were happy with the service they received and were experiencing positive outcomes.

This is the first time the service has been rated Requires Improvement.

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.

Staff were aware of the different types of abuse that could occur and the signs to look for, but improvement was required to ensure staff consistently followed safeguarding procedures.

Improvement was required to ensure staff only supported people to take medicines where this was part of their assessed needs. There was insufficient detail in people's support plans about the help people required to take their medicines safely.

The provider followed safe recruitment practices. Planned staffing levels were determined based on an assessment of people's needs but improvement was required to ensure sufficient staff were consistently deployed as planned.

Risks to people had been assessed and plans put in place to manage identified risks safely. Staff were aware of the details of people's risk management plans.

Staff followed safe infection control practices when supporting people.

Accident and incidents were recorded and reported appropriately and lessons learned to reduce the risk of a repeat.

Is the service effective?

Good

The service was effective.

People's needs had been assessed and support was delivered in line with nationally recognised guidance and standards.

Staff were supported in their roles through regular training and supervision, which included an appraisal of their performance.

People were supported to maintain a balanced diet, and to access a range of healthcare services.

Healthcare professionals involved in supporting people using the service told us staff worked well with them to deliver effective

care.

Staff were aware of the importance of seeking consent and demonstrated an understanding of their responsibilities under the Mental Capacity Act 2005 (MCA) where people lacked capacity to make decisions for themselves.

Is the service caring?

Good

The service was Caring.

Staff treated people with care and consideration.

People were involved in making decisions about their care and treatment by staff who considered their communication needs.

Staff treated people with dignity and respected their privacy.

Is the service responsive?

Good

The service was responsive.

People received care and support which reflected their individual needs and preferences.

People were supported to maintain relationships with relatives and friends, and to engage in a range of meaningful activities and hobbies.

The provider had a complaints policy and procedure in place. People told us they knew how to complain and had received information from the provider encouraging them to speak out if they had any concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a registered manager in place who understood the responsibilities of their role. However, improvement was required to ensure notifications were consistently submitted where required, in line with regulatory requirements.

There were systems in place to monitor the quality and safety of service provision, with a view to driving continuous improvement. However, improvement was required to ensure any concerns identified were shared across the service to ensure appropriate action was consistently taken to improve the service.

The provider worked with local authority commissioners to drive improvements, and sought the views of people and relatives through regular meetings and surveys.

Staff shared the provider's vision and values in the support they offered people. People commented positively about the management of the service, and the support they received.

Avenues London (South)

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. At our previous inspection of the service in July 2014 we rated the service as 'Good' overall.

This service provides care and support to people living in over 20 'supported living' settings, 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 also provides domiciliary care and outreach support. This includes providing personal care to people living in their own houses and flats. It provides a service to older adults, younger adults and children with learning disabilities.

We gave the service 5 days' notice of the inspection site visit to enable them to gain consent from people for an inspector to visit them in their home. Inspection site visit activity started on 08 and ended on 10 November. On the first day of our inspection we visited people in their homes. We spent time speaking with them about their experiences of the service, speaking with staff, observing the support people received and reviewing people's care records. We visited the office location on 09 and 10 November 2017 to meet the management team and office staff; and to review care records, staff records, and policies and procedures.

The inspection team consisted of one inspector who conducted the site visits on all three days. A second inspector made telephone calls to staff on the second day of the inspection, and two Experts by Experience made telephone calls to people and relatives over the second and third days. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the information we held about the service. This included notifications received from the provider about deaths, accidents and safeguarding allegations. A notification is information about important events that the provider is required to send us by law. We also received feedback from a local authority commissioner, a local authority contract monitoring team, three social workers and a mental health nurse who had involvement with the service. The provider completed a

Provider Information Return (PIR). This is a form that asks the provider to provide some key information about the service, what the service does well and any improvements they plan to make. We used this information to help inform our inspection planning.

During the inspection we spoke with twelve people and eight relatives to gain their views of the service. We also spoke with a community nurse, two physiotherapists, an activities outreach worker and an occupational therapist who were involved in supporting people using the service, who gave us their feedback.

