PossAbilities C.I.C

Harelands House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Outstanding ☆

Summary of findings

Overall summary

Harelands House offers short-term support accommodation to people over the age of 18 who have a learning disability. They provide respite to parents and carers of people who are cared for in their own home. Harelands House is adapted to meet the needs of profoundly disabled individuals. Admissions to the home are usually planned but the service can also be provided if an emergency arises. There are a number of communal areas including a lounge, a dining room and a garden. Parking is available to the side of the property. The service has 82 people who have access to the service. Three people were accommodated at the home on the days of the inspection.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection. However, the service improved to outstanding in well-led.

The inspection took place on 16 and 17 January 2018 and was announced in line with our guidance to ensure staff were present at the service.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager had been in post since October 2014.

Staff were consistently kind, caring and supportive and although most often they only supported people for a short period of time had developed positive relationships with people who used the service and their families.

The views of people who used the service were sought regularly using people's own individual communication methods.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. Staff also supported family members, for instance the service could take people if there was an emergency to ensure their care was maintained. Staff tried as much as possible to ensure that when people came into the service they followed their routines and activities they normally did at home.

The registered manager and staff understood the principles of the Mental Capacity Act (MCA) 2005 and worked to ensure people's rights were respected.

Staff were supported to undertake their roles and had incentives to perform better. Staff also received

induction, training and supervision relevant to their roles. This ensured they had sufficient knowledge to meet people's needs.

Managers at the home and head office audited systems to help maintain and improve performance.

There were safe systems in place for the storage and disposal of medicines. Staff received training in how to administer medicines and had their competency in this area assessed.

People received individual care packages which took account of their needs which were mainly a learning disability or Autism. Staff were trained in the care of people with these conditions and how to safely de-escalate any behaviours that challenge. There was also the provision of equipment such as track hoists for people with mobility issues.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains safe.	**Good**
Is the service effective? The service remains effective.	**Good**
Is the service caring? The service remains caring.	**Good**
Is the service responsive? The service remains responsive.	**Good**
Is the service well-led? The service has improved to outstanding in well-led.	**Outstanding** ☆

Harelands House

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 16 and 17 January 2018 and was announced. The provider was given 48 hours' notice because we wanted to make sure the registered manager and staff would be available to speak with us. The inspection was carried out by one adult social care inspector and an 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 care service.

Before the inspection we looked at previous inspection reports and notifications received from the provider. A notification is information about important events which the provider is required to tell us about by law. We reviewed the Provider Information Record (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, this tells us what the service does well and the improvements they plan to make. We used this information to help plan the inspection.

We spoke with six relatives, the registered manager and six care staff members. People who used the service were unable to communicate with us although we saw from their body language and replies they could make that they were happy using the service.

During our inspection we observed the support provided by staff in communal areas of the home. We looked at the care and medicines administration records for three people who used the service. We also looked at the recruitment, training and supervision records for four members of staff, minutes of meetings and a variety of other records related to the management of the service.

Good

Is the service safe?

Our findings

The service continued to provide safe care to people.

Relatives we spoke with said, "My relative is very wobbly. Anything unexpected, whether it's a noise, someone coming into the room or a sudden movement causes them to fall and safety depends on the awareness of staff anticipating and avoiding pitfalls. Nothing untoward has happened here. Obviously, I worry about him when he's away, but there are no undue worries about his safety here,"; "Yes, it's safe,", "There are no issues here, apart from little incidents, mainly minor friction with other clients, but nothing to complain about," and "It's very safe here. The staff members always look out for my relative and there are no concerns."

Staff had received training in safeguarding adults and understood their responsibilities to identify and report any concerns. Staff were confident that action would be taken if they raised any concerns relating to potential abuse. We saw that management audited any safeguarding concerns to analyse ways to help reduce further incidents. Staff we spoke with said, "I am aware of the whistle blowing policy. I would use it. I have completed investigations. We do not investigate within own service but the investigation would be completed by staff from another unit" and "I would be sure to use the whistle blowing policy. At the last service I did whistle blow but I felt like I was the one scrutinised. I have confidence that it would be handled sensitively here. Any investigations are handled professionally and productively here."

