The Lantern Community

# Field Maple Tree

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

The inspection took place on 6 February 2018 and was announced. The inspection continued on 7 February 2018 and was again announced.

Field Maple Tree is a service made up of three homes in a neighbourhood on a large community campus. It is based on the outskirts of Ringwood and provides care and support to people with learning disabilities. It is registered to provide personal care. At the time of the inspection the service was delivering personal care to 14 people.

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

Not everyone using Field Maple Tree receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

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

Medicines were not always managed safely. There had been a total of 41 medicine errors between January 2017 and January 2018. This had meant that on occasions people had not been administered medicines and other occasions insufficient quantities were available.

Robust governance and quality monitoring systems were not being completed regularly, established or embedded within the service. This meant that some areas for improvement to keep people safe had not been identified or actions put in place to address them. Staff supervisions did not take place regularly and annual appraisals were not completed.

Where it was thought that people had variable capacity, assessments and best interest decisions in relation to care and treatment and medicines had not been completed.

Incident reporting systems were not always effective or investigated appropriately.

People, relatives and staff told us that the service was safe. Staff were able to tell us how they would report and recognise signs of abuse and had received safeguarding training. People were provided with information about how to keep safe and were asked their desired outcomes following any alert made.

People's independence was promoted and staff supported people to develop life skills. People told us that staff were kind and caring.

Personalised care plans were in place which detailed the care and support people needed to remain safe whilst having control and making choices about how they chose to live their lives. Each person had a care file which also included guidelines to make sure staff supported people in a way they preferred. Risk management plans were completed, reviewed and mostly up to date.

People were supported with shopping, cooking and preparation of meals in their home. The training record showed that staff had attended food hygiene training.

People told us that staff were caring. During visits we observed positive interactions between staff and people. This showed us that people felt comfortable with staff supporting them.

Staff treated people in a dignified manner. Staff had a good understanding of people's likes, dislikes, interests and communication needs. Information was available in various easy read and pictorial formats. This meant that people were supported by staff who knew them well.

People, staff and relatives were encouraged to feedback. We reviewed the findings from quality feedback questionnaires which had been sent to relatives and noted that it contained positive feedback. There was an active system in place for recording complaints which captured the detail and evidenced steps taken to address them. We saw that there were no outstanding complaints and that other complaints had been managed in line with the local policy. This demonstrated that the service was open to people's comments and acted promptly when concerns were raised.

Staffing was delivered to a group of people in each house instead of being constructed to support individuals and medicines and care records were kept together in one centralised place like a care home setting. We found that this did not have a negative impact on people.

Staff had a good understanding of their roles and responsibilities. Information was shared with staff so that they had a good understanding of what was expected from them.

People, relatives and staff felt that the service was well led. The management team encouraged an open working environment. People and staff alike were valued and worked within an organisation which ensured a positive culture was well established and inclusive. The management had good relationships with people and delivered support hours to them.

The service was aware of their responsibilities under the Health and Social Care Act 2008, Duty of Candour, that is, their duty to be honest and open about any accident or incident that had caused, or placed a person at risk of harm. They also understood their reporting responsibilities to CQC and other regulatory bodies and

provided information in a timely way.

We have made a recommendation to the provider to seek guidance about good practice guidance on the subject of Supported Living.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

People did not always receive their medicines safely. There had been a high number of medicine errors during the last 12 months. Incident reporting systems were not always reviewed and analysed effectively which meant that some incidents were not always seen as significant.

Lessons were not always learnt or improvements made when things went wrong.

There were sufficient staff available to meet people's assessed care and support needs.

People were supported by staff who had completed safeguarding adults training and were able to tell us how they would recognise and report abuse.

People were protected from harm because risk management and emergency plans were in place and up to date.

People were protected by the prevention and management of infection control. Policies, equipment and schedules were in place.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

People were not supported by staff who were supervised to ensure they had the correct skills and knowledge to support.

People's capacity had not always been assessed and best interest decisions had not always been recorded.

Staff received training specific to the needs of the people they were supporting.

People's needs were assessed; goals and outcomes were set by people and supported by staff to achieve them.

The service worked effectively across organisations during transition and admission to assess, meet and whenever possible exceed expectations.

Staff supported people to maintain and understand healthy balanced diets. Dietary needs were assessed where appropriate and met by the service.