We spoke with 16 staff, including the regional director, three area managers and two service managers. The registered manager was not available to speak with us at that time so we also spoke with them during the week following our inspection. We looked at records, including 15 people's support plans, nine staff recruitment records, staff training and supervision records, and other records relating to the management of the service, including audits, surveys and minutes from meetings.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe with the support they received. One person said, "I feel safe [with staff]. They look after us well and help me to go out into the community." Another person told us, "I'm comfortable living here and feel safe. I would speak with [the manager] if I was worried about anything; we've talked doing that at the tenants meeting." A healthcare professional also commented, "People appear safe and well looked after when I visit."

The provider had systems in place to protect people from abuse. Policies and procedures were in place which gave guidance to staff on the processes to follow to protect both adults and children from the risk of abuse. These were reviewed regularly to ensure they were reflective of agreed safeguarding procedures. Staff received safeguarding training which was refreshed regularly to ensure they knew what action to take if they suspected abuse.

All but one of the staff demonstrated a good understanding of their safeguarding responsibilities. They were aware of the different types of abuse and the signs to look for that may indicate a person had been abused. They knew about the whistle blowing policy and were confident to escalate concerns if needed. One staff member told us, "I would report any allegations to my line manager or the area manager, but know I can contact social services if I need to." However, improvement was required because one staff member made reference to a safeguarding concern which they had not reported appropriately. We raised this issue with the management team who took immediate action to ensure people were safe.

Staff followed the provider's safeguarding procedures where allegations of abuse had been raised. Concerns were shared with the local authority for investigation, and the provider had submitted relevant notifications to CQC. Senior staff had taken appropriate action during investigations to ensure people were protected. For example policies and procedures had been reviewed and amended relating to the support people received with their finances in response to an allegation which was still being investigated.

Improvement was required to ensure that support people received with their medicines was consistently safe. Staff undertook an assessment of people's needs when they started using the service which included the support they required to take medicines. However, improvement was required because support plans did not always include clear information about the support people required to take their medicines. One person required staff to prompt them to take their medicines, but did not identify the times at which this support was required.

On one occasion staff had supported a young person to take a medicine whilst in the community, at the request of a relative when this was not part of their support plan and had not been risk assessed. We spoke to the management team about this who followed up with staff to ensure they were aware to only provide support in line with the provider's procedures.

There were procedures in place which gave guidance to staff on their role in supporting people to manage their medicines safely. Records showed that staff responsible for medicines administration had received

relevant training which included an assessment of their competency to do so. Medicine Administration Records (MARs) were in place where people had been assessed as requiring support from staff which included details of any known allergies and a copy of each person's photograph to reduce the risks associated with medicines administration. We reviewed a sample of people's MARs and found them to be up to date with no omissions. Protocols were in place where people had been prescribed medicines to be taken 'as required' which gave guidance to staff the circumstance in which these should be offered..

People told us they were happy with the support they received to take their medicines. One person told us, "Staff help me with my tablets. They've told me what they're for." Another person said, "They [staff] give me my tablets on time." Medicines were stored securely in the supported living scheme that we visited, and staff made regular checks on storage area temperatures to ensure medicines were maintained safely. Remaining stocks of medicines showed that they had received their medicines as prescribed when cross-referenced with their MARs. We observed staff providing people with appropriate support to take their medicines, giving them sufficient time, direction and encouragement and considering any guidance in place about people's preferred method of administration.

Staffing levels were determined based on an assessment of people's needs and the hours each day in which they required support. Rotas were planned by service managers according to the requirements of people at each supported living service. People told us there were sufficient staff deployed to keep them safe and meet their needs. One person said, "There are enough staff. They come when I need them." Another person told us, "Staff help me when I need them to."

However, feedback from relatives regarding staffing levels was mixed. For example, one relative told us, "I'm confident that if any bells went, the carers are upstairs and they would be there." However, another relative told us that there had been occasions when staff had not arrived to provide support to their loved one which placed them at risk. There had been two occasions in 2017 when this occurred which had impacted on other people. Improvement was required to ensure sufficient staff were consistently deployed to meet people's needs safely. The management team confirmed the most recent issue had occurred because a member of staff had not been allocated to attend the shift. This had been addressed with staff.

The provider followed safe recruitment practices. Staff files contained completed application forms which included information about previous employment history and the reasons for any gaps in employment. The files also contained confirmation of the provider having checked each staff member's identification and right to work in the UK where applicable, and having conducted criminal records checks and sought references to ensure staff were off good character and suitable for the roles they were applying for.

