Outward

Antill Road

Inspection report

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05 December 2016
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12 December 2016
13 December 2016
15 December 2016

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Antill Road on 5, 6,7,8,12,13 and 15 December 2016, the inspection was announced. Our last inspection took place on the 8 August 2013 where we found the provider was meeting all of the regulations we checked.

Antill Road is registered to provide personal care and support to 169 adults with complex needs in their own homes including people with a learning disability, mental health needs and people with autism spectrum disorder (ASD). The services are provided to people in supported living schemes and in addition to this a floating support service and a specialist outreach service is provided for people on the autism spectrum. Some people fund their care packages with the specialist outreach service through direct payments from their local council, which meant they had chosen to buy services from the provider.

The provider is the landlord for the majority of the supported living schemes that were provided in Waltham Forest and some of the schemes are owned by private landlords and the local authority. The schemes are located in the boroughs of Bromley, Camden, Enfield, Hackney, Haringey, Islington, Tower Hamlets and Waltham Forest. The Care Quality Commission regulates the provision of personal care services but does not regulate housing support. At the time of our inspection there were 120 people receiving personal care services.

There were four registered managers in post during the time of our inspection. 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.

Information about the home was accessible and understood by people who used the service. People had communication plans in place and staff followed these. People were listened to and their rights were respected and staff provided person-centred care.

Recruitment checks were completed to assess the suitability of the staff employed. Staff received suitable training and good support to enable them to carry out their roles. There was a suitable number of staff to meet the needs of the people who used the service.

The provider ensured the administration, storage and disposal of medicines were managed safely. Suitable arrangements were in place to ensure people received good nutrition and hydration.

Staff had a good understanding of safeguarding procedures and followed protection plans to minimise the risk of harm to people. The provider worked in in partnership with other stakeholders to minimise future re-occurrences of any incidents.

People were supported by staff to attend health care appointments when there were changes to their health care needs or associated risks to their health. Staff followed the legal requirements in relation to the Mental Capacity Act 2005. Staff understood the MCA and presumed people had the capacity to make decisions first.

People were supported to maintain positive relationships with their relatives and friends. Relatives were complimentary regarding the care and support provided by staff. People had access to activities that were important to them and were encouraged to be active in the community.

Relatives knew how to make a complaint but some felt their concerns were not resolved within the appropriate timescales. There was an easy read complaints policy available for people.

Systems were in place to effectively improve the quality of care delivered.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were supported by staff who understood how to keep them safe and report concerns.

Risks to people's health and well-being were assessed and staff were guided about how to manage any risks.

Sufficient staff were deployed to ensure people's needs were met.

People were supported to take their medicines as prescribed.

Is the service effective?

Good

The service was effective.

Staff followed the legal requirements in relation to the Mental Capacity Act 2005.

Staff had completed essential training to maintain their knowledge and skills.

People received good nutrition and hydration and were involved in making choices regarding food preferences.

People were referred to healthcare professionals promptly when required.

Is the service caring?

Good

The service was caring.

Staff developed positive and trusting relationships with people.

People were involved in discussing their needs, preferences and wishes.

Relatives told us that their family members were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People received support which was personalised around their individual needs. Staff promoted people's independence and adapted support when their needs changed.

Opportunities were available to people to access the activities that were important to them. These met their diverse needs, which promoted people's well being.

People's individual religious, cultural and lifestyle needs were met. The service had a strong commitment to providing person-centred care.

People knew how to complain. Relatives had mixed views about how complaints were responded to, however the provider had identified this as an issue to be addressed.

Is the service well-led?

Good

The service was well led.

Staff felt supported and valued in their roles and showed a high level of commitment.

The provider carried out regular audits to identify and address any shortfalls.

There were systems in place to measure the quality of the service and the provider was committed to using every opportunity to drive improvement.

Antill Road

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.

We visited Antill Road on 5, 6,7,8,12,13 and 15 December 2016, to undertake an inspection of the service. The inspection was announced. We gave 48 hours' notice of the inspection because senior staff could be out of the office supporting staff or visiting people in their homes. We needed to be sure that someone would be in. We told the registered managers that we would be visiting six of the supported living schemes over the following two weeks.

The inspection was carried out by two inspectors on the first day and one inspector on the following six days and four experts by experience. The experts by experience made phone calls to people and their relatives to seek their views on the care and support the service provided. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We checked information that the Care Quality Commission (CQC) held about the service including the PIR, their previous inspection report and notifications sent to CQC by the provider. The notifications provided us with information about changes to the service and any significant concerns reported by the provider.

