Larkfield With Hill Park Autistic Trust Limited

Milestones Outreach Support Team - MOST

Inspection report

2 Maidstone Road
Paddock Wood
Tonbridge
Kent
TN12 6BT

Date of inspection visit:
10 October 2016
11 October 2016

Date of publication:
16 December 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Milestones Outreach Support Team (MOST) on the 10 and 11 October 2016 and the inspection was announced to ensure that we could access the records we require. MOST support 56 adults, some of whom live in one of the 11 supported living schemes managed by MOST and some of whom live in their own homes with outreach support. However, of these 56 people, only nine people received support with personal care which is an activity requiring registration by CQC. Therefore this inspection focused on the care and support provided to those nine people receiving personal care as outreach in their own home or in one of the supported living schemes.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager and staff had received training and were knowledgeable about of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). However, mental capacity assessments were not always completed in line with legal requirements and the MCA Code of practice. Mental capacity assessments were needed for people who may not be able to consent to, for example, bed rails.
Risks to people were not consistently managed, incidents and accidents were not consistently being recorded and action was not always taken to change people's support plans following incidents or accidents.

People had access to their medicines when they needed them. However, the registered provider had not ensured that all staff had completed the medicines competency check after being trained. We have made a recommendation about this in our report

People received a person centred service that enabled them to live active and people's decisions. However care plans lacked detail about how people like to be supported and did not show that the person was involved in their care plan. You can meaningful lives in the way they wanted. People could decorate their rooms to their own tastes and choose if they wished to participate in any activity.

Complaints were not consistently being recorded. This meant that the registered provider cannot always investigate and learn from complaints. You can see what action we told the provider to take at the back of the full version of the report.

Staff received training in safeguarding and they understood what to do and how to report concerns to keep people safe. However, the most up to date information around safeguarding was not available to all staff. We have made a recommendation about this in our report.

Staff were well trained with the skills and knowledge to provide people with the care and assistance they needed. However, the induction process for new staff was not being consistently carried out across the organisation. This meant that potentially staff may not be trained to the standard identified by the registered provider before they provide care and support to people. We have made a recommendation about this in our report.

People had enough to eat and drink, and received support from staff where a need had been identified. People's special dietary needs were clearly documented and trained staff ensured these needs were met.

Peoples' health was monitored and they were referred to health services in an appropriate and timely manner. Any recommendations made by health care professionals were acted upon and incorporated into peoples' care plans.

The staff were kind and caring and treated people with dignity and respect. Good interactions were seen throughout our inspection, such as staff talking with people as equals. Staff knew the people they cared for well and treated them with kindness and compassion.

People could have visitors from family and friends whenever they wanted. People and their relatives spoke positively about the care and support they received from staff members.

There was an open, transparent culture and good communication within the staff team. Staff spoke well of the registered manager and registered provider. However, not all staff had access to regular supervisions and team meetings to receive support and give their feedback. We have made a recommendation about this in our report.

Quality monitoring systems were not effective and were not being consistently applied. The registered provider had employed a quality manager who had identified shortfalls using a new audit. However, we could not see that changes had occurred or were embedded. We have made a recommendation about this in our report.

The registered manager, who was recently recruited and registered with CQC, provided clear leadership to the staff team and maintained an active presence in the services. They had a clear vision for the service and were aware of challenges and how to overcome them.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff understood safeguarding and how to keep people safe from avoidable harm, but did not always have access to up to date information. Incidents and accidents were not always recorded and followed up.

Risk did not always contain up to date and consistent information. Some risks were managed positively.

Staffing levels were adequate to keep people safe and recruitment processes were safe.

People had access to their medicines but some staff had not completed their medicines competency check.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had access to training but the induction process for new staff was not applied consistently.

The principles of MCA were not consistently being applied.

People had adequate food and drink and people with specialised diets were having their needs met.

People had access to healthcare professionals and had their health needs met.

Is the service caring?

Good

The service was caring.