The provider continued to have safe recruitment and selection processes in place. Recruitment records contained the relevant checks. These checks included a Disclosure and Barring Service (DBS) check. A DBS check allows employers to check whether the applicant has any past convictions that may prevent them from working with vulnerable people. Two written references were obtained and any gaps in employment checked to ensure staff were safe to work with vulnerable adults.

Risk assessments we saw helped ensure care was safe but allowed people to remain as independent as possible. We saw that risk assessments were undertaken and reviewed for personal care needs and to be safe in the community. A person's age, gender, disability, religion or sexual orientation was assessed and any risk assessments would take account of any special needs.

People were supported to take risks, which was balanced with their safety and health care needs. Staff identified when certain behaviours from people could impact on their safety and others within the home. Staff considered what triggers may affect behaviours so these could be avoided, for example pain, animals or places that people did not feel comfortable with.

There were sufficient numbers of staff to look after the people accommodated at the home. There was a system to ensure enough staff were on duty for pre-booked respite care and staff can be called on when needed from a sister home or the main part of the service, the Cherwell Centre.

There were safe systems to administer medicines. Staff were trained in medicines administration and

regularly had their competency checked. We looked at the storage and recording systems and found them to be safe. Medicines were checked in when people came for respite care and checked out again when they left. There was provision to obtain medicines in an emergency if a person ran out of any medicines, which were usually provided by families. The systems in place showed people were kept safe from the risks associated with the management of medicines.

Relatives told us, "The home always seems to be clean and fresh smelling"; "It's clean here" and "Harelands House has always been clean when I've visited. It's a pleasant environment, not at all institutional, and it feels homely." The service was clean and tidy on the days of the inspection. There were systems to prevent and control infection. The service used best practice guidelines (National Institute of Clinical Excellence) to prevent the spread of infection and staff had access to personal protective equipment when needed. Managers regularly audited the infection control systems to keep people who used the service and staff safe. We saw the audits which were robust.

The provider had a policy in place for investigating concerns, accidents and incidents. We saw how an investigation detailed the steps involved and included looking at why the incident had occurred and identifying any action that could be taken to keep people safe. This meant the registered manager and staff had clear guidance on how to investigate accidents and incidents and learn and make improvements. There was always a debrief after any behaviours that challenge occurred. This was to support staff and try to find out if there were any triggers that could be avoided.

Good

Is the service effective?

Our findings

The service continued to provide effective care..

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The service used the NICE decision making and mental capacity guidelines for the MCA, DoLS and best interest meetings which is considered to be good practice.

People were supported in line with the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. Staff had received training about the MCA and understood how to support people in line with the principles of the Act. The registered manager said, "We have completed best interest meetings and Deprivation of Liberty Safeguard (DoLS) applications. Because it's the parents that need the respite if people stay longer than 72 hours and do not have capacity we will put in a standard application. We currently have 11 applications with the DoLS team who have given us great support." We saw evidence of best interest meetings and DoLS applications. This helped protect the rights of people who used the service.

Relatives we spoke with said, "The staff go out of the way to help. For example, I spoke to one staff member in December 2017 about a particular matter at our home and she advised me to get in touch with Occupational Health. I can ask her for guidance at any time" and "My relative has just had a dental operation and a lot of time was devoted by the staff here to giving input into planning for the operation and managing their post-operative recovery. Staff members are also actively involved currently in planning for another operation. I honestly feel that this is exceptional in terms of day care provision."

Each person was assessed prior to admission. This could be a brief phone call if the person used the service regularly or an extensive visit. For new people we saw examples of the assessment process. A case study was produced which looked at their background history, where other services and professionals were involved with the person's health care, social needs and family relationships. People were encouraged to start with short visits, take a meal, perhaps go for an activity or stay for one night. The person was observed to see how well they were able to settle in. This ensured people's diverse needs were recorded prior to admission. One person needed her bed facing a certain way and another required only female staff. This was provided following assessment and showed how the service ensured people's support met their needs. There was a staff member dedicated to assessing prospective service users to ensure there was a consistent approach.