Risks to people were assessed and plans put in place to manage risks safely, although risk management plans did not always provide comprehensive guidance for staff. For example, one person's risk assessment identified them as living with epilepsy and guidance was in place for staff to contact emergency services if they had any concerns. However the assessment lacked detail as to the type or frequency of the seizures the person had or the typical length of time their seizures may last. This would help inform staff whether emergency support was required. We raised this with the management team who told us they would update the risk assessment to include further detail.

Risks to people were assessed against their daily life, including their health and well-being, the time they spent at home, their money and possessions, and the time spent in the community or involved in activities. These areas were broken down into specific areas relevant to people's needs, for example with regards to risks associated with their mobility, personal care and continence any potential behaviour which may require a response and risks associated with medical conditions. Risk assessments were reviewed

periodically or following a change in a person's condition to ensure they remained up to date and reflective of their current needs.

People's risk assessments considered both the potential positive and negative factors of risk taking in each area as well as identifying any control measures for staff to follow. For example, one person's risk assessment in relation to their living in their local community, leisure time and work identified the positive outcomes of them working which included social interaction and inclusion, as well as identifying the areas of support they would need to be safe whilst accessing the local community.

Staff were aware of procedures for reporting accidents and incidents. Accident and incident records included details of the incident, when it had occurred, the people and staff who had been involved, and any action taken to keep people safe. This information had been reviewed and we saw examples of senior staff having taken action to improve people's safety. For example one incident record related to a medicine error and included information about the action taken at the time the error had been identified. The incident was followed up and as a result administration procedures had been changed to reduce the risk of similar incidents occurring. The incident had subsequently been discussed at a team meeting to ensure staff were aware of the changes.

Staff were aware of the risks to people they supported and how they should be managed. For example, one staff member was aware of one person's condition of dysphasia, and described the support they required with food and drink preparation to manage this safely. In another example, staff were able to identify the people who may present with behaviour requiring a response. They knew the details of their behavioural support plans and the potential triggers that may cause a change in behaviour. They described the techniques used to manage this which involved the use of de-escalation and diffusion techniques and focused on the least restrictive intervention at all times. The management team told us that staff had received relevant training in these techniques to support people safely.

The provider also considered risks associated with people's health and safety in respect of their living environment. For example, staff told us, and records confirmed that they undertook assessments on people's homes with regards to fire safety and made routine checks on maintenance. Any issues they identified were referred to people's tenancy providers for action. An issue had been identified with a fire door which had been raised with the tenancy provider who had arranged for it to be repaired.

People were protected from the risk of infection. Staff were aware of the need to ensure they wore protective personal equipment (PPE) when supporting people and told us that this equipment was available for them to use. We confirmed this to be the case at the service we visited. Staff also told us they supported people to clean their homes when this was part of their assessed support. One staff member said, "The home is cleaned every day by staff. Our shift plan says what we need to do." Where cleaning was not part of the staff team's responsibilities, they knew to escalate any concerns they had in respect of the cleanliness of people's living environments to senior staff, so that the issue could be raised with the respective tenancy provider. Staff had also received training in food hygiene, and were aware of the steps to take in ensuring that they supported people safely with regards to food preparation.

Good

Is the service effective?

Our findings

People were assessed before they received support in order to ensure their needs and preferences could be met. The assessments considered each person's day-to-day needs, choices and preferences, and identified the areas in which they required support in order to achieve positive outcomes. Assessments covered a range of areas including people's physical and mental health, communication needs, social needs, personal care, mealtime needs and any night time support requirements.

Guidance for staff was developed in accordance with current legislation and nationally recognised standards to help ensure they were following good practice. For example, the procedure for managing people's medicines had been developed with reference to guidance published by the National Institute for Health and Care Excellence (NICE). Staff we spoke with understood the procedure and how it should be followed, and we observed examples of staff supporting people to take their medicines in line with the provider's procedures.

People's assessments included consideration of their support needs with regards to any identified protected characteristics and staff we spoke with spoke positively about the provider's approach to equality within the service. One staff member said, "We would never discriminate, and would seek to support the people here in any aspect of their lives that they needed." People's independence was promoted through the use of technology, where appropriate. For example, staff had worked with the local authority to put an alarm system in place on one person's front door which notified them if the person was about to leave. This increased the person's independence by reducing the need for staff to monitor them.