People were supported to access health care services and local learning disability teams.

## Is the service caring?

Good

Staff had a good understanding of the people they cared for and supported them in decisions about how they liked to live their lives.

People were supported by staff that respected and promoted their independence, privacy and dignity.

The service was caring. People were supported by staff that spent time with them and treated them with kindness and compassion.

People were supported by staff that used person centred approaches to deliver care and support.

## Is the service responsive?

Good

The service was responsive.

Care file's, guidelines and risk assessments were up to date and reviewed and reflected people's current needs.

People were supported to access the community and take part in activities which were linked with their own interests and hobbies.

Information was provided to people in a variety of formats in line with the Accessible Information Standard.

A complaints procedure was in place which included an accessible easy read version. People and relatives were aware of the complaints procedure and felt able to raise concerns with staff.

End of life care processes were in place which ensured that

people's preferences, beliefs and choices were respected.

## Is the service well-led?

**Requires Improvement**

The service was not always well led.

Governance and quality monitoring systems were not being completed regularly, established or embedded within the service. This meant areas of improvement and actions required to keep people safe were not always identified.

The management all promoted and encouraged an open working environment by including people and recognising staff achievement.

The management were flexible and delivered support hours as and when necessary.

The registered manager and nominated individual were aware of their responsibilities under the Health and Social Care Act 2008, Duty of Candour and demonstrated an open, honest approach.

People, staff and relatives felt involved in developing the service.

The service worked in partnership with other agencies in ways which benefitted people using the service.

# Field Maple Tree

**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.

Inspection site visit activity started on 6 February and ended on 7 February 2018. It included visits to eight people in their own homes and the office. We visited the central office on the afternoon of 7 February to see the nominated individual and office staff; and to review staff records.

The care service had been developed and designed in line with the values that underpinned the Registering the Right Support and other best practice guidance. These values included choice, promotion of independence and inclusion. People with learning disabilities and autism using the service could live as ordinary a life as any citizen.

The provider was given 48 hours' notice. This was so that we could be sure the manager or senior person in charge was available when we visited and that consent could be sought from people to a home visit from the inspector. The inspection was carried out by an inspector and expert by experience on day one and a single inspector on day two. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their experience related to supporting people with learning disabilities and autism.

Before the inspection we reviewed all the information we held about the service. This included notifications the home had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive.

We had received a Provider Information Return (PIR) from the service. 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 this into account when we inspected the service and made the judgements in this report.

Prior to our inspection we sent people, relatives and staff questionnaires about the service. We received four completed questionnaires from staff.

We spoke with eight people who used the service and five staff. We called three relatives and two professionals who had experience of working with the service.

We spoke with the registered manager, two coordinators, an assistant house coordinator and the nominated individual. We reviewed four people's care files, policies, risk assessments, health and safety records, consent to care and treatment, quality audits and the 2017 satisfaction survey results. We looked at eight staff files, the recruitment process, complaints, training, supervision and appraisal records.

We visited eight people in their own home and observed care being delivered to people.
We asked the nominated individual to send us information after the inspection. This included policies and staff training records. The nominated individual agreed to submit this by Friday 9 February 2018 and did so.

Requires Improvement

# Our findings

Medicines were not always managed safely. The registered manager told us that there had been a total of 41 medicine errors between January 2017 and January 2018. These included, medicines not being administered, topical creams and ear drops running out of stock and medicine being dropped. One person had missed three doses of their medicine in the past five months and become more anxious as a result. A staff member said, "(Name) has missed their medicine three times and this has made them more anxious and restless. They have required a bit more staff 1:1 support because of this. We contacted the GP on each occasion". We found that the medicine audit did not check stock levels of medicines, creams or ear drops. This had led to insufficient quantities being readily available. The registered manager told us that no one else had had an adverse reaction or come to any harm as a result of the medicine errors. However, they understood that the potential risks to people were high and said, "there is no excuse". One member staff told us they did not feel the audits had been completed properly and reflected they would learn from this Another staff member said, "We need to be better at managing people's medicines".

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that they would review medicine management systems, audits and ensure that staff receive refresher training and further competency checks. We found that medicines were discussed at staff meetings on day two of our inspection and a new audit which checked numbers of medicines, creams and ear drops was being introduced.