We saw that the service provided a comprehensive induction, including completing the care certificate if they were new to the care industry. Training was ongoing and included mandatory training such as health and safety, first aid, food safety, fire safety, medicines administration, infection control and moving and handling. Staff were encouraged to complete a recognised course in health and social care. Staff also had access to training for Autism, learning disability, behaviours that challenge and end of life care. This ensured staff had the skills to meet people's needs.

Staff also had access to managers for support. This included regular supervision and an appraisal. Staff were able to discuss their careers and enabled managers to monitor their performance.

People were supported to maintain their nutritional needs. Staff received training in good nutrition and told us they would advise people to take a healthy diet. The service could and did cater for special diets for cultural or health needs. On assessment people helped complete a food and fluid pen picture. Records we saw showed one person needed soft foods, had input from a speech and language therapist and needed extra time to eat safely. Staff used people's known communication methods to determine what they liked to eat including the use of pictures, easy read information or use of a notepad and pen.

We saw people had access to professionals including GP's, specialist nurses, dieticians, hospital consultants, occupational therapists and dentists. We saw that staff would escort people to appointments, which was recorded in the plans of care if the arrangements had been made prior to admission. This helped meet people's health care needs.

The environment was suitable for people who used the service and had bedrooms on the ground floor which were adapted for people who had mobility problems. People who used the service usually chose the room they wanted to stay in and in the past had helped choose the décor. One family member had thought there was not sufficient communal space so the service had built another building in the garden for people to use. This building had light, electricity and was furnished and used for activities.

We saw that staff asked for consent before assisting someone and encouraged people to do the things they wanted to do. Families were consulted about people's care and best interest meetings held for supporting people who may not understand their care.

Plans of care and other documentation showed how staff communicated with people in various ways to ensure they were aware of what people wanted. A lot of the documentation was in an easy read format. Staff also used pictures to help people communicate their needs, electronic aids like a communication pad or pen and paper. We saw that staff had a good knowledge of how people communicated which helped ensure they could meet their expectations. The service trained some staff to be champions. Staff are taught specialist knowledge about a specific aspect of care and support. Two staff were communication champions. They provided expertise on sensory stories, talking mats, dignity and creating tools to assist people. The tools would help explain to a person who used the service, in easy terms, topics such as going to the dentist or moving house to help alleviate any distress. The champions passed on their knowledge to staff who needed assistance.

Good

Is the service caring?

Our findings

The service continued to be caring.

Relatives told us, "Staff can manage my relative's condition with a firm, but fair hand. The staff listen to us and understand the whole nature of how my relative operates and on what level. They understand him as an individual. This place is a lifesaver though. This place is our anchor in life"; "Staff members are pleasant, friendly and flexible. What's good is that they seem to have a common sense approach and don't follow a rigid formal procedure. The staff members must be caring, otherwise my relative wouldn't be happy about coming here."; "They genuinely care. It's been right from the word go, for example in programme planning. They are flexible and accommodating here. I feel that my relative come on so much with the ability to cope more effectively and engage much better with the community. During the last two to three years, the excellent care and support that has been given has had a massive impact. My relative likes their own space, but now tolerates other people much better than he used to", "All of the staff are caring and they listen" and "This is a caring home and all the staff seem to be very kind. My relative wouldn't want to come if they weren't." Family members were satisfied with the support they and their relatives received and that staff were kind and caring. They also told us how much they appreciated the service and gave them a regular break which they needed.

Family members also said, "I believe that my son's independence is supported well here. For example, he's allowed to do things for himself, albeit supervised, for example, making a cup of tea" and "My relative's independence is limited. However, he is able to make a cup of tea supervised here, just like at home." People were supported to be independent.