Staff knew people well and used that information to support people effectively.

People were involved in their lives through care reviews and tenants meetings.

People's privacy and dignity was respected by their staff teams, and their independence was encouraged.

Is the service responsive?

Requires Improvement

The service was not responsive.

Staff members supported people in a person centred way but care plans did not have enough detail to capture people's unique character or care preferences.

Complaints were not consistently recorded and lessons had not always been learned from complaints

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The culture was open and inclusive but staff had not consistently been supervised or had access to staff meetings.

Quality monitoring systems had not been effective or consistently applied. A new audit tool had identified some problems but changes had not been made or embedded.

The management team had a clear vision for the service and were aware of challenges and how to overcome them.

Milestones Outreach Support Team - MOST

Detailed findings

Background to this inspection

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

This inspection took place on 10 and 11 October 2016 and was announced. We told the provider we would be coming so they could ensure they would be available to speak with us and arrange for us to speak with care workers. The inspection team consisted of two inspectors and one expert by experience. An expert by experience is a person who has personal experience of using, or caring for someone who uses this type of service.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. Before the inspection, the provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We took the PIR in consideration.

As some people who are supported by MOST were not consistently able to tell us about their experiences, we observed the care and support being provided and talked with relatives and other people involved with people's care provision during and following the inspection. As part of the inspection we visited two of the ten houses and spoke with the registered manager, two care co-ordinators, one community nurse, seven care staff, six people and four people's relatives. We looked at a range of records about people's care and how the service was managed. We looked at four people's care plans, medication administration records, risk assessments, accident and incident records, complaints records, health and safety checks, fire safety documentation and quality audits that had been completed.

We last inspected MOST in September 2012 when it was registered at a different location and no concerns were found.

Requires Improvement

Is the service safe?

Our findings

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. One staff told us, "We have a responsibility to make sure a person is safe and doesn't harm himself or others and that they aren't abused by someone else. A person could be financially, verbally, physically or emotionally abused. If a person had unwitnessed bruising I would complete a body map and record it in the daily notes. I would report it to my senior and it would be shared with social services, CQC and possibly the police or the GP." Another staff member commented, "If I had concerns about how a member of staff was supporting a person I would report it to my line manager. I know that I could whistle blow to the CQC, social services or the police. I have a copy of the whistle blowing policy which I could refer to if I needed to." Where unexplained injuries, such as bruising, had been reported this was investigated by a manager.

However, safeguarding alerts were not consistently monitored. On the day of our site visit there was no safeguarding folder at the office, or management system, to store safeguarding information. This meant that some notifications may have not been followed up or not received by the local authority. There was no up to date information around safeguarding in the office, such as the local authorities' latest safeguarding policy. We spoke to the registered manager about this and they informed us that they would put a safeguarding folder in place to centrally manage all notifications of potential abuse, and would ensure the most up to date information was available to visitors to the office. Some of the supported living services displayed safeguarding information in an easy read format for people who lived there. At the end of our site visit the manager showed us that they had put in place a system to manage safeguarding referrals.

People were not always kept safe from potential harm. There were safety certificates, such as gas safety, portable appliance tests, five yearly electrical installation checks and contingency plans amongst others. Supported living services had fire safety systems and checks in place. However, the office did not have adequate safety measures in place. For example the fire fighting weekly inspection record had not been completed since January 2016. Monthly inspection of fire doors had occurred on four occasions but these were not dated. There was no record of a fire evacuation in the past 12 months. There had been two fire drills but there was no report on whether the fire drill was successful, or any problems that may have occurred. Fire extinguishers had been serviced by an external company and were safe. We raised fire safety in the office with the registered manager who told us that they would ensure that all future checks were completed as per the company policy.