Effective arrangements were not in place to respond to and learn from all incidents that had occurred. Some incidents were reported using an online system and other incidents were recorded using paper incident reports. The registered manager told us that arrangements had not been in place to review and investigate incidents reported via paper format or incidents reported electronically. This meant that medicine errors had not been analysed for trends or the number of occurrences and safety measures put in place until the Saturday before our inspection. A staff member told us, "Incident reports have been completed for some errors but not all".

The registered manager and nominated individual acknowledged that incident reporting systems at Field Maple Tree needed reviewing. In response to this we were told that learning would be shared with other managers via management meetings. The registered manager told us that appropriate measures would be put in place and actions set following the errors identified as a matter of priority.

At the time of the inspection no one was receiving covert medicines. There was a clear comprehensive medicines policy in place which highlighted the requirement for discussion and best interest meeting with family, pharmacy and the importance of clear instructions for administration and review. This was in line with guidance and the Mental Capacity Act 2005.

A safeguarding policy was in place which included an easy read version for people who used the service. This detailed definitions, preventative measures, the investigation process, key contacts and record keeping. Safeguarding alerts were recorded and actions from outcomes were completed. A family member told us, "I have no safeguarding concerns at all". Another relative said, "I have never had any safeguarding concerns. The service is on the alert and I am confident with the policies and procedures in place". Advocate services were available to people and learning was shared in staff meetings. People were protected from discrimination and their equality and human rights were respected. Information was provided to people to support them to understand what keeping safe meant.

Staff were able to tell us how they would recognise signs of potential abuse and who they would report it to. Staff told us they had received safeguarding training. We reviewed the training records which confirmed this. A staff member said, "Abuse could be; not looking after a person's money, not keeping people safe. It could be emotional or physical. Signs may include distress or change in behaviour. I would report it to the manager, nominated individual, CQC or trustees. I wouldn't have any concerns reporting. I have no safeguarding concerns here".

People, relatives and staff told us that they felt the service was safe. A person told us, "I like it here; I do feel happy and safe". Another person said, "I am happy and staff always help me if I need them to". A relative said, "(Name) is safe. They tell me (name) is settled there and happy". They went onto say, "(Name) is always relaxed when we see them, he has freedom to do what they want". A staff member told us, "This is a safe service, there are always staff around. There are risk assessments in place and health and safety checks are completed".

People's care files were up to date, identified people's individual risks and detailed steps staff needed to follow to ensure risks were managed and people were kept safe. For example one person was at risk of dry skin as a result of showering a lot. Measures in place included; use of cream and raising the person's awareness of the causes of dry skin. Actions for staff to take included; supporting the person to apply cream and monitoring dry areas as and when.

Risk management plans covered areas such as; traffic, accessing the community, strangers and internet safety. Staff were able to tell us what risks were associated to which people and where to find people's individual risk assessments. One staff member told us about a person who required oxygen for a health condition. They said that the person was able to use it and told us, "I need to know that they have everything they need before going out. Their care plan and risk assessments tell me this information". This demonstrated that the service ensured safety systems were in place to minimise and manage risks to people.

Some people presented behaviour which challenged staff and the service. We found that emotional wellbeing objectives reflected this in people's care plans. A traffic light system was used with positive behaviour support plans. Green reflected proactive approaches which aimed to keep the person happy and content. Amber gave staff approaches to calm people down and red reflected reactive approaches staff needed to follow when the amber approaches failed to be effective. The plans identified behaviours people displayed and guided staff through actions to take to keep the person, themselves and others safe. For example, one person was known to hurt themselves when they felt anxious or worried. Staff actions

included, offering them a cushion or something soft, using key words and reassure the person.

Behaviour charts were completed by staff; these detailed what happened before an event, during an event and what preventative actions were taken. These were then monitored and analysed by management. Field Maple Tree had good working relations with the local learning disability teams and came together with them, the person and family in response to new trends occurring and/or set a review. The support people had received had a positive impact on their lives and meant that they could access the community more with support from staff who had a clear understanding of active and proactive strategies to support them safely.