We saw that people were able to stipulate the gender of the member of staff they wanted and this was provided if possible. We also saw people's wishes were taken into account with regard to the delivery of their personal care. Relatives commented on how they appreciated how routines were followed which helped protect the dignity of people who used the service because they received the care they wanted.

Plans of care were developed with the person, family members and relevant professionals. This showed how the service supported people to express their views and be actively involved in making decisions about their care, support and treatment as far as possible.

People were asked what they wanted to do and encouraged to do new things. For example one person had never been to the cinema and after a trial visit liked it. This was another activity the person now had the confidence to enjoy.

There was a policy on equality and diversity. This gave staff information on how best to plan care for an individual. Plans of care took account of a person's gender, culture, language or communication method, religion and sexual orientation. There were various examples of how this was put into practice. People had a choice of staff, what they ate, how their religious needs were met and attended suitable activities.

Information was stored safely and securely. Records were kept in a locked office in cabinets and computer screens were not in public view. There was a confidentiality and data protection policy for staff to follow good practice. This ensured records were only seen by the staff who needed to have access to them and helped protect people's privacy.

We observed staff at various times during the two days. Staff were kind, caring and compassionate. People were taken out to places they wanted to visit and supported by staff to do so. We also saw there was a good rapport with a visitor of one of the people who used the service.

Staff we spoke with said, "I would be confident to refer a member of family if they needed this care. I have always actively involved my own children in mixing with people with a learning disability" and "I would be absolutely happy for a member of my family to use this or the sister service. I like working at this service. I like the challenge. I work well under pressure. I like the people who use the service. It is like working in a holiday home."

Good

Is the service responsive?

Our findings

The service continued to be responsive.

The service's aim was to provide regular, planned respite care for people who had been assessed as requiring it. However, the service responded to urgent requests for respite care. If the home was full the service used a local holiday company and provided staff in lodge type accommodation. This meant the people who used it had the care they needed but also remained local and could enjoy the activities they were used to. The service was therefore flexible in providing an emergency service that met people's needs.

The care plans we looked at remained good. We looked at three plans and saw they showed how the service met their individual needs. People's choices, likes and dislikes where recorded for people to be treated as individuals. Plans were reviewed at each new admission and updated as required when people were staying at the home. We saw some reviews included people who used the service, family members, staff from the home and associated professionals. This ensured people's care was understood by all and therefore was consistent. If required the review was also published in an easy read format to help people understand any changes.

There was a daily record which showed what a person had done and how they had been. This was a comprehensive record and any relevant information was passed on to other staff during a handover between shifts.

We saw that the service was developing a new care plan system which would be computer based. People who used the service would be able to access it and add their own comments, ideas and if they wished photographs. When fully operational this would show how people could contribute to their care planning.

Information about how to raise a compliant was displayed at the service. It was written in an easy read format to help people to understand the process. There was also a version which told people how to complain, who to complain to, how the service would respond within timescales and the details of other organisations such as the Care Quality Commission. We saw the service had responded to family members who had complained, which was around clothes going missing but the two family members who told us this said the clothes had been found. We saw staff were reminded about the importance of keeping an inventory of people's clothes on admission so they were aware of what needed to be returned when they left. This showed the service responded to concerns in a timely manner.

One family member also told us about an incident around a person accommodated at the home who showed inappropriate behaviour to her relative and thought the investigation could have been better communicated to them. We spoke with the registered manager and were satisfied the concern had been investigated and told her of the family member's view. Other family members said staff acted upon any concerns or wishes they told them. All family members said managers were approachable and they could talk to them.

Staff had close relationships with day centres and colleges and attended meetings with them to discuss a person's needs. People were supported to attend them which ensured people's routines were followed and they did not lose out on activities or learning.

People had access to activities of their choice. One person had shown an interest in photography and this was now part of their care package whilst in the home. The person had also been on a tram, to the pub, bowling, watching steam trains and learning to use a computer. The service also had other activities on offer in separate locations. There was a building where people could join in various activities including making pottery, gardening, growing fruit and vegetables, cooking and arts and crafts. The activities coordinator said they had made chutney and sold it with the money put towards other activities.