Risks to people were not consistently being managed. People's risk assessments included specific risks such as two people not to be left alone together and more generalised risks such as travel, road traffic accident, fire safety, and medicines, amongst others. When plans were made for people to travel abroad medical insurance was arranged, and staff ensured they had people's missing person sheet which contained details about their conditions and support needs, their medicines and their health passport. The relatives of one person told us that they had concerns about the safety and well-being of their relative, and how staff responded to risk. Where incidents had occurred or concerns had been identified, appropriate notifications had been made, and referrals had been raised to the local safeguarding teams and the local authorities who

funded placements. Investigations had been undertaken and responded to, and the local authority was satisfied that risk and incidents had been appropriately managed. However, not all risk assessments contained consistent and up to date information. For example, one person had a risk assessment for self-medicating when they were not currently self-medicating. The person was self-medicating with a hay fever tablet in the summer but this was not recorded on the risk assessment. We spoke to the senior carer about this who agreed that there should not be a risk assessment for self-medicating if the person is not currently doing so, and that if the person is self-medicating for hay fever in the summer only, then this should be clearly stated on the risk assessment.

People involved in accidents and incidents were supported to stay safe but action had not consistently been taken to prevent further injury or harm. One incident recorded that further action was needed to update the person's support plan and behaviour plan and this was not done. Some incidents that had occurred had not been recorded on file in the office. Another incident that recorded a physical confrontation between two people had not recorded any further action or amendments to behavioural plans. We spoke to the registered manager about this and were shown an audit completed recently by the registered provider that highlighted this concern and an action plan to address the shortfall.

The failure to safely manage risks to people was a breach of regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Thorough recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Criminal records checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. Staff members had provided proof of their identity and right to reside and to work in the United Kingdom prior to starting to work at the service. References had been taken up before staff were appointed and references were obtained from the most recent employer where possible.

People told us they felt there were enough staff on duty to meet their needs. One person told us, "Yes we have three or four main workers who we know well and sometimes one we don't know well but they get used to the house soon. We don't have anyone sleeping overnight. But there is a phone list by the house phone with numbers to call if we need something or emergency numbers if it is an emergency. There is always 'on call' people we can talk to." One relative told us, "They would probably say they are short of staff, but they always seem to cope well." Rotas and staff planners showed that there were adequate staffing numbers in place to keep people safe. Each service had its own level of safe staffing and these levels were consistently applied over the one month period that we looked at. One person's relative told us that correct staffing levels were not being provided in accordance with the agreed levels. However, when we checked with the funding authority and the registered provider we found that staffing levels were being provided above the level that was commissioned.

There were safe medication administration systems in place and people received their medicines when required. We observed two medicines rounds, in different supported living services. People's medicines were stored in a locked cabinet in their bedroom, or private bathroom. Good administration practices were observed, such as staff members washing their hands, checking the person's name and medicines against the medicines administration chart (MAR). The member of staff put protective gloves on to handle medicines and ensured the person had a glass of water, and in one instance a drinking straw as the person preferred this. Medicines were administered in the way that was described in the person's care notes, i.e. the medicine was placed in the person's mouth and then the drinking straw was offered.

However, not all staff had been assessed as competent to administer medicines. The registered provider's

policy states that staff members must complete several observations and be observed by a competent person themselves over several observations before passing a competency test. Three staff members had annual observation of medicine competency in 2016. The competency check recorded that staff members had met the guidelines: they knew how to dispose of medicines and could describe side effects of three medicines a person was taking, what to do in the event of a medicines error and how to order more medicine. Two staff did not have competency checks on file; however they were able to describe the correct process for administering medicines. We spoke to the registered manager about this and it was confirmed that both of the two staff we identified had completed medicines training, but neither had completed the registered provider's medicines competency check.

We recommend that the registered manager reviews medicines competency checks for all staff in line with the registered provider's policy.

Requires Improvement

Is the service effective?

