Advance Housing and Support Ltd

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out this comprehensive inspection on 18, 19 and 22 May 2017.

Advance Housing and Support provides a supported living service to adults with learning disabilities across 11 sites in East London and Kent. At the time of our inspection there were 47 people using the service, of whom 44 people lived in the supported living services.

At our last inspection in March 2016 we rated the service "good", but made a recommendation about how the service monitors medicines and people's finances. At this inspection we found that the provider had made improvements in this area, and remained "good."

The provider had made improvements to ensure that people received their medicines safely and that systems were in place to audit the management of people's finances.

The provider had measures in place in order to safeguard people from abuse and manage risks to individuals. We saw that when allegations and complaints were made, these were investigated by managers and appropriate action was taken in response. There were detailed plans in place for assessing and mitigating risks to individuals. This included the use of positive behavioural support plans to enable to staff to manage and prevent episodes of behaviour which may challenge.

Care plans were person centred and contained detailed information about people's needs and wishes. The provider had clear guidelines in place for people to ensure they were supported in the way that they wanted and to ensure that care was effective. People received support to eat healthily in a manner of their choice, and we saw that staff supported people to maintain good health through health action plans, and working with other health professionals.

Staff understood how best to communicate with people, and this was aided through communication passports and detailed information on how best to support people to speak up. The provider used daily records, tenants meetings and other methods for consulting people about their care. There were systems of audits completed by managers to ensure that services were safe and that care was delivered appropriately. Staff were recruited in line with safer recruitment measures, and staffing levels were in line with people's support plans.

People had consented to their care, and when people lacked capacity to do so the provider met its responsibilities to assess people's capacity and demonstrate that they were acting in people's best interests. 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 supported this practice.

Staff received appropriate levels of supervision and benefitted from a detailed induction programme. Staff were required to undergo regular refresher training in key areas, however in some areas staff had not had

this on time, and systems didn't always allow managers to detect when this had happened. We have made a recommendation about this.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The provider had taken action to ensure that people's finances and medicines were safely managed. There were measures in place to safeguard people from abuse and to manage risks to people, including checks of people's accommodation.

The provider carried out safer recruitment measures to ensure staff were suitable for their roles, and there was sufficient staffing provided in line with people's support plans.

Is the service effective?

Requires Improvement

The service was not effective in all regards.

Staff received regular supervisions and a thorough induction, however some staff were overdue for refresher training and there was not a centralised system in place to monitor this.

There were measures in place to show that people had consented to their care, and where people lacked the capacity to do so, that the provider had met their responsibilities in line with the Mental Capacity Act (MCA) 2005. People received support to eat healthily and to maintain good health.

Is the service caring?

Good

The service remained good.

Is the service responsive?

Good

The service remained good.

Is the service well-led?

Good

The service remained good.

Advance Housing and Support Ltd

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This was a routine comprehensive inspection.

This inspection took place on 18, 19 and 22 May 2017 and was announced. The provider was given notice of this inspection because the location provides a supported living service for younger adults who are often out during the day; we needed to speak to people in their own homes and needed the provider to let people know we would be coming. The inspection was carried out by a single inspector.

Prior to carrying out this inspection we reviewed information we held about the service, including notifications of serious incidents the provider is required to tell us about. We also contacted commissioners in three local authority areas to ask if they had any concerns about the service.

In carrying out this inspection, we visited three sites where the provider supports people to live in their own homes. These were Rotheley House, Hackney, Springtail Court, Newham and Orchard Avenue, Bexley. We spoke with seven people who used the service and made calls to two relatives. We spoke with the registered manager, deputy manager, three service managers, two link workers and a support services auditor.

We looked at records of care and support and financial support for seven people, and records of medicines administration and management for seven people. We reviewed the personnel files of six staff, including records relating to recruitment and supervision. We also looked at records relating to the management of the service, including training, supervision and checks and audits that managers had carried out.

Good

Is the service safe?

Our findings

At our previous inspection in March 2016, we made a recommendation about how the provider monitored people's finances and medicines. At this inspection we found that the provider had made improvements in these areas.

Where people were supported with their finances, we saw that the provider kept records of when people were supported to make withdrawals and receipts were kept of people's transactions. Managers checked cash tin balances against these transactions, and where appropriate managers had checked people's bank statements against these, or recorded whether there was a financial appointee responsible for doing this. There were guidelines on people's plans which detailed people's ability to manage their finances, and the provider completed risk assessments which contained detailed information on how people were to be protected against loss or financial abuse. Managers submitted monthly information on whether the support people received was documented in their support plans and when cash tins and bank statements had been checked or who was responsible for doing this. An external auditor had carried out checks at some of the services regarding the management of money, and where issues had been highlighted these had been addressed.