We were told that all support hours were covered and that vacant shifts were covered by staff taking on additional hours. The provider told us that they did not use agency staff. The registered manager and nominated individual said that there had recently been a number of staff changes and that they had experienced recruitment challenges over the past year. However, this had improved recently. A staff member told us, "There are enough staff. We work with a mix of staff and people". Another staff member said, "Enough staff work here. There is a good rota system in place which works well". Another staff member told us, "I feel there are enough staff overall". A person told us, "Staff are available when I need them and there's enough for us". A relative told us, "There are enough staff for (name)". The nominated individual told us that staffing levels and 1:1 hours were assessed and agreed during the initial pre admission assessment stage. The nominated individual told us that they would refer to the commissioning team for additional hours should people's needs change.

Recruitment was carried out safely. Checks were undertaken on staff suitability before they began working with people. Checks included references, identification, employment history and criminal records checks with the Disclosure and Baring Service (DBS). The DBS checks people's criminal record history and their suitability to work with vulnerable people. Where gaps in employment history were apparent on the member of staff's application form, these gaps were explored and documented as part of the recruitment process.
People were supported to be involved in the recruitment of staff. Depending on their ability and choice people either met new staff in their homes or would sit on interview panels and participate in asking questions to potential new staff. Staff records showed evidence of this involvement and feedback was recorded .

People were protected by the prevention and control of infection by staff who had received training and used Personal Protective Equipment (PPE). Staff had a good understanding of food hygiene and correct procedures were followed where food was prepared and stored. For example, open foods were covered and labelled appropriately.

Requires Improvement

# Our findings

Regular staff supervisions had not taken place. The organisational policy stated that staff supervisions should take place six to eight weekly. This meant that the registered manager could not always be sure that all staff were supported to keep their professional practice and knowledge up to date. A staff member said "I receive supervisions every three months I think. I have one booked next week. I find them good, I can say if I want any more training etc." Although supervisions had not been regular for staff they told us that they felt supported and able to discuss matters with house coordinators or the manager at any time. The registered manager told us they had reflected on their practice.

The nominated individual and registered manager told us that staff appraisals did not take place. We were told that there had been discussion in management meetings about these and how best to complete them. The nominated individual showed us that a letter had been sent to all staff in February 2018 informing staff that they will receive an annual appraisal. In preparation for these staff had been asked to complete a self-assessment appraisal form and review their job descriptions.

All staff undertook a comprehensive induction, which followed the Skills for Care, Care Certificate framework. The Care Certificate is an identified set of standards used by the care industry to help ensure care workers provide compassionate, safe and high quality care and support. Following the induction staff shadowed more experienced staff and did not work alone until the management were confident they had the right skills to carry out their role. A staff member told us, "My induction was good. It covered a lot of areas and helped me understand how best to support the people I work with".

Staff told us that they were provided with the training they required to carry out their roles effectively. One staff member said, "I receive training and feel it is enough". Another staff member said, "We receive good training. I have done things like; safeguarding, medicines and moving and assisting". Other areas or local core training included; first aid and fire training. We were told that staff also received training specific to the needs of people they were supporting, for example; epilepsy and positive behaviour support. A staff member said, "During our induction training we learnt about learning disability and autism. We then covered it in more detail in staff meetings". Staff also had the opportunity to complete their diploma level two to five in Health and Social Care.

The registered manager told us that in response to a new person receiving the service they had arranged practical autism training. They explained that this training gave staff the opportunity to experience what it may be like for people with autism in some situations. For example staff wore restricted view glasses, were

guided by staff and faced obstacles and surprises. Staff told us that this put them in people's shoes and was very informative.

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.

Some people were living with a learning disability, autism or had needs relating to their mental health, which affected their ability to make some decisions about their care and support. We found that the service had started to complete capacity assessments for people in relation to their medicines.

Staff had not received specific training in the MCA however; they showed some understanding of the Mental Capacity Act 2005 and their role in supporting people's rights to make their own decisions. During the inspection, we observed staff putting their understanding into practice by offering people choices and respecting their decisions. Staff told us how they supported people to make decisions about their care and support. A staff member told us, "We encourage and support people to make their own decisions by give them the information they may need. I would involve management and families in more difficult decisions". The nominated individual told us that they were in contact with the MCA lead at the local authority to arrange staff awareness training and that they had booked all managers to attend an annual MCA conference in March 2018.