We spoke with seven people and 21 relatives and spent time observing the care people received, visited people in their homes and listened to staff handovers. Prior to the inspection we contacted seven local authorities and received feedback from four of them. Furthermore, we spoke with four health and social care professionals.

During our inspection we looked at 25 people's care records including their medicines records. We also spoke with a volunteer, 10 support workers, three deputy managers, three scheme managers, the clinical

lead, the human resources manager and administrator, the quality assurance manager, three heads of service, the chief executive and four registered managers. We looked at 10 staff recruitment and training records, minutes of meetings with staff, quality assurance audits, complaints, staff rotas and a selection of the provider's policies and procedures.

Good

Is the service safe?

Our findings

People and their relatives described the service as safe. One person said, "Super very good, very happy with the service " and relatives commented, "Yeah they keep [my family member] safe, well they look after [them] I haven't had any kind of worry or concerns, [my family member] seems happy", "I have no concerns I know carers come and go it is down to [the person] to sort out who he/she is comfortable with", "[My family member] does look comfortable but [the person] does not talk in general I think [the person] is ok", "Very safe", "There is no better place but [my family member] is not as verbal as he/she was [they]] seem quite happy, there have been some minor issues but it is quite positive now", "I know [my family member] is safe, he/she has a lovely flat and they do care for [them]", "Generally yes [the person] is safe [they] share accommodation with [another person] with learning disabilities, [the person] can come and go as [he/she] pleases.", "[My family member] has been there for years now I'm happy that he/she is safe there, the carers come in three times a day to check on [them]", "[Person's name] has only recently moved, it's only been three weeks so far he/she is happy ", "[My family member] doesn't feel rushed and seems to be settling in, [the person] has a tendency to get up and about at night and will go downstairs to the lounge, they are aware of this. I know the night staff are on duty and will look out for [them]."

People were protected from the risk of abuse because the provider had effective systems in place. There were clear procedures to follow in the event of staff either witnessing or suspecting the abuse of any person using the service which staff demonstrated that they understood. Staff also told us they received training for this and had access to the provider's policies and procedures for further guidance. Records confirmed training in safeguarding adults was up to date. Staff were able to describe what to do in the event of any incident occurring and knew which external agencies to contact if they felt the matter was not being referred to the appropriate authority. Provider concerns meetings had taken place with the local authorities to respond to safeguarding concerns to help keep people safe.

The provider raised awareness of safeguarding with people who used the service. Meetings included safeguarding as an agenda item and this was also discussed in one to one sessions with people. For example, in one service the meetings included honest conversations about encouraging positive relationships with other people who shared living spaces and what was right and wrong. In another service, a safeguarding meeting was held with the local police and the trading standards in relation to fraudulent mail being sent to a person. To respond to this staff had worked closely with the housing management team, the postman, and the person to ensure that the mail was delivered to the staff office to collect and then sent to the trading standards to be investigated. Furthermore, a note was left on the office door to inform the temporary postman to deliver post to the staff office in the event the permanent postman was on leave.

Whistleblowing procedures were displayed on the office notice boards and leaflets were displayed in the services that gave clear guidance on who concerns should be reported to, such as the Care Quality Commission and other public organisations.

Risk assessments were detailed and informative and included measures that had been introduced to reduce

the risk of harm to people. These covered areas such as the environment, personal care, health, communication needs, crossing the road, community access and medicines management. We saw there were risk assessments in people's care files' to help staff understand behaviour that challenged and identify ways of supporting behaviour change, these were called antecedent, behaviour and consequence (ABC) charts. The aim of using an ABC chart is to better understand what the person's behaviour is communicating so that the person can be appropriately supported.

These were used as best practice about how to support people whose behaviours challenged the service and discussed at staff meetings to update the positive behavioural support plans. These plans were written jointly with the provider and other professionals, which lead to detailed guidelines for staff to follow in many areas of support. 'Skills teaching' was then identified to support people to take positive risks and remain as independent as possible. For one person the plan highlighted that the person was to be supported by same gender staff in the community to reduce the risks associated with their behaviour. There were detailed instructions for staff to plan activities in a way which made it more likely a person would return to the service which included their personal belongings and to watch a personalised 'keeping safe' DVD before leaving the house.

When we visited two of the services we were given information about a particular person's behaviour that was included in the visitors risk assessments. This told us what we might see, how to respond and what we should do. Hazard checklists were in place to give guidance to staff on how risks should be considered in relation to staff lone working in people's homes, and their environment. For example, staff were asked to check certain areas of the environment when carrying out health and safety checks if there was an assessed risk.