We found that medicines were safely managed by the provider. In response to our last inspection report, where we identified issues with auditing of recording of medicines in some services, these services had introduced weekly checks, which meant that this was now completed satisfactorily. People's support plans recorded the name, form, dose and time of medicines, as well as the reason for the medicine and any possible side effects. Medicines administration was recorded on suitable Medicines Administration Recording (MAR) charts. We reviewed recent MAR charts for seven people who received support with medicines, and found that these were completed correctly by staff and checked by managers either monthly or weekly, depending on the service. Where checks had revealed issues with recording these were followed up by managers. Staff had received observations of their competency and knowledge of administering medicines safely.

There were personalised guidelines in place for people's medicines, this included how people liked to take their medicines, and provided advice specific to people, for example what staff were to do if a particular person was asleep at the time their medicines were due. There were also guidelines in place for when staff should administer medicines which were taken as needed (PRN medicines). In some cases this included emergency medicines to give to people when they displayed behaviour which could challenge. There was clear guidance for staff about when these should be given, and we found that these medicines were not administered frequently. We saw that stock checks were carried out for controlled drugs on a daily basis.

People who used the service and their relatives told us they thought the service provided a safe place for people to live. Comments included "The staff are very diligent and the security measures are fine" and "Nothing concerns me, nothing at all really." Staff we spoke with were aware of their responsibilities to report suspected abuse, and were confident that this would be taken seriously by managers. Where abuse was suspected, the provider had met its responsibilities to inform the local authority and the Care Quality

Commission (CQC), and investigated these concerns, drawing on a number of sources of evidence such as interviews with staff and CCTV footage from communal areas. The provider had an independent safeguarding panel with an independent chair. We saw records of this panel which showed it discussed recent incidents across the services and recorded their views on issues highlighted by this, including further actions for managers to take.

The provider had measures in place to address and monitor risk. Where risks were identified the provider documented their likelihood and severity, causes, and a risk reduction strategy. Plans included clear dates for review, and staff signed to indicate they had read and agreed with the contents. There was detailed information on people's plans for how these risks were managed, for example whether people had road safety or required support when accessing the community, and how risks were managed in a way which maximised their independence. For example, one person was provided with a sign to stick to the office door to show that they had gone out. There were guidelines in place for how to safely support people living with epilepsy, for example to bathe safely. There were missing person's profiles on people's files which included a recent picture and any relevant information which would need to be passed to police in the event of the person going missing.

Where people showed behaviour which may challenge the service, there were detailed guidelines in place for how staff could manage this, which included the use of positive behaviour support plans. These were colour coded based on build-up, crisis measures and post-reactive stages, and included signs that a person was in this stage and measures that staff could take to support the person. Where people had displayed behaviour that could challenge, this was recorded on charts which recorded the events leading up to the incident, what had occurred and what measures were taken in response to this. These charts showed that the service had been effective at managing and reducing behaviour which may challenge.

There were managers on site in the larger services and staff signed in and out on arrival, which meant that the arrival of staff could be checked. CCTV was in use in communal areas of the building, which was used to monitor staff arrivals when there were concerns about punctuality. Health and safety checks were carried out regularly for people's accommodation, these included checks of floor coverings, smoke alarms, fire exits and checks of food storage. Fire drills were taking place regularly, and managers recorded the response of people to the alarm and the level of support they required to evacuate safely, and this information was also recorded in personal evacuation plans, with procedures in place for what staff should do if a person was unwilling to evacuate the building. A quarterly audit was submitted by managers to the registered manager based around fire safety, infection control and safe storage of hazardous substances.

Where incidents had occurred, these were recorded appropriately with information on the nature of the event, severity, and whether the incident needed to be reported to the local authority and whether emergency services were involved. These were entered onto a central database along with any actions taken in response, and reviewed annually by the provider. Where appropriate, managers carried out a debrief with staff to learn more information about what had happened and any support which was required.

Staffing levels were sufficient to meet people's needs and staff were allocated to particular people in line with their support plans, including whether people required support for particular activities or tasks, or required constant support. Where appropriate, staff provided sleep in support for people. We reviewed the personnel files of six staff and saw that the provider had safer recruitment measures in place. This included checks of people's identification, address and verification that they had the right to work in the UK. Where staff had an employment history in health and social care, the provider had obtained two references. There was a checklist on each person's file to verify that these checks had taken place. The provider also carried

out a check with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, in order to help providers make safer recruitment decisions. Where this showed information of concern, a risk assessment had been carried out which was reviewed every three years. The provider carried out three-yearly checks of staff with the DBS, and maintained a central record of these checks in order to manage these.

Requires Improvement

Is the service effective?

