Avocet Trust

Avocet Trust - 523-525 Marfleet Lane

Inspection report

523-525 Marfleet Lane
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

523-525 Marfleet Lane consists of two bungalows which are registered to provide care and accommodation for up to seven adults with a learning disability. Number 523 has room for three people and number 525 for four people. Number 523 was currently unoccupied as two people had recently been moved to number 525. This meant the people who lived in number 525 were of a similar age and needs to each other. It left number 523 vacant and ready to accept three people of similar age and needs.

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

We undertook this inspection on the 22 March 2016 and saw there were four people using the service. We decided to give a short notice period of 48 hours regarding the inspection, as some people who used the service accessed the community on a daily basis and we wanted to be sure people were in. At the last inspection on 6 October 2013, the registered provider was compliant in the areas we assessed.

The people who used the service had complex needs and were not able to tell us about their experiences. We relied on our observations of care and our discussions with staff and other professionals involved.

We found there was a quality monitoring system in place but this needed some improvements to make sure it was effective in identifying areas to improve and ensuring these were completed. A new system was currently being developed and when fully implemented should address the shortfalls.

We found new staff had been recruited safely and all checks had been completed prior to them starting work. However, we saw that when positive information was recorded on disclosure and barring service checks, these had not been communicated to the registered manager of the service so that risk analysis could be completed and management plans put in place. We have made a recommendation about this in safe and well-led sections.

Staff and rotas confirmed there were sufficient staff on duty during the day but since one of the bungalows has closed, there is only one member of staff on duty at night. When the second bungalow re-opens the issue will be resolved as a second member of staff will be on duty there. In the meantime, the registered manager told us this would be monitored to make sure there was no impact on the people who used the service and staff. We have made a recommendation about this. There was an on call system for emergencies.

We found medicines were stored securely and administered as prescribed to people. There were some recording issues which required improvements to make sure there was a good audit trail of why medicines were omitted and to ensure staff had clear guidance for some medicines which were to be administered

'when required'. We have made a recommendation about this.

We found risk assessments were completed to guide staff in how to minimise harm during activities of daily living. There were also policies and procedures, and training, to guide staff in how to safeguard people from the risk of abuse. In discussions with staff it was clear they knew how to recognise abuse and how to report it to the appropriate agencies.

We saw people's health needs were met. Staff kept a log of when people had contact with health professionals in the community. Staff followed advice about treatment plans the health professionals prescribed.

People's nutritional needs were assessed and met. Meals provided to people were varied and in line with risk management plans produced by dieticians and speech and language therapists.

We saw people were supported to make choices about aspects of their lives when they were able to. Staff were clear about how they supported people to do this and in discussions they provided examples. We saw when people were unable to make major decisions, staff acted within the law and held meetings with relevant people present to decide a course of action in their best interest.

We saw staff had developed good relationships with people and it was clear they knew their needs well. Staff approach was kind and patient. Staff supported people to maintain family relationships.

People received care that was tailored to their individual needs and care plans provided staff with information about how best to support people in line with their known wishes and preferences. Reviews were carried out to make sure care plans were updated when required.

We saw people participated in activities within the service and staff supported them to access community facilities and to go on day trips and annual holidays.

Training was completed; records and staff confirmed there was sufficient training to enable them to feel confident when supporting the people who used the service. There was a system to identify when refresher training was due.

Staff told us they received supervision and support and could speak to the registered manager or senior managers when required. Annual appraisals were behind schedule but the registered manager was aware of this and had plans to complete them.

We saw there was a complaints policy and procedure which guided staff in how to manage them. The complaints procedure was also available in easy read for the people who used the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Recruitment of staff included employment checks prior to their starting work in the service. However, we could not see records of discussions and risk management plans when there were positive issues identified in disclosure and barring service checks. The registered manager is to address this.

There was sufficient staff employed during the day to meet the current needs of people but there was only one staff on duty at night as one of the bungalows has recently closed for a short while. This is to be monitored to see if it has an impact on people.

People generally received their medicines as prescribed, but there were some recording issues that required attention so that this could be assured.

We have made recommendations about these three points.