Systems were in place in the event that a person needed to be reported as missing. People's care plans contained relevant information to give to the police; such as a photograph and a physical description of the person, places known to the person, and their communication needs. People carried an 'Outward help card' that informed other people that they may become distressed in an unfamiliar place, contained information on the person's diagnosis, how the person communicates and who they should contact if they had any concerns. One relative told us, "They keep a check on [my family member] if he/she goes missing in 48 hours they report [them] missing."

There was extensive partnership working with other agencies. In one service we found there was a comprehensive missing person procedure for staff to follow. This included a well-planned and a co-ordinated response from a wider network of health and social care professionals to ensure that the person was kept safe. This was reviewed regularly so the procedure remained reflective of the person's needs and helped staff to determine the support the person needed if their condition changed suddenly or the risks increased. A staff member said, "The biggest strength of the team is the communication." This showed the provider had systems in place to ensure people were safe when accessing the community.

People's relatives had mixed views about whether there were enough staff available to support people, and some told us there was a frequent change of staff. Relatives told us, "Some staff are fantastic, they need more staff they have a big turnover", "[My family member] has high needs and amount of time is not enough, they have increased the time to 12 hours but there is no night time cover, just waiting to see if they can accommodate", "The staff have real trouble with shortages", "[My family member] has a care worker allocated however there are a lot of care staff so [the person] has different carers, there is a rota system so [their] personal care is met", "The carers are all familiar to [the person]", "The person has a keyworker whom she/he sees twice a week [the person's] keyworker takes him/her out shopping and they go out to pubs and cafes", "Some staff [my family member] has had for years", "There is a keyworker ,the carers come in three

times a day to make sure everything is alright" , "I think [the person has regular carers but I can't be sure, well it is usually a one to one and two at night on, I am not up there in the night but I presume that happens", "They don't fill me with confidence, too many staff changes" and "[My family member] has an excellent service because [the person] suffers with their health quite a lot. [The person] has gone home from the hospital and I have thought they could not look after [them] but they have and they got [them] back on feet, there are times when I thought it is not going to work, but they do need more staff, they are concerned about the people that live there. I see [my family member] regularly but there are people that live there that don't see anyone and they seem happy. I can't fault the care."

We spoke with the staff in the services we visited who told us there was enough staff to support people. We checked the staff rotas and saw that the provider used their bank or agency staff to provide cover when staff took planned leave. We found some management roles had changed and there had been a reshuffle of staff and some staff had moved on. One relative said, "The turnaround of management is quite quick, you just get to know one and then it changes." The chief executive told us this was to align the organisation with changes in the delivery of services. They acknowledged there was a need to attract and retain staff and to manage these changes the provider offered incentives such as staff team rewards, staff volunteer schemes, apprenticeships and long service awards.

Where people required additional hours of support we found the provider had requested this, for example, a waking night support for a person leaving hospital and additional hours for staff to shadow and attend meetings relating to another person. In one service we visited we found that the staff had worked there for a number of years. Records showed that a person was referred to them from a hospital with a pressure sore and that this had now healed. The deputy manager told us how having regular staff had contributed towards this. They told us said, "The consistency of staff here, particularly the night staff helped in respect of healing [person's name] pressure sore as we all knew how to support [the person]."

Recruitment records showed that the provider carried out thorough checks of employees' suitability before they started work. These checks included evidence of the candidate's experience, good character, right to work and criminal record checks. The human resources manager showed us the systems that were in place to make sure that staff were only employed once the provider was satisfied they were suitable to work with people who used the service. Disciplinary processes were followed and acted on where there were concerns about staff conduct and failure to follow the provider's procedures.

People received their medicines when they needed them. Relatives told us, "[My family member] self-medicates, staff will oversee it and sign the book that she/he has taken it", "[My family member] is autistic, they help [them] with medicines, I'm happy with this", "I'm on top of that. I check the medicine administration record (MAR) chart and call in unannounced; they are very good at recording. We have a three monthly review", "There have been times when meds have been missed but not since the new manager has been involved", "[My family member] has been moved next to the office for constant supervision [of medicines] no problems as far as I know" , "They do give [the person] medication, [the person's] diabetes seems to be under control" and "I do try to get up for the medical review, I do worry about [the person's] medication, also people like [my family member] can never say if they have side effects and I do worry about that."

In the services that we visited we saw that people's medicines were held in locked medicines cabinets in their homes. Records contained a photograph of the person, what the medicines were used for, the type of medicines, the dose required, GP details and any allergies or reactions they may experience. We observed that staff followed the appropriate guidance when administering people's medicines. We looked at the MARs for 10 people and found that administered medicines had been signed for. We found that staff helped

some people to take their medicines independently, for example, they were encouraged to open the tablets from their blister packs. There were records to instruct staff in what circumstances to give medicines prescribed as 'when required' to ensure these were only administered as needed and staff gave us examples of this. People's medicines were reviewed regularly and staff were knowledgeable about the importance of administering different types of medicines for people, for example, topical creams. One relative told us, "[My family member] has a bit of dementia settling in and the assisted living is better for [them] and they are very supportive, they help with [their] eye drops, which they give [them] every day. It's best that staff give her/him medication."