Staff sought consent from people when offering them support and respected their right to refuse assistance if they wanted. One staff member said, "I always ask people if they want me to help them. We wouldn't force anybody to do anything. I might try a different approach if they refused initially, but I'd respect their wishes." Another staff member told us, "I only do what people here want. If they were to refuse my help, then I would report it but people have the right to decide things for themselves where they are able to do so."

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Applications to deprive people of their liberty in their own homes must be made to the Court of Protection. We checked whether the service was working within the principles of the MCA.

Records showed that where people lacked capacity to make specific decisions for themselves, staff had conducted mental capacity assessments and made decisions in their best interests, in line with the

requirements of the MCA. For example, we saw a mental capacity assessment had been conducted and best interest decisions made with the involvement of a social care professional, around the support one person received with their finances. In another example staff had followed the principles of the MCA in order to make a decision regarding the support one person received with their medicines, in their best interests.

Senior staff demonstrated an understanding of the conditions under which a person would be considered to be deprived of their liberty. Records showed that the provider had contacted local authorities where they believed people were being deprived of their liberty in order to start the process of seeking Court of Protection orders in line with the MCA. None of the people had orders in place at the time of our inspection.

People and relatives told us staff had the skills and experience to meet their needs. One person said, "The staff here know how to support me." Another person said, "They know what they're doing; I've been here six years." A relative said, "The staff I've had contact with seem well trained. I've got a lot of confidence in [a member of staff]; he was able to answer my questions when we met."

Staff told us, and training records confirmed, they completed an induction when they started work for the service. This included training at the provider's registered location, familiarising themselves with policies and procedure, and a period of orientation at the supported living scheme they were going to work in, which included time spent shadowing more experienced colleagues and getting to know the people they were going to be supporting.

Staff had training considered mandatory by the provider, including safeguarding, food hygiene, health and safety, first aid, moving and handling, and information governance. Training was refreshed periodically to ensure staff remained up to date with current practice. We noted that staff were either up to date with their training or had training courses scheduled where they were overdue. Staff also told us, and records confirmed that they received additional training where required to support people's individual needs. For example, staff received training in supporting people with epilepsy where they supported people with this condition, and we saw training scheduled for staff around autism and diabetes.

Staff spoke positively about the training they received. One staff member told us, "It's been helpful to have refresher training to help remind us of the things we need to do." Staff also demonstrated a good understanding of the areas in which they had been trained. For example, staff we spoke with understood their responsibilities with regards to food hygiene when supporting people to prepare meals.

Staff were supported in their roles through regular supervision which included an appraisal of their performance. Staff told us they met with their line managers for supervision on a one to one basis regularly. We reviewed supervision schedules which confirmed this to be the case. One staff member told us, "I find the supervision process helpful; we can discuss areas for my development, but I'm also able to discuss any issues I'm having, such as around childcare at home. My manager has been supportive in considering my needs in this area."

People's needs were assessed with regard to their dietary requirements, with the involvement of healthcare professionals where required, such as a dietician or speech and language therapist (SALT). The assessments included consideration of the level of support each person needed in purchasing and preparing food and drink, as well as any specific dietary requirements they had, and whether they needed any support at mealtimes. Staff were aware of people's dietary requirements and told us they supported them accordingly.

Staff involved people in decisions about what they wished to eat, and this was confirmed by people we spoke with. One person said, "I get help [from staff] with my meals and I get to choose what I want to eat."

Another person told us, "Staff help me to do my food shopping, but I decide what to buy. I prepare my own meals."

People told us they enjoyed the meals prepared for them where they were unable to do so for themselves or with support. One person said, "The meals are absolutely delicious." Another person told us they prepared their meals with staff, explaining they were, "Very good." Staff were aware of the importance of encouraging people to maintain a balanced diet. For example, one staff member described how they worked with one person whose preferred to eat junk food, to consider more healthy options such a fruit or yoghurt.

People were supported to access a range of healthcare services when needed in order to maintain good health. One person told us, "If I was unwell, they [staff] would take me to the doctor." Another person said, "I see my GP if I need to." Records showed people received support from a wide range of healthcare services including GPs, community nurses, occupational therapists, dentists, physiotherapists and opticians. People also had recorded information in place which accompanied them on appointments which provided healthcare professionals with details about their communication needs, medical conditions, any known allergies and any spiritual beliefs they had.