Staff knew how to safeguard people from the risk of abuse and harm and who to contact if they had any concerns.

Is the service effective?

Good

The service was effective.

People had their health and nutritional needs met and received treatment from a range health care professionals in the community when required.
Staff followed dietetic advice and guidance to ensure people received their meals safely.

People were supported to make choices about day to day living. The registered provider worked within mental capacity legislation when people were assessed at not having the capacity to make major decisions.

The environment had been adapted to meet people's needs.

Staff had access to a range of induction and training suitable for

their role and tasks. They received supervision and support from their line manager.

Is the service caring?

Good

The service was caring.

We observed staff approach was kind, caring and friendly. They provided people with explanations prior to tasks being carried out.

Staff had developed positive relationships with people and knew their needs well. People were treated with dignity and respect and confidentiality was maintained.

Is the service responsive?

Good

The service was responsive.

People's care was provided to them in a person-centred way. Staff had guidance in care plans to help them deliver care and support that met their needs and wishes.

People participated in a range of activities and were supported to access facilities in the community.

There was a complaints procedure to guide staff in how to manage complaints; this was available in easy read format.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was an organisational wide quality monitoring system in place and regular compliance audits had been undertaken. However, these were brief and lacked full analysis. Improvement was required to ensure any shortfalls identified had clear timescales for action to be completed. We did see the implementation of a new more in depth quality monitoring system had been commenced, but this would need some time for it to be embedded across the organisation.

Meetings took place for registered managers in the organisation to share information. However, a system for ensuring important information that required risk management by the registered manager needs to be further developed and put into practice. We have made a recommendation about this.

There were systems in place to enable staff and other

stakeholders to express their views. As the people who used the service were unable to be fully involved in completing questionnaires, the way their views and experiences of the service were captured could be further developed.

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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 registered 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 22 March 2016 and was unannounced. The inspection team consisted on one adult social care inspector and an adult social care inspection manager.

The registered provider had not yet been asked to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. However, we checked our systems for any notifications that had been sent in as these would tell us how the registered provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection we spoke with local authority contracts and commissioning team and safeguarding team about their views of the service. A recent safeguarding allegation was currently being investigated by a consultant commissioned by the registered provider and an outcome will be sent to the local safeguarding team when completed. Following the inspection we received information from a health professional who visited the service.

People who used the service were unable to communicate verbally with us so during the inspection we observed how staff communicated with them. We also observed staff approach and how they interacted with people who used the service throughout the day and at mealtimes. We spoke with the company's Head of Service for the east of Hull, the registered manager and three care support workers. Following the inspection, we spoke with a relative of a person who used the service.

We looked at two care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as all four people's medication administration records [MARs] and monitoring charts for food, fluid, weights, pressure relief and bathing. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included three staff recruitment files, training records, the staff rota, minutes of meetings with staff and managers, quality assurance audits, complaints management and maintenance of equipment records.

Requires Improvement

Is the service safe?

Our findings

A relative spoken with told us the staff were caring. They said, "Yes, I feel she is safe there. It can be a bit confined as one person's chair is quite large [for their relative to manoeuvre round] but she manages."

Recruitment files indicated employment checks were completed prior to new staff starting work in the service. These included an application form to look at gaps in employment, verifying identity, obtaining two references, a disclosure and barring services (DBS) check and an interview to assess fitness for the role. We could not verify that when positive information was received on a DBS, a risk assessment had been completed and discussions with the person and reasons for continued employment made clear and recorded. We could not see that monitoring and supervision arrangement were in place to reflect this. This was discussed with the registered manager to address.

We found there were sufficient numbers of staff on duty during the day to support the four people who used the service. The numbers of staff on duty during the day fluctuated to take account of specific activities which may have been planned with people, for example, shopping or other trips out into the community. The registered manager confirmed, "We have three staff on every shift [during the day] and sometimes an additional senior to help with paperwork." However, there was one member of staff on duty during the night; this was a recent change as when both bungalows had people living in them, there was a member of staff in each of them at night. This could potentially leave one member of staff unsupported at night and staff told us two people required two staff to move and assist them. The registered manager told us there was an on-call system for emergencies. They said, "We do cover and staff come in if needed." This situation needs to be monitored and discussed with staff. When there are new admissions to the current vacant bungalow, this will be resolved.