Where people had refused medicines this was recorded accurately in the MARs and staff told us that this was reported to health professionals immediately to ensure that people were supported with any adverse effects of this. The returns medicines book demonstrated that any surplus medicines were disposed of.

Risk assessments showed how medicines should be given. Staff told us that they were trained to administer medicines safely and their competency was regularly checked, and their records confirmed this. Where medicines errors were identified we found that that action had been taken in relation to this. People's medicines were reviewed regularly and the provider's medicines guidelines detailed how staff should administer medicines safely.

To ensure the home was kept safe for people, professional maintenance and servicing of equipment was routinely carried out, including regular water temperature and legionella checks to ensure the safety of people's health and well being. People's care plans noted that 'staff must check the water temperature before people use the bath or the shower or before washing their hair'. Fire practice evacuation drills were regularly held involving both people who lived in the service and staff, and people had specific written plans on how they should be supported when evacuating the service in the event of a fire.

Good

Is the service effective?

Our findings

People's rights were protected as staff understood their responsibilities in relation to consent under the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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.

We checked whether the service was working within the principles of the MCA. We found that care assessments forms had been completed to determine each person's capacity to make specific decisions about their care needs and health management, and one of the registered managers confirmed that these assessments would be reviewed in response to people's changing needs. The provider had assessed people's capacity to carry out decisions using a tool which asked what the decision to be made was, what support was provided to help the person make the decision, what their decision was and if they understood this. Where people were not able to read or write consent was documented in appropriate ways, for example by documenting the person had verbally agreed by using their body language. In one care plan it was recorded that the person's capacity could change and the person could be easily distracted, and made staff aware when assessing capacity that this must be shown in the decision records.

Best interest's discussions had taken place with social workers and relatives about specific decisions in relation to people's care. Where people might not have capacity, the provider had requested support from the local authority. One person was able to make decisions about their daily routines but they had requested support for bigger decisions about their accommodation and changes to their care and support. For two people, applications had been sent to the Court of Protection to seek authorisation for potentially restrictive measures such as establishing the whereabouts of a person who regularly went missing. One person required frequent night checks due to their health needs and an application was sent to the local authority to seek permission for staff to access their flat to carry out safety checks. A registered manager showed us when they had undertaken a review of the actions following a best interests meeting to support a person with a particular behaviour. They found a solution that supported the person's right to make their own decision whilst minimising the implications of their behaviour.

We saw that staff obtained people's consent before carrying out any aspect of care and relatives had had been involved in any decision making on behalf of their family member where appropriate. Meetings were held and consent was sought in relation to opening people's mail, their healthcare needs and collecting and monitoring people's finances. Some people had a financial appointee for their finances to be managed by a local authority and two people had relatives who held lasting power of attorney for their finances. The registered managers and staff had received training and had a good understanding the principles of the MCA and DoLS. One staff member said, "We have to assume capacity, allow them to make decisions for themselves for activities for the day and choice of clothes, hobbies that could involve risk. We ask

permission before opening their fridge, it's important to explain what you are doing."

Staff received appropriate training to meet the needs of people who used the service. All staff completed a period of induction when they commenced employment to make sure they had the basic skills and knowledge to care for people. This included the opportunity to shadow more experienced members of staff. One care worker said, "When we do face to face training we get a lot out of it. I had an appraisal, they make sure we are properly inducted, that you read the support plan and shadow people in the services. I am having autism training in January." There was a learning and development catalogue, made up of online and classroom based training. This included approaches to mental health, understanding depression, epilepsy, observation and reporting. One scheme manager told us they were supporting staff to learn Makaton, to be able to communicate more effectively with people. Makaton is a language programme using signs and symbols to help people to communicate.

The scheme managers held a training matrix that highlighted when staff training was about to expire or when they required specific training, and showed us where this was highlighted as a priority. Reminders were sent to staff when they were due to attend refresher training and staff then booked themselves on to available courses. The training courses which staff had completed included moving and handling, infection control, autism, food safety, emergency first aid, fire safety and equality and diversity. Staff had also received specialist training on positive interventions to support people who behaved in a way that challenged. This was tailored to the individuals using the service and gave staff the skills to diffuse situations and reinforce positive behaviours when people behaved in a way that put themselves and/or others at risk.