Our findings

People and most of their relatives spoke positively about staff and told us they were skilled to meet their needs. One person told us, "I'm happy here. They [staff] help me with my chores every day. I do most things for myself and they make sure I am OK." One relative told us, "They [staff] are brilliant. X has one key worker who works with him and he needs a lot of care since [a medical problem]. He is cared for and well fed, he does his laundry for him, takes him to gardening, shopping, bowling and to the doctors. They have just been on a week's holiday; they normally go to a [holiday camp] where they can get a drink and dance. X does some things for himself and the key worker supervises him, he is not left alone." Another relative told us, "They're a nice staff, small team of regular staff, sometimes there is a new worker who is learning how to do things." A third relative commented, "X has had a few key workers; he has [name] now, who is very good and accommodates him in what he wants to do. She texts me anything she thinks I need to know."

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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Staff understood the principles of the MCA. One staff told us, ""A person might have a condition that prevents them from making a decision and so we may have to support them to make a decision. If they can't make the decision then a best interest decision is made, the person would be supported by an advocate, social services care manager and their keyworker. If a person can't make a decision about one thing they could still be able to make other decisions."

However, we found that the principles of the MCA were not being applied consistently. We saw examples of good practice such as, one person who required dental treatment who had an MCA assessment and decided to decline dental treatment: this decision had been respected. The person was not experiencing any pain or discomfort and they were able to make an informed decision to wait until the treatment became necessary. However, there were examples where the principles of the MCA were not applied. One person living in a supported living scheme, for whom the registered provider had made an application for a DoLS, required the use of a lap strap on their wheelchair and bed rails to keep them safe. There was no evidence that a MCA assessment had been completed for these measures. We spoke to the care co-ordinator of the scheme and they confirmed that they did not have an MCA assessment on file.

The registered provider had failed to ensure the principles of the Mental Capacity Act 2005 were followed. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Staff told us they had the training and skills they needed to meet people's needs. One staff member told us they had received training in Makaton: Makaton is a language programme using signs and symbols to help people to communicate, "Each person has their own version of Makaton. One of the people I support prefers

to use Makaton but they don't need to. Learning Makaton has helped me to get to know the person better, I know he uses it when he is anxious and I am able to reassure him." Another staff member told us, "I had autism training. It's about realising that everyone with autism is different, there isn't any one thing that is autism. We treat all service users individually and respect their differences and individuality. When I communicate with the person I make sure they know I am focussing my attention on them so that they are aware that I am listening to them and I let them know I have understood them." Staff training was up to date and where training was falling due for renewal it had been booked. Core training included adult protection, health and safety, infection control, mental capacity, equality and diversity, and moving and handling. There was further specialist training offered in subjects including autism, conflict resolution and dementia amongst others. Staff also had access to health and social care diplomas in levels two to five. One staff member had requested level two training in their 2015 supervision. This had not been followed up. When brought this to the registered manager's attention the staff member was placed on the list for level two diploma.

Staff studied for the care certificate as part of their induction. The care certificate is a set of standards that health and social care workers follow in their work and forms the new minimum standards that should be covered as part of induction training. Staff felt supported during their induction, with one staff member commenting, "The induction was good, I shadowed for 4 weeks because I was not confident and I asked them for more shadowing which they arranged for me." However, the induction process was not consistently applied, nor in line with the registered providers policy. We spoke to the registered manager about this and were told that they intended to implement a more structured induction schedule to include written feedback about people's performance from staff and service users, and to ensure that each scheme is following the same induction model.

We recommend that the registered manager reviews the induction process and implements a consistent approach across the supported living and outreach services.

The staff were all aware of people's dietary needs and preferences. Staff told us they had all the information they needed and were aware of people's individual needs. People's needs and preferences were also clearly recorded in their care plans. One staff member told us, "There are three people I support who have been identified as needing to lose weight. We encourage them to have a healthy balanced diet and to prepare their lunch at home. We suggest healthier options for them to choose. We weigh them weekly and when they have lost weight we congratulate them and encourage them to continue. One person is a borderline diabetic and has a low carb diet; he is aware of what he can and can't have and to have smaller portions. These people have capacity about their food choices so we try to encourage them to make healthier choices." Care plans included weight charts where necessary. One person told us, "I cook with support; we make a food plan every week so we know what we're having." People told us that they liked the food they make with staff and observations showed that people were encouraged to drink. Some people required additional help to eat their meals and the staff know how to cut the food up in to smaller pieces and support the person to eat using an adapted plate and special spoon.