We recommend the registered provider puts in place systems to assess and manage risk issues that have been highlighted from staffing numbers and staff recruitment checks.

People generally received their medicines as prescribed, however we did have some concerns with recording and in one instance with administration. The administration issue referred to a discrepancy on the medication administration record (MAR) for one person regarding Calogen Liquid. This had been prescribed three times a day on the MAR but staff were giving this to the person between four and five times a day. When we checked this with the registered manager, they said the dietician had increased the dose, but it had not been reflected in the person's GP prescription yet. The instructions and date of increase had not been made clear on the MAR. One of the recording issues referred to when a medicine, regulated as a controlled drug (CD), for two people was returned to the pharmacy when no longer used. Staff confirmed the medicine had been returned to the pharmacy but the CD book recorded it as in stock in the cupboard. This was mentioned to the registered manager to adjust the CD book.

There were two systems for signing medicines into the service, which could potentially cause confusion. There were the MARs which was signed when medicines in monitored dosage systems was received into the service. There was also a companywide stock control log to use when specific 'when required' medicines

were received into the service and when amounts were carried forward from one month to the next. We found not all medicines received into the service had been recorded as such which was possibly due to the two systems. There were some medicines which had been omitted for specific reasons; at times there was a blank space and at the others the reason was coded as 'O' which meant 'other' but had not been defined on either the front or reverse side of the MAR. Blank spaces and undefined codes made it difficult to audit why the medicine had been omitted. There were instances when staff had adjusted instructions on the MARs but there was no date and reason for the change and no signatures of who had made the change. There were protocols for some 'when required' medicines but not all. These recording issues were mentioned to the registered manager to discuss with staff and to monitor improvements.

We found medicines were stored securely in trolleys in a lockable cupboard. However, we saw a medicine which was required to be stored and recorded as a CD was held in a locked metal box inside one of the trolleys instead of in the designated CD cupboard which was secured to the wall. Staff recorded the medicine as a CD and the way it was stored was rectified on the day of inspection. The temperature of the medication cupboard was recorded to ensure medicines were stored correctly and in line with manufacturer's instructions.

We recommend the registered provider ensures all staff follow current legislation and guidance with regards to recording of medicines.

We saw there were risk assessments completed to help guide staff in how to minimise the risk posed to people during their activities of daily living. These included travelling in motor vehicles, correct posture when seated in chairs and wheelchairs and when eating and drinking to prevent choking, nutrition, moving and transferring, skin integrity, bathing and the use of bed rails. Through observations and via discussions with staff we saw they were aware of the risk assessments and how to support people safely. There were no personal emergency evacuation plans for each person who used the service. The registered manager told us they would address this.

There was a policy and procedure to guide staff in safeguarding people from the risk of abuse. Staff had completed safeguarding training; in discussions, they described the different types of abuse and the signs and symptoms that would alert them to concerns. They knew how to record issues and report concerns to their line manager. The registered manager and area manager were aware of the risk matrix tool used by the local safeguarding team and how to refer any allegations of abuse; they confirmed they used the risk matrix tool and described the situations when it would be used. There was evidence the area manager and registered manager had used the safeguarding policies and procedures correctly. Prior to the inspection we received information about an allegation of potential abuse. The local safeguarding team have asked the registered provider to investigate this and provide them with details of the investigation when completed. We saw there was a system in place to ensure people who used the service received the 'personal allowance' part of their benefits. The registered provider was the appointee for the finances of people who used the service; financial records were maintained. The systems and policies and procedures helped to ensure people's finances were not mismanaged.

We found the service was generally clean, safe and tidy. We saw there was an easy chair in the sitting room and some dining chairs where the fabric was torn or had perished. Also the floor covering in the sitting room had small areas of raised and torn rips made by wheelchairs. This meant the chairs and the floor could not be cleaned effectively and could harbour dirt. The registered manager told us they were aware of these and they were due to be replaced when the service was refurbished. Staff confirmed they had sufficient personal, protective equipment such as gloves, aprons and hand sanitiser when required. There were appropriate clinical waste facilities and contracts with providers for the service. A legionnaires risk assessment had been

completed and the temperature of stored water recorded.