In another location there was a petting zoo and café. People could go there to socialise or join in activities which included getting involved with the animals. One person had gone to this centre during the inspection.

People were taken to places of interest. This included a safari park, various parks for a walk, to the seaside, to play snooker or pool, pamper sessions, board games, music therapy, going to the gym and swimming. Sometimes there were parties in the home for people to enjoy.

People were also assisted to learn life skills. We saw people were encouraged to cook, bake, tidy up communal areas, keep their bedroom clean and improve their abilities to care for themselves. Activities were meaningful and fulfilling.

Family members we spoke with told us, "I have attended the yearly meeting, but we have regular, ongoing communication, which I think is most effective"; "I've received questionnaires asking similar questions to the ones that you have asked. Areas include asking about the staff, their care, any changes and if we're happy with the service in general. I feel that changes have been accommodated, for example, with the bathing", "I am very anti-questionnaires. I'd rather deal with people directly and speak on a 1 to 1 basis and it usually gets sorted out" and "There are questionnaires to actively seek feedback. It all works well. We've never needed changes. As far as I'm concerned this is the perfect place."

Outstanding ☆

Is the service well-led?

Our findings

The service had improved to outstanding.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager had been in post since October 2014.

Relatives we spoke with gave us extremely positive comments about the service and what it meant to them and their family members to visit and stay Comments included, "All the staff members here are great. The whole thing makes us feel more relaxed. Everyone is approachable and we know that he's in the hands of good people, who care"; "I can talk to the managers here for hours on end. They are very approachable and give good advice. I honestly don't know where I would have been without them. My relative comes in either from Monday to Friday, or at the weekends. It's a great facility"; "I can talk to the manager about my relatives care. They are approachable people and they do listen"; "I feel that we have very good relationships. Everything is worked through relatively informally, such as sorting out holidays and time changes in covering support needs. I feel comfortable with the way it all works. I'm more than happy with the provision, limited to a budget. One staff member in particular has been exceptional, terrifically supportive of me as a carer and goes way above and beyond"; "I think it's well led here and I can approach any of them about my relatives care. I think the best advert would be that I could recommend this place to anyone. In fact I have recommended it and people are now using the service and are pleased that it has been my recommendation" and "I can talk to the manager, who is very approachable and everybody seems to listen, apart from the clothing issues, which is very positive. I feel it's a blessing having a few days peace of mind each month."

Staff we spoke with told us, "The managers are massively supportive. We all spend time together. One big happy team"; "I am supported by managers. They have an open door policy. They are not frightened to tell you when you have done well" and "The managers are here when you need them."

The service trained some staff to be champions. These staff are taught specialist knowledge about a specific aspect of care and support. They were available to provide mentoring or advice in their areas of knowledge to other staff in the organisation. Staff were provided with a list of names and their roles to be able to contact them. Champions had been trained for Autism, equality and diversity, communication, dementia care, mental capacity and DoLS, moving and positioning, nutrition and safeguarding. This meant there were specialist staff to provide advice and guidance for many aspects of care the service provided and meet people's diverse needs. They also used this knowledge and expertise to improve practices in the service.

The service had a three year strategic plan which looked at difficulties facing the care industry, valuing people, ensuring people received good health and social care and setting goals. We saw the goals included the use of technology which had been commenced with the new plans of care which showed the service were working towards the plan.

Staff who wished were put on a career succession plan. This meant staff could put forward their goals for the future. Management would through discussion and appraisal decide what training the staff member would need to achieve promotion to the post when available. One staff member told us how it worked and said, "I stood in for the registered manager with support, training and I am now completing level five in management in the health and social care field. Some of the staff have completed all the training with a view to be promoted and this cuts down on the need to look for external staff." Staff were encouraged to improve their career prospects within the organisation and given the guidance and training required.