Staff told us they received regular supervision and appraisals, which encouraged them to consider their care practice and identify areas for development. Staff told us, "Supervision and training is very good, they send us reminders, it's good experience, the training helps us to work with people better" and "We get yearly training. We have not had any incidents here, we are regularly supported by the manager."

In one service there was a student volunteer who worked across some of the services fulltime. They were taking a person to a museum and were able to tell us about the person's needs and how they would react to the challenges they may face when supporting people in the community. For example, they told us about the use of distraction techniques to calm people and diffuse any anxieties the person may experience. They explained they were treated like a member of staff and received full training including supervision. They said, "They are the best trainer of people; it's been great. I did the newsletter for customers, the service provides accommodation for student volunteers. I support customers, we go to cafés and have a chit chat."

People were supported to make decisions about what they would like to eat and drink and to maintain a healthy, balanced diet. Relatives said, "It's very good they help [my family member] decide, take [them] shopping and help [them] to cook for themselves", "[My family member] will go to the fridge for a drink, the staff cook for [them] and I do the shopping", "Food is good [my family member's] cultural needs are met", "[My family member] is definitely well fed, there is food and drink [the person] buys her/his shopping."

People were involved in developing their own menus and staff were aware of their likes, and preferred meals. There was a pictorial menu to show people the choices of food that were available that day and we saw in people's care files their dietary needs had been reviewed. There were steps about how to ensure people ate healthy food, for example, one person's calendar identified there was a National Cupcake Day and staff recorded in meetings with the person that they would take part in this in a healthy way.

Staff, on the whole, supported people where they could to teach them cooking skills, but in addition people were encouraged to participate with staff in shopping for foods, meal preparation and keeping the kitchen

areas clean. Relatives echoed this, "It is very good they go shopping once a week with [my family member], fruit, veg and butter, bread, there is a risk of fire so [they] can't use the cooker on [their] own" and "They make sure [my family member] is preparing the meals and eating well, she/he does like to go out and eat so they will take [the person] out to dinner also, pubs and cafés."

Staff had an understanding of people's nutritional needs and specialist diets. For example, a soft diet was made available for people who had difficulty with eating and swallowing. They were able to describe the requirements of people's specific diets and specialist food items and adapted utensils were available to meet their dietary needs, as detailed in their nutritional assessments. However, in one service we found that the pictorial menu displayed in the person's home did not reflect the foods in their assessment, we asked staff to update this and this was acted on. Records were kept about people's individual food preferences and dietary requirements and also what food each person had chosen to eat. Relatives told us, "The dietitian checks [my family member] is having the right food" and "[Person's name] does have a few eating issues, we try to ensure we are there. There are guidelines which are individual."

In two services where people shared the communal kitchens we found that good food hygiene practices were followed, fridge and freezer temperature checks were completed daily and food items were stored appropriately, sealed and labelled with the dates they were opened.

People were supported to access health professionals. Relatives explained, "[My family member] had a dentist appointment, [the person] had put on a bit of weight and they made a doctor's appointment and made sure she/he attended" , "Definitely, sometimes I go to the hospital with [my family member] and they come with me and they will advise the staff on how to get [the person] to do things", "[My family member] sees the doctor regularly, usually assisted on a one to one" and "They look after her/his health needs and keep an eye on [them]."

Staff supported people to attend appointments with health and social care professionals, such as their GP, neurologists, dentists, audiologists, psychologists, speech and language therapists (SALT), district nurses and occupational therapists (OTs). We found that people attended health appointments frequently and outcomes of the appointments were written in people's Health Action Plans (HAPs).This holds information about the person's health needs, the professionals who support those needs, and their appointments. The plans showed that people had full health checks and their needs were regularly reviewed. People had comprehensive oral hygiene plans in place that showed how staff should support people with their dental health care.

Care plans contained information about how to identify and respond to the health needs of people with complex needs who may not have been able explain how they were feeling. For example, there was guidance for staff about how people behaved when they were in pain. At one service a person had been supported to see a sleep specialist as the person had difficulty sleeping. Where people experienced periods of anxiety, there were distress passports for staff to complete and monitor when this occurred. In a second service where a district nurse attended to check the on the integrity of a person's skin, a referral had been sent to the OT to provide a sling to aid safe transferring and staff were reminded to use a sliding sheet to move and position the person safely. Also a professionals meeting was held regarding the safe use of a wet room. At a third service, a person experienced falls due to their health condition. They had refused the support of a healthcare professional therefore discussions had taken place with staff to help mitigate the risks whilst balancing the person's right to make this decision. We also saw that staff received adequate training and guidance to support people following their discharge from hospital to ensure this was managed safely.