There was an emergency plan to guide staff in dealing with issues such as floods and utility failure, however, we found this could be expanded to include the actions staff would need to take and facilities which would be used. Also there was no individual service maintenance plan. These points were mentioned to the registered manager to address. Equipment used was checked, maintained and serviced appropriately to make sure it remained safe to use. This included portable fire and electrical equipment, fire detection and alarm systems, moving and handling equipment, first aid boxes, the nurse call, gas appliances, electric circuitry, hot water outlets, fridge/freezer temperatures and hoist slings.

Good

Is the service effective?

Our findings

A relative spoken with told us they had been consulted about their family member's care. They confirmed staff supported the person to attend health care appointments. They also said staff supported the person to manage their nutritional intake. Comments included, "I was consulted about her recent move into the other bungalow", "She has changed recently and is quiet now; she has been visited by CTLD [community team for people with a learning disability] and staff are keeping an eye on her", "She has regular appointments with the dentist and doctor when needed and sees a chiropodist" and "She has lost weight in the last two years but has seen her GP and has food supplements. Her meals are mashed up now and she is picking up."

We found people's health needs were met. The care files showed people who used the service had access to a range of community health and social care professionals. These included GPs, community nurses, social workers, dieticians, occupational therapists, physiotherapists, speech and language therapist, dentists, chiropodists and opticians. We saw people attended outpatient department when required and had appointments with specialist learning disability services. One person received daily visits by a district nurse to manage their diabetes. Specific health professionals had been involved in providing risk management plans to staff for specific issues such as epilepsy management, seating and posture, and swallowing difficulties. People had been assessed for specialist equipment such as personalised wheelchairs and shower/commode chairs with support to ensure the correct seating position for their needs. A record of health and social care professional visits and any treatment prescribed was recorded in people's care files. In the care files we looked at we saw people had a health action plan which brought together all their health care needs in one document; this helped to guide staff in ensuring people's health needs were met.

A comment from one of the health professional visitors in a survey stated, "Very good at making appropriate referrals." A health professional told us staff were always approachable and acted as advocates for the person they visited. They said staff arranged a best interest meeting and invited family and professionals to discuss issues of concern.

We found people had their nutritional needs met and there was plenty of food and fresh fruit and vegetables in the service. Each person had been seen by a dietician and speech and language therapist to assess their nutritional needs and to provide staff with specific instructions about the texture of food and fluids they could consume to ensure their safety and wellbeing. The file containing the information was held in the kitchen and in discussions, it was clear staff were aware of the special instructions for each person. Staff told us the menus were due to be updated now that the four people who used the service had joined together in one bungalow; this would be to accommodate everyone's needs. Each person had a list of likes and dislikes so menus could be arranged around these.

We saw there was a range of charts completed so staff could monitor people's needs and actions and contact health care professionals quickly when required. These included food and fluid intake, weight, bathing and showering, behaviours which could be challenging to the person and other people, oral hygiene, bowel frequency, bouts of coughing and skin monitoring with a body map. In discussions, staff had an understanding of the need to monitor people's heath and obtain medical assistance quickly when

required. They were able to describe the signs and symptoms of chest and urinary tract infections and how to prevent pressure ulcers from occurring. One member of staff was able to describe the signs to look out for and what measures to take if the person with diabetes became unwell.

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. We saw assessments of capacity and best interest meetings had taken place to discuss the option of the four people who used the service to live together. An independent mental capacity advocate (IMCA) had been involved in supporting one of the people in this decision. We saw people had capacity assessments and best interest meetings to discuss proposed medical procedures, health screening which may cause them distress, the use of 'when required' medication and restrictive equipment such as bed rails and safety lap straps. The process of capacity assessment and best interest meetings was also used for decisions about financial expenditure for holidays and large items such as televisions; staff told us they could make decisions about minor expenditure for clothes and other items. We saw relevant people were involved in decision-making on people's behalf.