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required. People had a health action plan which described the support they needed to stay healthy. One staff member told us, "If I had any concerns about a person's health I would approach their keyworker, if I didn't think the keyworker was taking appropriate action I would speak to a coordinator." Care plans showed that people were supported to attend appointments at their local GP surgery, as well as having other health appointments, such as aromatherapy sessions and a visiting chiropodist. One person told us, "I do say when I am not well, but they [staff] also notice when I don't say anything and they call the doctor when I need them, or they help me

when I don't need the doctor." People had access to a range of healthcare professionals. For example, one person moved from a residential home to a supported living scheme. Staff ensured that an occupational therapist was involved in the move to ensure the person's needs were met at the new home.

Good

Is the service caring?

Our findings

Staff knew people well and were aware of their likes and dislikes including calling them by their preferred names. One person returned from a trip out and started chatting with staff; they asked if the staff was sleeping in that night and said "I am seeing my friend later for coffee" One person told us "At the weekend I go out with my one to one. This weekend I went to a hop farm. Sometimes we go to the cinema, I decide what to do." Another person showed us patterns they had coloured in and staff talked with the person about a competition the person wanted to enter from one of their magazines, which they were excited to talk about. Staff said that the person really enjoyed art activities including colouring and drawing and they enjoyed activities in art magazines that they purchased. One person enjoyed pottery classes and a Viking dragon ship they had made was on display in the communal kitchen. One person was supported by staff to attend church on a Sunday.

Staff members were attentive to people's needs and offered kind support. One person was using a tablet to watch clips from pantomimes, they called out to staff "not working, help" staff responded quickly and reassured the person the video was loading. The person enjoyed attending pantomimes at Christmas and he had a leaflet for the pantomime they would be going to this year which staff had supported them to book. This was reflected in their care plan and review which showed they had attended their choice of pantomime the previous year. One person's care plan stated they enjoyed listening to radio stations; staff members were able to use their knowledge of the person to get them to talk about a visit to a London radio station where they had met some of their favourite radio presenters. "I've been to heart radio and met Toby Anstis." Staff members were able to talk with the person about their preferred radio stations and music artists.

People were supported to express their views and be actively involved in making decisions about their care, treatment and support. One staff member told us, "We have a tenants meeting every Sunday where we talk about lots of things and people can have their say. We do menu planning and the shopping list. People choose the food they want to eat each day; most of it is cooked from scratch. People say what they do and don't like. We encourage variety so that they don't have the same thing too often and suggest alternatives for them to choose from. We do regular checks of the smoke detectors, with people, to make sure the battery is working and we talk about stranger danger. We talk with people to remind them not to let people in the house they don't know and to lock up when they go out so they are taking responsibility for their own place."

Decision making was included in care plans. One person's care plan explained that, "Anything X is familiar with she is able to communicate verbally or by pointing. She is able to let you know if she does not want to do something. X requires more support in other areas and pictures and symbols are used to support X in making an informed choice." People were consulted about their care in regular review meetings. One person commented, "Yes I'm involved with the annual review every year, they let me know of any changes and help me with the changes." One relative told us, "My partner and X go to the meetings for the care plan. X would probably steer the group to do what he wants, he is very good at telling people what he likes and doesn't like."

People's privacy and dignity were respected by staff. One staff member told us, "When doing PC [personal care] we cover a person's body with a towel. One person prefers to go into the bathroom wearing their robe and I knock and make sure they are ready before I go in." Another staff member commented, "One person requires 2 to 1 support for their personal care. Sometimes, during personal care, their housemate will knock on the door so one staff will go and ask them to come back later." One relative commented, "X needs a lot of personal care, and I am sure would broadcast to the world if they did something he didn't like." Observations on the day of our inspection showed that staff members knocked on people's doors and waited for permission to come in before entering and treated people in a way that upheld their dignity.