Good

Is the service caring?

Our findings

People said staff were, "nice", "caring" and "respectful". Their relatives agreed and told us, "They care and [my family member] is happy and that's what matters.", "They are always jolly, the carers are caring and do look after [the person] well, the atmosphere is good, they have birthday parties for the residents too", "They are very caring and polite, [my family member] seems to be happy there, they do keep asking if [the person] wants to go home for the weekend but she/he refuses so they must be happy" and " Very happy with the permanent senior staff and the other staff very good and caring, they try very hard."

Staff were observed to be supportive and caring when supporting people in the services we visited. Conversations with people were kind, respectful and appropriate, and explanations were provided when people needed these. We heard staff offering people choices and we saw how people were encouraged to express their decisions. People were included in all conversations with staff whenever they were present, they were allowed time to reply in their own way. We observed staff communicating with people well. They understood the requests of people who found it difficult to verbally communicate. When asked, staff members knew how people communicated different feelings such as being unhappy or in pain so that they were able to respond to these. We observed staff spending one to one time with people where this was required.

Communication with people was highlighted in people's care plans as being an important aspect of their well-being. There were detailed communication profiles in place for people. These documented the person's level of understanding, how they communicated, their styles of social communication and interaction, effective strategies for communicating with them, methods of supporting choice and the things staff should not do. These contained useful information, such as, "Assure [person's name] there is no right or wrong thing to do" and "If people don't respond [the person] will need an explanation of why" and "[Name of person] relies on objects of reference, photos and Makaton to be used, has limited awareness of other people's views, do not ignore [their] attempt to communicate" and "[Person's name] has a sensitivity to noise such as the hoover." Where there were particular words which caused people distress, these were clearly documented with suitable alternatives for staff to use. In two services the staff informed us what these words were before we spoke with people.

Each person had a one page profile; with a recent photograph outlining the things they liked, what was important to them and how to support them. These were detailed and clearly focused on person centred care. The profiles consisted of information on topics the person was interested in, the importance of staff maintaining consistency and also included information about what to do if people became anxious or distressed.

People were involved in discussing their needs and wishes. They were listened to and their rights were respected. One person said, "I make my own decisions, any decisions the staff arrange it, whatever I want, they always ask how I am, what I would like to do." Advocacy support was accessible for people to ensure they were represented and supported to make decisions. For example, one person was supported by their key worker in collaboration with their social worker for an advocate to represent them in respect of their end

of life care needs. They were also given brochures to offer choices and point out the options available to them.

There were specific sensory profiles which assessed the person's sensitivity and perception in areas such as the five senses, co-ordination and balance and body awareness. These included triggers such as "not being included in conversations about her/him" and "easier to escalate in rooms with low lighting/curtains drawn," and "look out for hypersensitivity, avoid certain colours such as grey." One scheme manager showed us the sensory room with appropriate equipment for people to use as some people liked "things that reflect the light."

People's privacy and dignity was respected. Relatives told us that their family members were treated respectfully and were always well presented in all aspects of their personal care and appearance. Care plans showed that people liked to be offered a choice of specific hair, bath and foot products when being supported with their personal hygiene and there was guidance about how this should be done in a dignified manner. Some people's personal care needs had been assessed by health professionals and showed how they chose to be supported with their continence care. When personal care was carried out for one person it was noted that the person enjoyed baths and should be given their private time. The scheme manager of one service had liaised with the housing provider in relation to the use of a quiet room for people to relax and form friendships with others.

Preferences about people's night time routines were discussed with them, for example, one person preferred to have their curtains open and the light off at night as a bedtime routine, and another care plan documented how staff should help the person to "put on the pop channels, say prayers with them and change their pyjamas". We saw that staff knocked on people's doors before entering their rooms and when people were being supported with their personal care needs this was done privately in their own rooms. Relatives said, "They don't go into her/his room without knocking first", "They are very respectful, they always knock before coming into [their] space" and "I think her/his privacy is protected [the person] has their own space, TV and own shower." One person had a hearing impairment and it was noted that they may take out their hearing aid. Their care plan advised staff to "knock loudly and shout their name before entering." Where people refused to engage it was noted to allow them some time before offering support again, and if they were still upset offer somewhere private to talk and play music to allow the person time to relax.

People were supported to maintain positive relationships with family, friends and staff. Relatives confirmed they visited the services frequently. Background information about the importance of people's relationships with their family members was recognised and valued. Information about people's friendships was acknowledged. In care records it was noted that a person was given a present by their friend which they cherished and how another person liked to spend their time with friends in the area they grew up. In response to a person's uncertainty about whether a staff member would be returning, the staff had compiled a social story from the staff explaining why they were not coming back, including "I'll miss seeing you, I'll see you in 2017 for a nice cup of tea." This was loaded onto the person's iPad, and the service had received compliments from other professionals for this piece of work.