In discussions, staff were clear about how they ensured people consented to care and support. They said, "We ask people; they are able to understand", "Even though some people can't verbally tell us, we still talk to them, show them clothes and give other choices and watch for facial expressions", "They would let us know if they didn't want to do something. This could be verbally or non-verbally" and "You can't force people. If they don't want to do something we just try later and log it. We know our clients."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered provider had acted appropriately and assessed all four people who used the service as meeting the criteria for DoLS. The registered manager had made applications to the local authority for DoLS for each person who used the service but these had yet to be assessed and authorised. The registered manager told us they will continue to follow these up with the local authority.

Staff confirmed they had access to a range of training, supervision and support. We looked at the training records for each member of staff who worked in the service; there was a selection of training courses considered to be essential by the registered provider. These included, MCA/DoLS, safeguarding, medicines management, infection prevention and control, fire safety, basic food hygiene, first aid, moving and handling, epilepsy, health and safety, equality and diversity, and management of actual or potential aggression (MAPA). Staff confirmed there were other training courses they may be able to access if appropriate for their role such as autism and dementia awareness. Two staff told us they had completed an awareness course in diabetes although this was not on the training records we saw. We found it would be useful for staff though, as one person who used the service had insulin-controlled diabetes. Most staff had completed a nationally recognised training course in health and social care.

Staff said, "We have enough training. We can always enquire at HQ if we want more training; they inform us when refresher training is due. We have personal development files", "Supervisions (meetings) are about monthly but if anything crops up you can always talk to the manager" and "We have supervision about every six to eight weeks and discuss policies and procedures, how well we are doing, any concerns and client issues." New staff completed a two-week induction which included the essential training. We found appraisals were behind schedule although the registered manager was aware of this and had plans to

address it.

We saw the environment had been adapted to meet the needs of people who used the service. The corridors were sufficiently wide to accommodate specialised wheelchairs and doors had mechanisms on them so they could be left in the open position. There was a ceiling track hoist in the bathroom and individual bathing equipment for specific people. There were grab rails on corridor walls and in bathrooms and toilets. The flooring was a non-slip cushioned variety to make it easy for wheelchairs to be manoeuvred.

Good

Is the service caring?

Our findings

We observed staff were kind and caring in their approach and interactions with people. We observed staff support people to get ready for a visit to local shops, they explained where they were going and ensured they had appropriate clothing on. We observed another member of staff support a person to eat their breakfast. They sat nearby to them, made eye contact and chatted to them throughout. They also supported the person to participate in a craft session later in the morning. The support was friendly, chatty and professional. We saw and overheard one member of staff used phrases and a tone of voice which could be interpreted as inappropriate for the age of the people who used the service; we saw there was no intent to be disrespectful to people but it was a training issue. We mentioned this to the registered manager who was already aware of the situation and had plans to address it.

A health professional told us staff respected values in everyday activities and interacted well with people. They said staff had a good understanding of the person's choices, likes and dislikes and showed respect towards these.

We saw a relative had completed a compliment slip which stated, "I should like to congratulate the staff at Marfleet service for the sterling job in the garden and for bringing [person's name] to visit me after my operation; it was greatly appreciated." A relative spoken with said, "She has a good relationship with staff and has a nice keyworker; they are taking her to Blackpool this year for a holiday", "They invite me to reviews of her care" and "Staff bring her to visit me."

We found staff knew people's needs well. One member of staff said, "We have a very good staff team here. We know the clients so well. We pass on our experiences to new staff as there is a lot of important history."

The registered provider had policies in place in relation to promoting respect and dignity. We found staff supported people to maintain privacy and dignity. Each person had their own bedroom for use when they wanted personal space. We observed staff knocked on bedroom doors prior to entering. Bathrooms and toilets had privacy locks. In discussions with staff, they described how they respected people's privacy and helped to maintain their dignity. Comments included, "Keep people covered during personal care", "Use the least amount of staff as possible and make sure all the equipment is ready to hand" and "Knock on doors." The care files we looked at reminded staff to respect people's privacy and dignity. We observed staff supported people to keep their bedrooms tidy and to maintain their clothing. Clothes were hung neatly in wardrobes and placed tidily in drawers.