People can only be deprived of their liberty to receive care and treatment, which is in their best interests and legally authorised under the MCA. The Deprivation of Liberty Safeguards (DoLS) authorisation procedure does not apply to supported living services. For this type of service, where a person's freedom of movement is restricted in a way that may amount to deprivation of their liberty it has to be authorised by the Court of Protection. The nominated individual was in the process of identifying people who may require a court of protection application.
We recommend that the provider considers good practice guidance to ensure that the service understand and meet the requirements set out in the Mental Capacity Act 2005.

Management and staff worked effectively across organisations to deliver effective care and support to people. People were involved in the planning and coordinating of both admission and move on. Information was obtained, shared and meetings with people, families and professionals took place.

People were supported to maintain good health and have access to healthcare services. A staff member told us how they had supported a person during the morning of day one of our inspection to a doctor's appointment. They said, "I haven't supported (name) for a while so I refreshed my skills by looking at their care plan before going. This helped me support them correctly and keep them safe". The registered manager told us that they had a good relationship with other health professionals. We found that health visits were recorded and detailed people's preferences, medicines, communication needs and allergies. These records were taken to appointments and information was recorded about what was wrong with the person, what support they needed, who they were going to receive the support from and when their next appointment was.

'Grab' sheets were available for people if they required emergency hospital admission. These sheets included relevant information about people including their needs and any allergies and were easily

accessible to be provided to emergency services if needed. This demonstrated that the service was working effectively to ensure that people received consistent support across different services.

People receiving personal care were supported with shopping, cooking and preparation of meals in their homes. People told us that they were supported to choose meals of their choice each Wednesday via house meetings and during people's individual cooking sessions.

People's dietary needs were assessed and where appropriate, plans put in place. For example some people were vegetarian, one person was on a dairy free diet, others required a gluten free diet whilst others were enjoyed meat. The plans reflected safe foods including treats. Healthy eating guidance was available to people and staff to develop their understanding. We found that meals times were a special occasion to people and that they all came together and ate with each other.

Good

# Our findings

There was a strong, visible, person centred culture established across Field Maple Tree. Staff and management spoke about people in an affectionate way with kindness and compassion. Staff knew how each person liked to be addressed and consistently used people's preferred names when speaking with them. It was clear people had developed good relationships with the staff that supported them. People were relaxed and happy in the presence of staff and it was apparent that staff knew people well. During home visits we observed a lot of smiles, laughter, and affection between people and the staff supporting them. One person said, "I like the staff. They (staff) care for me. I am happy today". A family member told us, "Staff are kind and caring, they are watchful and observant". Another relative said, "Staff are most defiantly caring and kind. There are never any raised voices; they (staff) speak to (name) softly and in a kind manor".

Staff promoted and supported people to make choices and decisions about their care and support. We observed people being asked choices. A relative said, "Staff enable (name) to make decisions. They (staff) offer choices and information and then support (name) to decide". A staff member said, "I ask people to make choices and give options. With people who are non-verbal I use pictures. Sometimes we need to use assumption but really it's all about knowing the people". Another staff member told us, "It is always people's choice. We can only guide them. I always provide people with information and alternatives". Information, procedures and advice was made available to people in different formats to meet their individual needs. This included easy read pictorial information. Advocacy information was made available to people however at the time of our inspection we were informed that no one used these services.

Staff we observed during home visits were polite and treated people in a dignified manner throughout the course of our visits. Staff told us how they maintained people's privacy and dignity. Comments included, "knocking on doors", "talking people through what I am doing" and "locking information away". A relative said, "They certainly respect (name's) privacy and dignity". People were supported to build and maintain their independence. A staff member said, "We always encourage independence". We observed a person laying a table for lunch. A relative told us, "When (name) moved into the service they wouldn't walk back from the workshop on their own. With staff support (name) now has the confidence to do this independently".

People were supported to spend time with family outside of the homes. Staff had a good knowledge of family and friends that were important to people. A person said, "I like to keep everything very tidy, my family live close by and visit me every week". Another person told us, "My family come and visit on Sunday's, I have my own room and I do some of my own cooking, I like it here very much". One person introduced

themselves to us and was excited to tell us that they were seeing their family member the following day and staying with them for their birthday. A relative said, "I always feel welcome as do the rest of the family. I am offered cups of tea and always talked to".