People were encouraged to be as independent as possible. One staff member told us, "If a person wants a drink I encourage them to make it. I involve them in preparing their meals and when we go out to the shops I encourage people to work out how much they need to pay for their shopping." Another staff member commented, "One person has limited use of their arm so we encourage them to do what they can, for example to put his cup on the side and to clean his tray. I encourage him to be part of the activity doing what he is able to. If he asks or wants to do something for himself we support that." People were encouraged to answer their own front door, giving people a sense of independence and dignity.

Requires Improvement

Is the service responsive?

Our findings

Care plans were not always personalised or detailed enough to convey the unique characters of different people. People had admission assessments carried out by the registered provider when they started being supported by the service. The assessments included people's diagnoses, for example learning difficulties and Down's syndrome, along with information about people's medicines and allergies. The assessment had a dedicated place to document people's personal histories including specific events or issues but these had not been recorded. This information was not recorded anywhere else within the care plan. This meant that important life events and personal information that was unique to each person was not carried through the care plan.

People support plans had not been signed to show that they had been involved in the process of assessment or review. We raised this with the registered manager who acknowledged this. However the support plans had been updated to include information about events that had occurred since the last review. For example, at one person's review in March 2015 it had been identified the person had a lifelong goal to travel abroad. The person was supported to arrange the trip with the involvement of social services and the GP and it was arranged for two staff to accompany them. At the review it was documented that the person undertook their trip in April of 2015.

Care plans lacked personalised detail when discussing personal care. For example, one person's care plan stated, "X needs daily help with having a bath, brushing their teeth, washing and combing hair, applying creams, changing incontinence aids, choosing appropriate clothes, helping to get dressed, cleaning nails, putting on makeup and medicines." However there was no detail as to how the person wanted to be supported in any section of the care plan. Potential new staff who had not worked with the person before would not know what support to offer the person in the bath, for example, hand over hand support or verbal prompting. Other care plans had a similar lack of personal detail. One person's care plan stated that they required full support for personal care, medicines and continence management. We raised this with the care co-ordinator of the home the person lived in. We were shown a document that stated, "I'm fully dependent on staff to assist me with personal care." The care co-ordinator agreed that the care plan did not clearly state what the person's preferences are or how to carry out the personal care.

The failure reflect people's preferences in their care plans was a breach of Regulation 9 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

People were being supported by staff who understood person centred care. One staff told us, "We care for people in a way designed specifically for them. I support a person where staff write in their diary about the activity, the person tells staff what to write. He likes to be involved in writing the daily notes about his care. If staff needed to share information about the person that wasn't in the daily notes we would record it in the communication book." Another staff member commented, "I never feel rushed when supporting people. One person I support doesn't speak so I take time to talk to her about what we are doing. I explain what we are going to do first and if she is relaxed and she allows me to then I know she is OK. If the person doesn't want help they may push away with their arms, and so I stop and try again later." A third staff member told

us, "X can say what he wants staff to do for him. We have an activities folder and staff show activities for X to choose. He loves going to a local coffee shop and we also encourage him to try other places. He likes to watch cars so he's gone to a local garage to watch how the MOT was done on his mobility vehicle and he enjoyed that. He's chosen a firework display today and he goes out in the car."

People's support plans included pictures of the things they liked to do including hobbies. One person's interest was listed as Dr Who and Scooby Doo. This was consistent with observations made. There was information about other interests such as places the person had travelled to, such as Egypt. People's rooms were decorated to their preferences and included pictures and ornaments related to their hobbies and interests. People had distress passports which had detailed information about their appearance, sounds, speech and behaviour they emitted when they were content or distressed. At a review it was recorded that one person was regularly losing their hearing aids and they found them uncomfortable and the whistling noise the hearing aid made was painful to the person. Staff supported the person to get headphone hearing aids which they found more comfortable and were happier to wear when in conversation with other people. People were supported to stay in contact with their families.