We saw staff had supported people to make choices about aspects of their lives. For example, one of the people who had recently moved from one bungalow into number 525 Marfleet Lane had been supported to choose wallpaper for their bedroom and a new television which was to be fixed to the wall. The bedroom had been decorated and looked very personalised, clean and fresh. Staff told us the person often liked to spend time in their bedroom watching the television programmes of their choice, which may differ from the one that was being watched in the main sitting room. There had been an advocate involved for one person to assist in decision-making.

The service had a 'service user guide' which provided information to people about what they could expect when living at 523 – 525 Marfleet Lane. We saw this needed some adjustment as it stated all the people who used the service signed a written contract, which some people would not be able to do. It also had inaccurate information about ensuite facilities, the number of bungalows on the site and the staffing numbers for the service.

We saw staff supported people to maintain contact with their family. Some people's relatives visited the service and staff supported one person to visit their elderly parent at their home. Staff told us how important it was for people to maintain their family relationships.

The staff were aware of the need for confidentiality with regards to people's records and daily conversations about personal issues. They said, "We maintain confidentiality, don't talk about people outside of work, use initials and keep care plans locked away", "We would only give the necessary information about the clients to their GP or nurse" and "We can make phone calls in private." People's care files and financial records were held in the registered manager's office which was locked when not in use. Medication records were held in a locked cupboard with the medicines trolleys. Telephone calls to and from relatives or health and social care professionals could be taken in the registered manager's office to ensure the conversations were not overheard. Staff supervision and appraisal records were held securely in the registered manager's office and personnel files including recruitment and training were held at headquarters. Some records were held electronically and the registered provider had completed registration with the Information Commissioners Office (ICO) in line with requirements when maintaining computerised records. Computers were password protected.

Good

Is the service responsive?

Our findings

We found people were provided with care and support that was personalised to their needs. Staff told us they ensured care plans were followed so that people's needs were met. They also said some staff had supported the people who used the service for many years and knew their needs well. One member of staff said, "It really is a nice home. I would be happy for a relative of mine to live here; the staff are friendly and the clients are happy." We saw staff had responded to one person's needs when they used a walking aid. They noted the person knocked their legs on the frame so had acquired Styrofoam padding and used this to clad the metal bars which resolved the situation and protected the person's legs. A health professional told us staff ensured any activities were person-centred.

People's bedrooms and communal rooms in the service were homely and personalised with photographs and items important to them. There was a television, DVD and music equipment in the sitting room for communal use. A relative spoken with said, "The staff are pretty good; they are going to decorate her bedroom for her."

We found people had assessments of their needs prior to admission to the service and on an on-going basis through reviews of their plans of care. Staff had completed a life history and profile of each person; relatives had been involved in providing information about life histories, likes and dislikes. There were support plans to guide staff in how to care for people in the way they preferred. We saw for one person this included how to manage their behaviours when they became anxious or upset. This covered what the person disliked which may prompt the initial behaviour, what the actual behaviours were, what staff were to do to support the person and what strengths the person had to enable them to respond to staff and prompt a speedy return to calmness.

Care plans were tailored to meet people's individual needs and promote their safety. For example, one care plan we saw described the measures staff were to take when supporting them to travel in a minibus. It reminded staff about giving explanations to the person especially during the tailgate lift into the minibus, to ensure safety precautions were taken such as seatbelts and wheelchair brakes, to ensure the person was seated comfortably and also to ensure adequate drinks and snacks were available. The person's care plan for posture management included a photograph of how the wheelchair back rest should be positioned and additional information from the physiotherapist. Another person had a specific epilepsy management plan.

We saw one person's care file had been recently audited. Improvements had been made to provide staff with additional information when supporting people to meet their needs. For example, there were scripts for staff to use to provide reassurance to the person and to ensure care and support were consistent. The care plans included information from health professionals and risk assessments were held with each section of the care plan for ease of access. Staff told us they had the opportunity to read care plans especially when they first started to work in the service but also when there were any changes made to them. One member of staff said, "I'm still learning and getting to know everyone."