We visited a service that had been nominated for an 'end of life care award' for a person who received palliative care. Their relatives and a health professional had written complimentary letters to the staff team about the way they cared for the person, explaining that the care given by the staff was exceptional; who went beyond what was required of them. In light of this, the staff team at the service had been awarded the 2016 'supporting older people with learning disabilities' award in recognition of the care that was provided from an external awarding body. This demonstrated that people's wishes and preferences were recognised,

valued and celebrated.

Good

Is the service responsive?

Our findings

We asked people's relatives if staff were responsive to their family member's needs and they said, "They are still getting to know [the person], they seem really friendly and are supporting [them] well so far", "They walk with [my family member] every day as [the person] has swollen legs and needs to walk and goes out every day, the people are good, she/he doesn't feel rushed, and feels comfortable", "Yes in terms of care they are good, very person centered, they do care for [my family member] wash [them] and her/his hair, I know they have to deal with other [people] too" and "They are pretty good, I visit [my family member] every week, they are getting to know [them]. They communicate with me and will let me know how [the person] is."

Care plans contained clear information about people's assessed needs and preferences and how these should be met by staff. This information helped staff to provide personalised care to people. Prior to people joining the service staff carried out a detailed assessment that assessed the support required in over 20 areas. The information provided detailed what was important to that person, how to keep people healthy and safe, flexibility of thinking including rituals and repetitive mannerisms, advocacy, religion and culture, relationships, how to give people recognition for an accomplished task and their likes and dislikes. They used pictures to help people understand their care plans. Staff who supported people had signed to say they had read and understood these plans.

There was detailed information for staff about how to support people in certain areas, such as personal care and travel. Staff produced a plan of what the person wanted to do for themselves, what staff needed to do and the order in which things needed to be done. The clinical lead told us, "We were told public transport was impossible for [the person] but we now do that weekly."

Staff acted as key workers for people and were required to meet with people weekly to check on their progress in their areas of support. In the some files that we looked at we saw these meetings had taken place. For example, after a recent meeting it was discussed with a person what else they would like to do with their time, such as a second day working at the garden centre. There were recommendations by health professionals as part of people's assessment, and the key working document reflected the progress they were making to plan this. However in five of the files we checked we found these key work meetings did not regularly take place. We found that some of these records were identical for each month, and some of the care records were not always signed by people and staff to demonstrate that both parties agreed about what was discussed and documented. We checked the provider's comprehensive audit in relation to these and found these issues had been identified. We spoke to the scheme managers of the services who agreed to address this.

People were supported to remain as independent as possible. Their achievements had been documented, and these were clear and specific to the person's needs in relation to what progress people had made and what they still needed to do, with defined timescales. Staff had documented telephone skills training they had carried out with a person. It gave the person clear phone rules to follow, and used a movie they liked to relay why they shouldn't phone emergency services without cause. Training was documented weekly, and showed a clear development of their skills. The clinical lead said, "[The person] lost contact with many

people [they] used to see regularly it's kind of opened up [their] life."

We met with a person who allowed us to view their home, we observed that they were thoroughly engaged with their art work, the staff member said, "We skill teach them, [person's name] has a great imagination and enjoys colouring." We later spoke with their relative over the phone who was complimentary about the care that their family member received. This service held accreditation with the National Autistic Society and particular reference was made to the integration of people into the community.

People had access to a full range of activities, which suited their individual interests. Relatives said, "My family member has art therapy going once a week and had an outreach carer visits three times a week taking [them] shopping and for cake and coffee", "Yes they do help [my family member] with one of their hobbies, [they] like crystals and they help her/him save money to go and buy the crystals and music and help [them] arrange it in their room" , "[My family member] loves discos, parties ,all social activities, swimming", "Horse-riding, swimming, bowling, musicals and shopping, [the person] comes back home with me for lunch and gets involved in day centre activities", "[My family member] likes cards, their favourite is snap or pairs", "Disco's, sandwich project, she/he is very enthusiastic about that and films."

During our visits we observed staff arrive to support people with their pursuits. They were provided with opportunities to take part in activities and social events. The staff explained they tried to make sure planned activities were meaningful and designed around what people wanted and the times they wanted to do them. We met people who had been out to the day centre and we were told other people attended the gym and another had a membership to watch their favourite football team. Staff supported people to places of interest that offered free admission or low cost entry fees, for example, theatres, dance clubs, exhibitions and museums, which were incorporated into their individual activity programmes. They encouraged people to participate in the activities programme in their homes, which included cookery classes, a gardening group, indoor games and quiz evenings, film nights and massages with essential oils. Authorisation forms had been forwarded to the senior manager for future holidays and outings to places people were keen to explore such as New York, Butlin's, Bognor Regis and a cruise. One person liked the woods and a camping trip had been booked to support them to pursue this interest.