People had a range of activities they could be involved in. People were able to choose what activities they took part in and suggest other activities they would like to complete. In addition to group activities people were able to maintain hobbies and interests, staff provided support as required. One care plan recorded the social activities a person had completed every month. A typical month consisted of, "Local shopping for the house; local personal shopping; swimming; local shopping trip; river walk; local shopping trip; social club; drive in the countryside; social club." One person told us, "I do horse riding every week. I set it up myself and I go on public transport to get there. My support worker is helping me to set up Sailing at the moment, I like extreme sports." Another person commented, "I do café bliss and prospects singing. I would like to go to [social club] on a Wednesday night with my friends. I will talk to my support worker about it." One relative told us, "X goes shopping Monday and Friday in 2 different towns, has a snack and lunch for 2/3 hours. Also on a Friday they do an art class at Pepenbury which has facilities for disabled. On Tuesday they do gardening at a private support gardening project."

Complaints were not always being recorded. The registered provider had a complaints policy that stated complaints should be recorded and responded to within 28 days. However, not all complaints were being responded to in accordance with the complaints policy. The complaints file showed only two complaints recorded in the past year. One complaint had been investigated and resolved. The second complaint around staff using their phones too frequently was not followed up or investigated. We raised this with the registered manager who told us, "There have been more than two complaints in the last year. The other complaints have possibly not been recorded as complaints." The registered manager agreed that the file required urgent attention. The registered manager had ensured there was an easy read version of the complaints procedure available for people at the office and at services.

Following our inspection we were contacted by a relative of a person who had been temporarily placed in accommodation with support from MOST as an emergency measure. The relative had raised a complaint about the care and support that the person was receiving, and told us that they were not happy with how the provider had responded to them. Their concerns had also been raised to the local authority who funded the person's placement. The provider told us about what they had done to respond to the relatives' concerns, as well as to meet the person's needs and keep them safe while alternative placements were being sought by the local authority. This included liaison with a nurse who specialised in mental health and learning disabilities, who told us, "They [MOST] liaised with involved professionals and explained the decisions for their actions. They asked for help and tried to implement the recommendations of involved professionals". The local authority were investigating the complaints and the registered provider was

continuing to respond to the relative's concerns.

The failure to establish and operate an effective system for recording and responding to complaints was a breach of Regulation 16 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

The service promoted a positive culture that was person-centred, open, inclusive and empowering. One staff told us, "I used the communication book to leave a message for staff about the house meeting. If not everyone attended then previously people's meal choices were being made for them by other residents. I have asked staff to leave it blank when people have not attended the meeting so they can be approached individually to make their meal choice." Another staff member commented, "If I have a problem I can contact the office and there is always someone there to help or reassure that you have done the right thing. The coordinators visit the houses and so there is the opportunity to discuss things when they visit so it can be sorted there and then. They come and give guidance and help find where information is recorded in people's support plans." A care co-ordinator told us, "We are here to promote people's independence; for them to make their own lifestyle choices and decisions about what they want to do." One person told us, "If I have a problem I can talk to my key worker, the house manager or any staff in the house." One relative commented, "If I need to speak to someone I talk to the staff or phone [care co-ordinator] and she filters down any problems and resolves them."

Staff members were not consistently supported by the management team. We looked at the registered provider's grievance procedure and found that staff members who had taken out grievances had their grievance heard openly and fairly. However, we found that one person who had lodged a grievance had not received supervision for over six months. When we spoke to the registered manager about this we were told that a formal supervision had been booked to support the person. Other staff we spoke to told us, "We have supervision every 6 to 8 weeks. I can sit down with the coordinator and sort out any worries I have about people I support or talk about any practice issues such as quality of staff recording. I can say what I think we need to do to support people. I have the opportunity to discuss professional development and if I wanted to develop further I feel I would be supported." Staff supervision records showed that some staff members were able to discuss any issues regarding people they supported or other staff members. Where one conflict between staff members had been identified the management team had addressed this through formal supervision which resolved the issue and allowed positive staff relations to develop.