Health and social care professionals involved in supporting people confirmed that staff worked well with them to ensure people received effective support across the different services they used. A physiotherapist told us, "[The staff] try their best to follow the programmes we give them." They also commented positively about the support staff had given one person to visit their local hospital, in addition to the home visits they made. An occupational therapist said, "The staff have been very supportive; we have a good working relationship and have worked together in developing [one person's] support plan. They've been working in line with this since we put it in place." A community nurse commented, "The staff communicate well with us and are prompt in letting us know if people need support." An outreach activities co-ordinator told us, "We work well together, I always get a handover and involved in reviews for people."

Good

Is the service caring?

Our findings

People and relatives spoke positively about the care and compassion shown to them by staff. One person told us, "The staff are very kind; they're nice." Another person said, "They're really good to us, you know." A relative commented, "They're lovely; absolutely brilliant." Another relative said, "[Their loved one] has had the same carer for three years. They're caring and kind."

We observed staff treating people with care and showing concern for their well-being. For example, one person came into a communal area from their flat during our visit to a supported living service and staff promptly noted they didn't have any footwear on, so encouraged them to sit down and suggested they go and some slippers for them, which the person happily agreed to. We also noted examples of staff moving promptly to offer reassurance to people when they showed signs of anxiety or distress. Additionally, during the telephone calls we made to people we heard staff in the background enquiring about people's well-being and ensuring they were happy to speak with us, offering support if they so wished.

Staff demonstrated a good knowledge of the people they supported. They were aware of people's preferences in the way they received supported and their daily routines, their family histories and details of the things that were important to them. They told us this information helped to ensure they built meaningful and engaging relationships with people and we observed this to be the case. For example, we saw one staff member comforting a person when they made reference to a relative who they later explained had passed away. In another example we observed staff chatting with people about their interests and noted that people were happy and engaged in these conversations. One person also told us, "I feel they [staff] know me well and we have a good relationship."

Staff treated people with dignity and respected their privacy. One staff member told us, "I always knock before entering people's flats, and wait for them to invite me in, even if the door is open." Another staff member said, "I would make sure we had privacy if I was supporting someone with personal care." We observed staff ensuring people had privacy whilst offering them support and knocking on people's doors and requesting their permission to enter their flats at the supported living service we visited. One person confirmed, "Staff always knock before coming in."

Staff were aware of the importance of keeping information about the people they supported confidential. They had received training in information governance and records showed the management team made regular checks to ensure information about the support people received was maintained securely. Staff also described the ways in which they worked to promote people's dignity. For example one staff member explained that they covered people up as much as possible when supporting them with personal care, so that they didn't feel exposed, and two people we spoke with described this practice as an example of staff treating them with dignity. A relative also explained the steps staff took in treating their loved one with respect, telling us, "They [staff] treat [their loved one] as an adult when they talk, which others don't."

People told us that they were involved in decisions about their care and support. One person said, "Staff do what I want [them to]." Another person told us, "I can choose the things I want to do; we went out shopping

today." A third person said, "They [staff] listen and they can follow my instructions." Staff confirmed they sought and acted upon people's choices when offering them support. One staff member said, "I involve the residents in decisions about all aspects of their lives as much as they are able or, wish to; from what they wear, to the activities they take part in, to the things they want to eat or drink." We observed staff offering people choices during our visit to a supported living service. They explained things to people in ways they could understand, and gave people time to make decisions for themselves.

We also noted that people's more complex individual communication needs were considered by staff when supporting people to be involved in decision making. For example, one staff member explained how they supported a person to make choices about the food they wanted to eat through the use of pictorial information which they used to help identify the products they wanted to buy, in line with the guidance in their support plan. Records also showed that people were given support to access advocacy services where appropriate, in order to receive independent support and advice. We reviewed the feedback from an advocate who had involvement with people at one address where the service provided people with support which indicated that staff were always ready to discuss any issues with them and that they felt people were receiving good quality support.

Good

Is the service responsive?

Our findings

People were involved in discussions around the planning of their support. One person said, "I have a keyworker and we meet to talk about how I'm doing and whether I need any help with anything. If I asked for any changes [to their support plan] they'd do it." Another person said, "We've talked about the help I need; I have a plan." One relative said, "I am invited to the meeting to discuss any [of their loved one's] wishes and wants." Another relative told us, "Before [their loved one] started using the service, two managers came round for a home visit and it [the support plan] was all written then."