Our findings

Staff received supervision every three months. Supervisions were used to discuss staff member's progress against agreed objectives and development plans and in order to give advice and staff to develop their practice, including how to use objects of reference or to follow positive behavioural support plans.

Staff underwent a four day induction on joining the service, this included training in health and safety, fire, safeguarding adults, administering medicines and handling money, incident reporting and missing persons procedures. There were also sessions for staff around mental capacity and deprivation of liberty, equality and diversity, learning disabilities and mental health awareness, risk assessment, support planning and lone working. Staff were enrolled on an online training system in order to receive refresher training, for example in fire safety and medicines. The provider told us that 42% of staff were working towards a National Vocational Qualification (NVQ) in health and social care or had completed this.

At the time of the inspection, the provider lacked a centralised system for monitoring training, and service managers monitored online refresher training. The provider told us that they would soon be introducing such a system, as it was not possible to monitor all staff training and the existing system did not incorporate courses which were part of an NVQ or provided online. This meant that in some areas staff were overdue for refresher training. Out of 74 staff, three staff required refresher training in medicines and six required refresher training in fire safety. This represented a small proportion of staff. However, more staff were overdue for other courses, with 17 staff requiring refresher training on food safety, and 24 staff being overdue for health and safety training. It was not always possible to tell from the provider's training matrix how overdue this training was.

We recommend that the provider take advice from a reputable source on how best to monitor and update staff training.

Where people had the capacity to do so, people had signed their plans in order to show their consent to their care and support. Where plans were signed by other people, there was information on file to show why a particular person had the authority to do so, for example due to orders from the Court of Protection. Where people lacked capacity to make particular decisions, the provider was meeting its responsibilities under the Mental Capacity Act 2005 (MCA). The Act 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. We saw that where people appeared to lack capacity in certain areas, for example consent to medical treatment or managing finances, the provider had assessed people's capacity to make this decision and where appropriate had held meetings where a person's best interests were discussed and agreed.

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. Where

people were at risk of being deprived of their liberty, the provider had met their responsibilities to obtain the necessary authorisation and inform the Care Quality Commission (CQC).

Support plans included information about people's nutritional needs, for example whether people required support to lose weight, and where necessary people had received support from a dietitian in order to draw up a healthy eating plan, which incorporated people's dietary needs and preferences. For example, where a person was attempting to lose weight, staff had worked with the person and a dietitian to compile a list of healthy recipes which were suitable for their vegetarian diet. Staff recorded on people's' daily notes what they had eaten, and there was evidence that people received varied diets. People's weights were monitored monthly to identity issues of concern.

Support plans also contained information about people's healthcare needs. For example where people had daily tasks which they required support with, such as applying a cream, this was documented in the plan and used to inform a daily shift support plan, which is a document which staff work from every day when supporting people, so that staff were prompted to support the person with these areas. Where people were recommended exercises such as from a physiotherapist, these were also included in support logs with a clear time for the person to be supported with these. A staff member told us that one person preferred to do these in a local café, and that staff supported them with this choice. Where people were living with epilepsy, staff monitored seizures as required.

People had health action plans, which included outlining aims and support required in key areas such as health appointments, maintaining mobility, foot health, nutrition, meals, shopping and emotional support, with particular areas of support carried forward into daily logs so that staff and people using the service were prompted to address these. Staff recorded health appointments, including what was discussed and recommended by health professionals and whether this had resulted in a change in the person's medicines.

Good

Is the service caring?

Our findings

People who used the service were supported to speak up. A relative told us "Staff respond in an appropriate fashion, with patience which is absolutely key. I have no complaints at all." A staff member said, "We need to be their voice when they need us to be." Tenants meetings were taking place in services, which were used to discuss matters which affected everyone, including day trips, gardening, housework and holidays.

The provider had recently held a national customer conference. This was used to discuss the provider's strategy going forward, and to give information to people on areas such as applying for jobs and how to keep safe. The provider facilitated a drama group for people who used the service, and we spoke with a person who had participated in a session at the conference which spread awareness of hate crime and how to keep safe when in the community. The person was able to demonstrate how they kept safe in public. A facilitator of the group said "[The group] is peer lead, we do it all together, the customers are just as involved in it."

Staff we spoke with were familiar with how best to communicate with people and what people's gestures and mannerisms meant, and support plans contained information on effective forms of communication, including the use of objects of reference or the exact phrase which staff should use. People also had communication passports, which included information on how people communicated, do's and don'ts for staff, what people like doing and what they did not like. Passports also included key phrases and pictures for people, and we saw evidence of a person routinely carrying and using their book.