However, supervisions and spot checks were not taking place regularly. We randomly selected three staff files and found that supervisions and spot checks on staff members were occurring with regularity in 2015, but were not happening consistently in 2016. A new member of staff had received three formal supervisions and one spot observation check in 2016. However, one of the two long standing staff we looked at had received only one supervision and no spot observations in 2016 whilst the other staff had received irregular supervision. Staff members told us that they felt they did not have adequate formal structures to provide input, through staff questionnaires or staff meetings. One staff member commented, "I have worked here for 3 years and have not completed a staff questionnaire. Staff meetings are not very regular, they used to be monthly but we haven't had one since July 2015. We can always feedback by contacting the coordinator or we could speak to the manager if needed, they are approachable and available when we need them." Another staff member told us, "I have been to one staff meeting a year ago. If I need to know anything or need support I know I can always ask." A third staff member told us, "I would prefer if there were more check ins to see how we are dong especially because of the change in manager and the merger."

We recommend that the registered manager reviews supervision schedules and ensures that all staff have access to regular formal supervision and regular staff meetings.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. However, these were not being consistently carried out. The registered provider had a quality assurance system which comprised of several checks including monthly monitoring checklist; feedback summary; monitoring visits; health, safety and environmental inspection and a medication audit amongst others. However, the monthly monitoring checklist which looked at numbers of incidents, service user reviews, staff sickness and other indicators or service quality had not been completed since June 2016. Other audits we looked at had also not been completed in recent months.

The audits that had been completed were of a tick box style and not focused on outcomes for people. We raised this with the registered manager, who had recently been appointed, and were told, "Our quality assurance manager has bought in a new audit tool that will be completed quarterly. The team co-ordinators do spot checks on staff, where one month they supervise and one month they observe them in their work. I've also bought in registered manager spot checks and have completed two and scheduled the rest in. I have made action plans from the monthly manager's audits. I will produce a service wide action plan form the latest quality audit to get things up to scratch." Some actions raised from the registered manager's audits were to review a person's hospital care plan and amend another person's risk assessment for travelling. We were given a copy of the quality audit produced by the quality manager. It had identified all of the issues we had highlighted and had produced an action plan for the registered provider and the registered manager to implement to make necessary improvements. However, it is unclear if the improvements suggested in the action plan had been made and embedded in the service

We recommend that the registered provider effectively monitors the quality of the services it provides.

The registered manager had a clear vision to make improvements to the service and to provide strong leadership to the staff team. The registered manager told us, "I try to lead by example and practice what I preach and incorporate the values of the organisation in to what we're doing. Those values are caring, self-confident, compassionate, principled, competence and open to change. I like to make sure I meet with staff in supervisions. They were used to passing problems to the registered manager and I'm trying to pass it back as part of their development. I'm trying to get support staff to write support plans and if there are vacancies I want support staff to step up."

The registered manager had recently been recruited and was aware of the challenges the service faced. We discussed the vision the registered manager had for the service and they told us, "I would like to see us more forward thinking around person centred reviews for example; make risk assessments more person centred and involve people. I previously used pictorial risk assessments and it worked well." The registered manager recognised challenges that the service faced and commented, "Recruitment is a massive challenge and we're looking at our pay. We struggle to recruit; some staff don't stay long and I want to understand the reasons behind that as well."

The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The locality manager confirmed that no incidents had met the threshold for Duty of Candour.

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 9 HSCA RA Regulations 2014 Person-centred care The registered provider failed to ensure that care plans reflected people's preferences.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had failed to carry out capacity assessments or best interest meetings for restrictions such as bed rails.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to safely manage and mitigate risks to people

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered provider had failed to establish and operate an effective system for recording and responding to complaints.