Records showed that staff had developed support plans for people based on an assessment of their needs. Support plans identified key areas of people's lives and the support they required to ensure positive outcomes in areas including, maintaining relationships with family and friends, communication and choices, managing their money and possessions, maintaining their independence, and maintaining good health and well-being.

Support plans also included information about people's preferences and focused on ensuring their independence in each area was maximised. For example, one person's support plan around managing their property and finances identified the things they typically liked to spend their money on. This gave guidance to staff to only offer support on areas where minor issues had been identified, such as food shopping and the potential for the person to overstock perishable items. Records also showed that people met with their keyworker on a regular basis to discuss their needs, in order to ensure the support they received continued to meet their needs and preferences.

People's support planning also considered the support people required with regard to any protected characteristics they had. For example, we saw guidance in place for staff on the support people required to practice their faith and one person we spoke with confirmed they received support from staff in this area. In another example, one person's support plan identified their preference to receive support from staff of a specific gender and staff were aware of this preference and told us they received support accordingly, wherever possible.

Staff were aware of the details of people's support plans and confirmed they supported people in line with their assessed needs and preferences. For example, one staff member was aware of the support one person needed with their personal care, including their preferences when having a wash. Staff were also aware of people's communication needs. For example, one staff member told us how they made sure they only used short, clear sentences when speaking with a person they supported and ensuring they gave them time to respond when asking them questions..

People were supported to maintain relationships that were important to them. People's support plans identified any help people required to visit or keep in contact with relatives or friends, and people confirmed they were supported to do so. One person said, "I like to spend time with my family; I go to watch the motor racing with my dad." A relative told us, "I can visit any time I like; out of politeness I phone up, but there's never been an issue with me visiting." The provider had also developed guidance for staff on people's rights

in developing personal relationships, in order that people could be supported safely and appropriately to developing loving relationships and where applicable, we saw support plans recognised the importance of these relationships in people's lives.

People took part in a range of activities where this was part of their assessed needs. Some people were supported to attend education and employment opportunities as well as taking part in more socially oriented day activities such as attending day centres, trips shopping or to eat out.. One person had been supported by staff to do some baking during the time of our inspection. Another person told us, they enjoyed going to watch their local football team and meeting their friends at the pub. A relative told us, "[Their loved one] has got a good set of weekly activities, which makes [their] life interesting."

The provider had also received lottery funding to undertake a project which aimed to connect people with learning disabilities with people from the local community which was being run across two London Boroughs. This included supporting people to get involved in activities such as line dancing, sports groups and local churches and had won the Greenwich Action for Voluntary Service (GAVS) Community Cohesion Award for the support people had received in this area in the Royal Borough of Greenwich in 2016.

People and relatives told us they knew how to make a complaint. One person said, "I would speak with the manager [of their supported living service] if I had any problems." Another person said, "Yes, I know how to complain." A third person told us they'd been supported to raise a complaint about the maintenance of their accommodation with the landlord, which they explained had been addressed to their satisfaction. A relative told us, "I know I can contact the head office, if I have any concerns; they gave us an information pack."

The provider had a complaints policy and procedure in place which gave guidance to people on how they could raise concerns, including the timescale in which they could expect a response. The complaints procedure was available to people in formats which met their needs and we saw information had been provided to people which encouraged them to speak out if they had any concerns. Records showed that the provider had taken action to investigate and address complaints which had been raised with them.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post who was experienced working in services for people with learning disabilities. They were aware of their responsibilities under the Health and Social Care Act 2008. For example, they were aware of the different events which they were required to notify CQC about. However, improvement was required to ensure notifications were always submitted as required because we found one example of an incident which had occurred, which had not been reported to the Commission. The management team told us they would ensure all notifications were submitted in future. We also noted that staff had submitted notifications appropriately as required, in response to other events that had occurred when supporting people.

The provider had a management structure which reflected the scope of the different services they provided. This included having service managers and deputy service managers who were responsible for managing specific supported living, outreach and domiciliary care services across south London. These managers reported to the senior management team, which included the registered manager and regional director.