We saw evidence of staff interacting with people respectfully and patiently, for example encouraging people to go out dressed appropriately, and we saw examples of staff and people using the service laughing and sharing a joke. Staff respected items which were important to people such as soft toys. Several people we met had pets, and there were guidelines in place for how best to support people to look after these. People we spoke with told us that they had chosen the colours and furnishing of their flats, and people had many personal items put on display. One person's plan stated they liked to have music playing constantly, which we observed was in place.

Staff supported people to compile one page profiles, which included information on what people were good at, what people liked and admired about them, what was important to people and how they stayed in control. There was also information on significant people such as family members or partners, and the skills and qualities that a person's supporter should have.

A manager told us that they had discussed a wish list with a person, and we saw photographs and records which showed that staff had met the person's wishes to purchase particular clothes and go on particular outings. The manager told us, "When I see [he/she] in those clothes, I can see [he/she] is living the way [he/she] wants to be….[he/she] said they had had the time of their life, I shed a tear."

There was information on support plans about how people had been supported with relationships, including sexual relationships and appropriate personal boundaries. This information had been used to

inform risk assessments and assess people's capacity to have sexual relationships. There was also evidence of staff seeking support from mental health professionals in areas such as bereavement. A manager told us "We're getting all the help we can and that's the main thing."

Good

Is the service responsive?

Our findings

The service used person-centred planning to ensure that people's needs and goals were met. Plans were based around eight key areas in which people needed support, and identified aims, action plans and preferred outcomes, with clear dates for review.

Different formats were available depending on people's needs, for example where people displayed behaviour which may challenge, plans were used with more detail about possible triggers and how staff could manage this, and other plans included more information on promoting independence within the community. There were highly personalised guidelines in place for areas of daily support such as domestic duties and personal care, which were based on the person's views and staff knowledge of the person. This included guidelines for how staff should respond when people showed particular behaviours which should challenge. One plan said "If [the person] does this, staff must ask if [he/she] is OK, hot or in pain….it opens dialogue." Another person's plan stated "If you are regularly late I may say I am OK, but it actually upsets me."

Plans were used to inform a daily support log, which acted as a plan for the day's support, with prompts for staff and the person on what needed to be done, and this was used to demonstrate that people received support as required. There was also summary information for staff who did not regularly work with the person.

People also had timetables in place, which showed that people accessed the community, college and employment. There was evidence of people regularly being supported to activity groups and spending one to one time with staff, for example for trips to museums and the park. There was evidence of the provider supporting people to move flat within the same service in order to provide sleep in support, and to provide a calmer environment for the people who lived there.

Complaints processes were displayed in services with an easy read format available. The provider had recorded complaints and documented how these were investigated, drawing on sources of evidence such as meeting with staff, examining equipment and records and other sources of information such as CCTV. Where people had complained, staff had recorded the complainants exact words and what they wanted to change. People we spoke with knew how to complain and who to talk to, for example one person used the Makaton sign for "manager". A relative told us "I was able to complain about it [the manager] sorted it out."

Good

Is the service well-led?

Our findings

People and their relatives told us they were happy with the way the service was managed. One relative told us "The current manager is very proactive and has done a cracking job," and a person who used the service said, "There is someone I can talk to, I can come down here and have a chat with someone."

The provider had extensive quality audits in place. Managers submitted a monthly report to the registered manager outlining regular checks, including those of support plans, risk assessments, medicines and finances. Service managers completed an audit of online training staff had completed, but this did not always include other sources of training. Where a service had identified issues, managers had put a service improvement plan in place, which included making improvements to supervision, medicines administration, health and safety and staffing. This plan was regularly reviewed by a manager to track and review progress. The provider was in the process of implementing regular external audits, and had appointed a support services auditor to implement this. This included checking records and making observations of care, and seeking the views of people and their relatives.

Managers encouraged a diverse range of approaches to care planning in order to meet people's needs, for example by implementing different types of support plans. The registered manager told us "We used to have a unified way of doing this, but this wasn't person centred. The key thing is that it works for the people we support." Support plans were used to outline the values of the organisation and its purposes, the aims for the plan and provided information on how staff were trained.

The provider hosted a national conference to learn about organisational changes and to provide an opportunity for people to voice complaints and dissatisfaction. Team meetings usually took place monthly within the services, these were used to discuss customer needs and recent changes, with a clear action plan agreed each time.

The provider had carried out a national customer satisfaction survey, which was used to record how satisfied people were with the service, whether they felt safe with staff and in control of their support. This survey could be broken down to this location, and showed a high level of satisfaction amongst people who used the supported living service.

The provider displayed their ratings from the previous inspection in the registered office and in the houses we visited, and this information was also on their website. The provider was meeting their responsibilities to inform the Care Quality Commission (CQC) of significant events.