We saw people had a 'communication passport' to help staff and other people understand how they made

their needs known. This was written in a person-centred way, for example, "I will push away if I have had enough or grab and pull you in if I want something", "Smiling and wide open eyes if I like something", "I use my hands in a wave motion for when I am happy" and "I shout out and sometimes hit myself if distressed or in pain." There were photographs of how the person looked when they were happy and another of their facial expressions when they were out of their comfort zone. In discussions, staff described the different methods people who used the service had to show they were in pain so staff could respond quickly.

We saw staff provided information and support when people received care and treatment from other services. For example, staff described how they responded to people's needs when they attended for dental care. If there was any need for treatment, this was discussed with the person's dentist and GP and if required, medication could be used to help them feel calm about the experience. We saw staff completed 'patient passports'. These included important information about their activities of daily living and the support required to meet them; the patient passports accompanied people to hospital when any assessment or treatment was required.

We observed staff supported people to access community facilities and also to participate in activities arranged in the service. People had weekly plans of activities although staff told us these could change dependent on the weather or the person's choice. We saw people participated in activities such as hair and nail pampering sessions, watching television, aromatherapy and listening to music. There had been trips out to museums, bowling, cinema, a nearby park, weekly pub lunches, food and clothes shopping, cafes and a local resource centre. Staff told us as the resource centre was very local, the cafe was well-used and one person enjoyed choosing talking books from the library. Staff also told us two people had enjoyed a trip to a spa at a hotel in Hessle for a hand and nail pampering package and 'high tea'. There was an enclosed garden for people to enjoy in warmer weather; the garden had a paved area to make it accessible to wheelchairs. A relative told us staff had taken their family member out to see a concert at City Hall last week. They also said, "I'm going to meet staff to look for something for her birthday."

On the day of the inspection, we saw two people enjoyed watching a musical DVD; their facial expressions and tapping their hands in tune to the music indicated they enjoyed it. Some people also went out with staff to the shops. Holidays were arranged for people each year and the registered provider also had an adapted caravan at the coast for people to use as a base for day trips out with support from staff. We saw one person's records showed they had day trips in 2015 to Meadowhall shopping centre, Scarborough, Skipsea and Flamingo Land theme park, and a five-day holiday in Blackpool. Staff told us this year two people were booked to stay in a holiday cottage in Whitby for five nights and the other two people had chosen to go to Blackpool for a week.

The registered provider had policies and procedures to guide staff in how to manage complaints. This was available in an easy read format. The procedure described how people could make a complaint and how to escalate it if required. A relative told us they were aware of the complaints procedure and felt able to complain in the belief it would be addressed. They said, "Yes, I would complain. I wrote a letter of complaint once and it was sorted out; they listened to me."

Requires Improvement

Is the service well-led?

Our findings

A relative spoken with knew the registered manager's name. They told us there had been several manager's at the service in the past but now management and the staff team were settled. They also told us they were part of a 'care quality committee' with Avocet Trust and met every three months to discuss quality issues.

The registered manager told us each week they worked three days at 523-525 Marfleet Lane service and two days at another service close by; they were available by telephone if staff required any advice or assistance. They felt this was sufficient time to oversee the service. Care support staff also had other registered managers at other services to contact for support and advice as required. The registered manager told us they had previously worked for two years at 523-525 Marfleet Lane as a senior care support worker so knew the people who lived there very well. They had completed a nationally recognised training course at management level. They told us they had requested additional training in health and safety at management level and were awaiting dates for this.

A handbook was given to all staff which included specific policies and procedures and expectations for their role and ways of working. This enabled staff to refer to it for guidance and also provided written confirmation of their expectations. Staff told us they felt supported by management. Comments included, "I love working here; yes, I do feel supported."

We spoke with the company's Head of Service for the east of Hull and the registered manager about the culture of the organisation and looked at the statement of purpose. They said they were able to raise concerns through the management structure. The statement of purpose said, "The Avocet Trust (Avocet) provides lifetime support to vulnerable people to enable them to live valued lives. It does this by using a person-centred, problem solving approach to make dreams come true. We enable choices to be made by regularly listening to and communicating with the individual and their stakeholders. We will value, train and support staff to enable them to take assessed risks whilst working dynamically to maintain accredited "quality" standards." We found these values worked in practice although it was recognised by the registered provider, the area manager and registered manager that the quality monitoring system required more input for it to be fully effective. The registered provider had commissioned a consultant to assess quality monitoring and provide guidance and advice to registered managers in improving the system. It was recognised that actions from this process would take time to embed across the organisation as a whole.