Good

# Our findings

Field Maple was responsive to people's changing needs. Throughout the inspection we observed a very positive and inclusive culture at service. Promoting independence, involving people and using creative approaches was embedded and normal practice for staff. A relative told us that the service constantly adjusted to and continually meet people's changing needs such as aging. Another relative said, "(Name) couldn't communicate much when they moved to the service. They (staff) have supported them with confidence and developing their communication skills and (name) is now able to hold conversations and is very chatty. They have done this through patience, time and praise".

People were involved in reviews which put them at the centre of their care. A relative said, "We are involved in reviews with social services if they are available otherwise it is between (name) the service and us (the family). The service hold such good reviews of (name's) care". A house coordinator told us, "People have annual reviews with social workers, families and other professionals if appropriate". They went onto say, "In addition we do individual support plan meetings with people each week". We observed one of these meetings on day two of our inspection. The staff member sat down with a person, areas covered included; feedback from the person on how they are feeling, what they have done that week, whether they had any concerns, future plans and if they were happy with their support. The person told the staff member that they were happy and visiting their family the next day. These meetings were then recorded.

People had 'things about me' profiles. These gave a one page overview of what was important to people and enabled staff to be responsive to their needs. We read that one person liked things to be facing the right way, needed to be informed of plans, liked to look their best and loved watching Disney movies.

Personal care delivery plans were in place which gave more detailed guidance to staff about how people wanted to be supported with their personal care needs for example; hair care, shaving, nail care, bathing and medicines. These had been put together by people and staff to ensure that the person's preferences and wishes were reflected. For example we read that one person prefers shampoo on their hand rather than on their head. A staff member told us, "It is important we know people's preferences".
People had been supported to achieve goals and outcomes. We were told about one person who had been supported to safely travel alone on the bus. The person said, "I like to travel to (local town) on my own by bus". A staff member told us, "We encourage (name) to travel to London on their own by train to Waterloo, we take them to the local Station and they are met by their parents at the other end of the journey". The registered manager told us about a person who liked Status Quo who played a gig in Bournemouth in December 2017. They said staff supported the person by letting them know there was a concert and talking

through if the person would like to go. Staff then supported the person to organise tickets and matching a staff member to accompany the person there. The registered manager said, "(Name) was supported to get there and back and to buy a concert DVD. After the event, he said he had had a great time".

People were supported to participate in activities that interested them and had flexible timetables which reflected chosen activities, hobbies and interests. We found that people had been both supported or independently gone to local towns and cities. A relative told us, "I thought (name) could do with more activities. (Name) now does cycling and goes on walks". A person said, "On Friday nights we have a DVD in the home where I live". People were supported to local clubs where they were able to meet other people and be involved in building their own social circles. People told us that they enjoyed these clubs and meeting up with their friends. The registered manager said that people also took part in a number of festivals arranged by the provider. People were preparing for their next festival which was going to be a carnival parade.

People were involved in weekly house meetings which were an opportunity for people to feedback to staff, plan their weekends and discuss menus, upcoming events and house job schedules. A person said, "On a Wednesday we have a house meeting and discuss how our week went and what type of food we would like to have". Another person told us, ""We have a house meeting and discuss various things. I like these".

People's equality, diversity and human rights (EDHR) were respected and reflected in their support plans. Spirituality and beliefs were clearly identified in people's care plans.

The service met the requirements of the Accessible information Standard. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. We found that information was available in easy read formats which included photos with supporting text. People's communication needs were clearly assessed and detailed in their care plans. This captured the persons preferred methods of communication and how best to communicate with them. Peoples communication needs were clearly detailed in their health visit books which they took with them to appointments and if admitted to hospital. These were then shared with health professionals with people's consent.

A house coordinator demonstrated how they had supported a person to develop their communication skills. This involved raising the palms of their hands to offer a yes / no tapping system for the person. The person was able to respond to this positively and the impact was that it enabled the person to be able to express their preferences and make choices. For example; activities, food, yoga lessons and the gym.

The service had a complaints system in place which captured complaints and reflected the steps taken to resolve them. There was a comprehensive complaints policy in place for staff and a visual easy read version for people. Both versions had contact details of both internal and external agencies including the local authority, CQC and the ombudsman. People told us that they would feel able to raise complaints with staff or the management. There were no live complaints at the time of the inspection. A relative told us, "I have only ever raised minor concerns but can't remember any which shows how small they were. When I have the service have always acted promptly and they always listen".