People spoke positively about their respective service managers. One person told us, "If I had any problems, I'd speak to the service manager or the deputy, and they would sort it out." Another person told us there were, "No problems." However, whilst most relatives also commented positively about the management of the service, one relative told us that they felt there had been on-going issues with the support their loved one received since the provider had taken on the contract to provide support in their area. They said, "I don't have much faith in Avenues; despite letting them know [of their issues], things haven't changed." Despite this negative feedback they also commented positively about their loved one's current keyworker who they felt was competent in providing support.

There were quality assurance systems in place to help identify issues, but improvement was required to ensure they were consistently effective in driving improvements. The provider conducted audits covering areas which included people's medicines, health and safety, information governance and checks on people's finances. Service managers also submitted regular information in relation to the provider's service Key Performance Indicators (KPIs) which included details of any medicines errors, accidents and incidents, and confirmation of activities such as team meetings having taken place. This information fed into action plans for each part of the service in order to drive improvements.

However, improvement was required to the systems used for sharing information relating to staffing concerns across different parts of the service. For example, records showed that senior staff had identified a staff member had been involved in medicines errors. This issue had been fed back to the provider with a request that they no longer work at a particular address. However, this information was not shared across the service and the staff member had subsequently been offered work at another supported living service. The staff member had not received further training in medicines management at the time of our inspection, despite the previous issues. We raised this with an area manager who told us they would ensure the staff member received further training and support in this area.

In other areas we found improvements had been made where issues had been identified. For example, a health and safety check had identified an issue with a fire door at one address and checks relating to fire safety at another address identified that the service did not have a copy of the tenancy provider's fire risk assessment. Both of these issues had been followed up and addressed.

Staff worked in partnership with local authorities to drive improvements. Staff had taken action to address issues raised by local authority contract monitoring teams following their visits to people. For example, staff had updated one person's seizure guidelines in response to feedback they had received. We also spoke with a social worker who told us that the provider had been working with them in looking at ways to reduce the number of hours the authority paid for, whilst ensuring people's needs continued to be fully met.

Staff had mixed views on the management of the service and team working. One staff member told us, "[A member of the management team] is always available to give me advice and I can talk to them about any personal issues I might have. I wouldn't be where I am without their support." This was reflective of the majority of the feedback we received when talking to staff. However two staff we spoke with commented negatively about the culture at the service and told us they felt unsupported by the management team. For example, one staff member said, "Some of the managers are not really there for the staff; you can tell by the way they speak to you."

We discussed these issues with the management team who acknowledged the challenges they had experienced in managing some staff. For example they told us that, where staff had transferred to the service from previous service providers due to contractual changes, some staff were unhappy about this. The management team explained that they had attempted to support these staff and encourage them to speak out about any issues they were experiencing. Staff well-being was discussed during supervision and at team meetings in order to ensure staff were aware of the support available to them.

Despite the mixed feedback we received from staff on the support they received from the management team, staff demonstrated a good understanding of the provider's vision and values. One staff member explained their role was to try and ensure the people they supported got the most out of their lives by promoting their life skills and encouraging independence. Another staff member told us they were proud of their role in supporting people to choose how they lived their lives.

Staff also received information about service updates through a range of methods. One staff member told us, "We receive a lot of updates on practice development through emails, our intranet and in feedback from manager's briefings." Another staff member said, "I attend regular team meetings. We get updates on the service and discuss any changes or on-going issues with the support we're providing people here." Records showed staff attended regular meetings and areas for discussion included training needs, and issues with the people staff supported, and updates on service developments.

Staff acted openly and transparently in response to any incidents or service issues. For example concerns were raised about the conduct of other staff members at one supported living service. This had been dealt with in an open an appropriate manner. This had included reporting the concerns to the relevant local authority and contacting family members to inform them. One relative we spoke with told us, "[The provider] contacted me a while ago to say the care hasn't been what it should be. The issue was referred to [the local authority] who investigated. When I visited their [loved one] last week things were better."

The provider had systems in place to seek the views of people about the service they received. One person told us, "I attend the tenants meetings. We can talk about any issues we have there." They also explained that they were happy with the service they received and didn't want any changes made. Another person

commented that the tenants meetings were, "Very good for [raising] issues," and confirmed that any issues they'd raised had been addressed to their satisfaction. The provider also sought feedback through regular surveys which people and relatives confirmed they'd received. We reviewed the results from the previous year which showed that people were experiencing positive outcomes through the support they received from the service.