We looked at the monthly compliance and health and safety audits for November 2015, December 2015 and January 2016 and saw these comprised of a tick box with limited space to record quality data. For example, the questions asked for the audit was whether specific documentation such as care plans were up to date. This had been ticked as 'yes' but the quality of the care plan had not been assessed. There was minimal shortfalls or corrective actions identified with this system. We saw the audit completed in January 2016 had more shortfalls and completed tasks identified which showed some improvement. The registered manager said, "The quality system needs work, we haven't started on improving it yet at Marfleet. The local authority and the consultant have told us it is not sufficient." The area manager said, "We do try and share learning across the managers and meet regularly, but I know there are areas that could improve." We saw a full care

plan audit had been completed by the consultant for one of the people who used the service; shortfalls had been identified and actions had been completed. The care file was neat and ordered and easy to follow after this audit and action. Other care files are to have similar overview and action.

We found incidents and accidents were recorded; the registered manager was aware of the responsibility to send notifications to the Care Quality Commission (CQC) and other agencies regarding issues that affected the safety and wellbeing of people who used the service.

There was a system of cascading information to registered managers in all the services and meetings were held. However, we found there had been one instance when important staff recruitment information had not been shared with the registered manager which meant they had not been able to initiate a risk assessment and oversee the situation. This was mentioned to the area manager to discuss at a higher level in case any similar situations occur. As this issue, the recording of medicines and the potential issue of staffing at night had not been identified during current quality monitoring we have made a recommendation.

We recommend a procedure for information sharing with registered managers, regarding issues highlighted in recruitment, is developed and put into practice. Also that systems to monitor staffing numbers at night and the recording of medicines are put in place and reviewed in line with current best practice. This will enable the registered manager to assess potential risk and put in place measures to manage it.

We saw shift handovers took place so that incoming staff were made aware of any issues to monitor. Shift handover records seen identified who was on duty and which staff were allocated to support specific people who used the service. It also identified tasks they had to complete such as checking hot water outlets, slings for any material that was fraying, medicines, petty cash and people's personal allowance. There were cleaning schedules for staff and logs identified the completion of daily and weekly tasks.

There was a repair log completed but we could not locate a redecoration/refurbishment plan for the service. The registered manager told us there were plans to redecorate the service and provide some new furniture; we had noted some areas were in of decoration and some chairs in need of replacement. We have asked for the plan to be forwarded to CQC.

Staff meetings were held to share information and enable them to express their views. Minutes of the meetings showed who had attended and what was discussed. The minutes of a meeting held on 3 March 2016 showed a discussion had taken place regarding the move of two people from 523 to 525 Marfleet Lane and the closure of one of the bungalows for the time being. Staff were also reminded to lock specific cupboards when not in use. However, during the inspection we saw one of these cupboards which was labelled, 'to be kept locked' was open. This was mentioned to the registered manager who requested staff to lock it straight away.

We also saw a meeting had been held with the relatives of two people to discuss plans for holidays for them and the expenditure this would incur.

There had been a survey completed with people who used the service in July 2015. This was in a pictorial format and all the written questions were all answered 'yes'. Staff had completed the survey with or on behalf of the people who used the service. There was no alternative means applied to gain people's views. For example, an extended period of observation and record of the results to gain people's experience of life in the service.

There was a staff survey completed in September 2015 and there were positive comments recorded about management support. For example, "The manager is very supportive, can ask anything." However, there was no analysis of the results or any corrective action planned. We saw there was a survey for relatives and professional visitors in 2015.

We found the registered manager had taken steps to improve working with other agencies. They said, "I have been delegated the responsibility for attending autism strategy meetings. This has been very good for networking; we've improved the HAPs (Health Action Plans) since attending those." They told us they also accessed Hull City Council training, "We have received training in the Care Act", and used the internet to download guidance.