We reviewed the 2017 satisfaction survey and found that it reflected a majority of positive responses and feedback. Results were collated and feedback analysed to identify trends, learning and development. We read seven surveys which had been completed by families in September 2017. Each person had feedback saying they were very satisfied with the care and support their relative received. Some comments read included; "(name) seems content and his housemates are very friendly and supportive". "The care (name)

receives is amazing" and "(name) gets very good support with their personal care".

The service had not supported people with end of life care. The nominated individual told us that people's culture and beliefs were always respected and would form part of plans. The service had an end of life policy in place.

Requires Improvement

# Our findings

The service had a registered manager in place. 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 nominated individual was also present during the inspection. A Nominated Individual has the responsibility for supervising the way that regulated activities are managed within an organisation.

The registered manager told us that quality monitoring had not been completed regularly nor were robust systems embedded. We found that over the past 12 months audits covering areas such as care and support files, staff records and the environment had only been completed once for two homes and twice for another. We found that monthly medicine audits had been back dated and not completed regularly which had led to the high number of errors over the past 12 months not being investigated until now. The current system did not refer to previous actions and had not identified the shortfalls in staff supervisions.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The nominated individual told us that service audits were now going to be completed the registered manager. They explained that the nominated individual would then complete quarterly audits across the locations.

Although staffing was delivered to a group of people in each house instead of being constructed to support individuals and medicines and care records were kept together in one centralised place like a care home setting this did not have a negative impact on people.

We recommend that the service seek advice and guidance from a reputable source, about the principles of Supported Living.

Field Maple Tree were aware of their responsibilities under the Health and Social Care Act 2008, Duty of Candour, that is, their duty to be honest and open about any accident or incident that had caused, or placed a person at risk of harm. The registered manager told us that they would be following this in response to the medicine errors and sharing their learning with the team and other managers in upcoming meetings.

The registered manager understood their responsibilities and felt supported by the provider. The registered

manager said, "I am very connected to my people and staff. I would always follow up any concerns or issues they brought to me". A relative said, "The registered manager comes back to me straight away and always passes information onto staff". The staff told us that they felt supported and had a clear understanding of their roles and responsibilities.

The nominated individual line managed the registered manager who received regular supervisions. The management promoted an open and inclusive culture. They were visible on the floor and delivered support hours as and required. People, relatives and staff spoke highly of the registered manager and house coordinators. A relative told us, "The registered manager is fine. Very approachable and a good manager". Another relative said, "The nominated individual is very, very good". Another relative told us, "The house coordinator (name) is fabulous". A staff member told us, "The registered manager is the best manager I have had. They are very dedicated and contactable". Another staff member said, "The registered manager is a great manager. Very fair, calm and genuinely cares about people and staff's wellbeing. Never bossy and I know if I had an issue I could discuss it with them".

There were clear fundamental values embedded which included; diversity, experience, openness, leadership and social environment. Staff were aware of these and demonstrated them in observations we made. For example, people's abilities, qualities and backgrounds were respected by staff. People and staff were open and honest with each other. The nominated individual told us that they were in the process of leading a review of the organisational vision, values and mission statement. We were shown how consultation processes had concluded and involved; management, staff, people, families and stakeholders. A staff member told us, "I feel able to voice ideas and suggestions. These are listened to". Another staff member mentioned that they felt staff were able to suggest new ideas and that they were listened to. The staff told us that an idea had been suggested that people would benefit from a sensory room and that this had been agreed by the management. A family member said, "I am able to suggest changes for development. I often attend the forums. These are very open and families are always listened to". This demonstrated an inclusive approach and told us that people, staff and others were involved in the development of the service.

The service worked effectively in partnership with key organisations including, local authority, safeguarding and commissioners. The service shared appropriate information with relevant parties for the benefit of people in a timely way. Families and professionals told us that they shared information in an honest and transparent way. The registered manager also told us that they were part of the local registered manager's hub. This was a group of managers from various providers who got together to share best practice and share learning and ideas.

# 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 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Medicines had not always been administered and sufficient quantities of medicines were not always available. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Governance and quality monitoring systems were not being completed regularly, established or embedded within the service.<br><br>Areas of improvement and actions required to keep people safe were not always identified. |