Staff were offered incentives for good performance. A ceremony was held and awards given. A staff member told us, "I won a staff award for leadership, which I attribute to the training and support I received from the succession plan." We saw the categories and how staff were nominated. Staff we spoke with were extremely enthusiastic and thought it was a good idea and got involved where they could.

The service had been nominated for the Skills for Care accolades which were due to be held in March 2018. This meant the organisation had been recognised by an external organisation for their delivery of service. The service had signed up to the Social Care Commitment which is the care sectors promise to provide people who need care and support with high quality services.

The registered manager and other managers regularly audited many aspects of the service provided. Audits included health and safety, infection control, complaints, the environment including the maintenance of gas and electrical equipment, activities, menus, fire systems, safeguarding, accidents and incidents, care plans, daily records, finances and training. The audits were analysed by the registered manager and also by managers at organisations head office. An action plan was produced to improve any areas managers thought were needed. The action plan document highlights which members of staff are responsible for completion and a date to be completed by. There was a coloured risk system to show if the action had been completed, was underway or not completed. From the audit we saw action had been taken to update policies and procedures, the implementation of the new plan of care and improved safety whilst people are out on activities.

There was a weekly house meeting. This was produced in an easy read format and told us what had been discussed. Activities were discussed and had been tailored that week for the people who were accommodated. From the last meeting two people had become more involved in the house. One had helped with domestic duties, the other had cooked. This showed the service ran a highly personalised service, tailored to individual needs and in accordance with their individuality.

There were various groups who met including well-being, a staff advisory group and a service user advisory group. The service user advisory group was open to staff, people who used the service and their carer's or relatives. From the meetings speakers had come in to talk about mental health and nutrition. Improvements had been made from discussion at the meetings which included improving the car park and drainage in the garden.

The organisation held board meetings to discuss performance and the future. The board was made up of senior staff from PossAbilities and four family representatives. This gave people who used the service and their family members the opportunity to help drive the service forward. Discussion at the last meeting was around the proposed development of more supported living flats to bridge the gap between respite care, living at home and moving to more independent living. This initiative will be of benefit to people associated with the service and their future care provision.

There were regular further general staff meetings held around every six months. At the last meeting of July

2017 new staff were welcomed and discussions were held around medicines administration, taking photographs for the new IT system, keeping the house clean, handover books and handovers, keeping diaries up to date, house rules, incident and accident reporting, fire checks, not using mobile phones at work, use of PPE, not using social media and discussions around the care of people who used the service. Staff were able to have a say at the meetings which gave them a chance to say how the service was ran and helped increase their responsibilities in improving the service.

Senior staff also held regular meetings. We saw at the last meeting items on the agenda included budgets, business updates, complaints and compliments, recording of accidents and incidents, the staff situation including leavers and vacancies, promoting choice and control (this is the promotion of individual budgets for people who used the service), future developments, encouraging employment opportunities, improving the health of staff and better access to healthcare for people who used the service. Senior staff were kept up to date with the organisations aims and objectives.

We looked at key policies and procedures and noted that many were produced in an easy read format. Easy read formats included how to complain, safeguarding, health and safety, finance safety, the mental capacity act, confidentiality, relationships and sexuality, whistleblowing, privacy and human rights. All policies were up to date and gave staff and people who used the service good practice guidelines and procedures a how to do it guide. Guidelines to support staff were usually from an organisation known as the Clinical Institute for Clinical Excellence. We saw this guidance for medicines, infection control and care in a residential setting. This guidance is considered to be good practice for services to follow.

There was a statement of purpose which told us who the provider was and key legal details and a service user guide to inform people who used the service, family members and professionals of the facilities and services provided.

We saw the service liaised with many other organisations including colleges, learning disability professionals, speech and language therapists, social workers, GP's and other medical professionals and advocates/independent mental capacity advisors (IMCA). An advocate is a person who acts independently to protect a person's rights and an IMCA acts in a person's best interests to ensure any decisions made on their behalf are the least restrictive. This showed how the service was able to keep people's health and social care needs up to date.