There was step by step guidance on how to support people with swimming and accessing the community. Where one person was supported to walk home from a day centre, there was a map of the person's chosen route walking home, including familiar places where they could use the restrooms. To increase people's skills, confidence and employability some people attended voluntary work placements and educational courses.

Two people who used the service gave us a tour of their home, including their vegetable patch, art room and their bedrooms that were personalised with items that they valued. One person said, "We chose the colours of the chairs, we liked them for downstairs." They showed us their activity board and achievement chart and how this worked. Another person had early onset of dementia and had a memory book added with pictures of the holiday they had been on. Objects of reference were used such as pictures, music and body language to help them verbalise. Their notes read that staff needed "to be patient, allow her/him to speak, not to impose on the person's timing in regards to their routine, can engage in domestic tasks with supervision and will spend tomorrow rearranging bed covers."

People's cultural and diverse needs were recognised and met. There was a diversity needs promotion leaflet that included background information about people's individual needs. This consisted of people's religious background and any important religious holidays, festivals and end of life care needs that were linked to this. Specific guidelines were produced on how staff should consider these needs in people's daily lives. For

example, there were guidelines regarding people attending their chosen place of worship, clothes, music, food and television channels that were culturally appropriate. In one service there was a dictionary of words in a person's language so the staff could communicate more effectively with the person, we observed that the senior managers used these words when interacting with the person. Where people required same or opposite gender care this was acted on. An easy read service use guide was available outlining people's rights and responsibilities such as people having the right to have visitors of their own choice, the right to manage their own money and the right to their own private time.

People had access to an easy read complaints policy and told us they knew how to make a complaint, however relatives had mixed views about complaints being resolved within the appropriate timescales. Relatives said, "No complaints, never had a bad word heard there", "Not with this manager, this manager now has a reporting procedure, it has now improved", "I don't remember ever having to bring up an issue", "There was one member of staff I complained about, I don't know but [care worker] didn't come back", "They don't respond", "I have been ill so have been unable to visit but it is difficult to get through on phone", "Communication is not good, very poor, they don't check on staff."

We looked at a sample of complaints and how they were analysed across all the services for 2015/2016. Some of these had been made in relation to the quality of support people received, staff changes, the delays in the provider's response to following up these concerns and service improvements that were required in respect of this. We found that complaints had been analysed and actions had been put in place to improve the service delivery. Actions included further medicines training for staff, support with liaison with the landlords, a more co-ordinated management response relating to incidents and a system to monitor and act on specific complaints in respect of time-keeping. One relative explained how improvements had been made following a complaint they had made, and said, "There was nobody on call so [my family member] had to go to the hospital on his/her own and they called me. I complained and they changed the policy and now there are staff on call." The provider had implemented a two tier out of hours service whereby if the first manager was unable to respond a second manager was to be contacted. In one service we saw that staff had supported a person to complain to the housing management regarding their facilities not working in their home and we saw records to show that they were duly compensated for this.

Good

Is the service well-led?

Our findings

Relatives opinions differed in relation to the way the services were run, "The way they respect the residents is very good", "They keep the family involved", "The [scheme manager] is absolutely lovely, when I first met them years ago [the manager] was the main carer for [my family member] and told me anytime you want to chat just give me a call", "Friendly, they do listen, all documented and keeps me informed", "They are not visible most of the time", "It seems to be well led" and "She (the manager) is very good and helpful."

Some relatives told us they wanted more consultations about any changes that may occur within the service and explained, "They used to have relatives meetings, there hasn't been one since December (2015)" and "More advance notice of changes that affect the residents, more consultation." Customer surveys had been sent to people using the service regarding housing management and the improvements in the home and the provider was waiting for the responses, but recent surveys had not been sent to people and their relatives to obtain their views about how the service was run. The chief executive told us these were due to be sent to people in March 2017 and described planned developments, such as the registered manager being the main point of contact to act as a family liaison to people's relative's and feedback forms to be provided to people in other accessible formats. They demonstrated to us that the improvements had been highlighted in the provider's business plan for 2016-17, which recorded the organisation's priorities, long term aims and how these would be achieved. Delivering high quality care for people, to include people's families, carer's and friends, staff recruitment and retention, workforce development and more effective reporting were documented as some of the main areas where the provider planned to improve how they delivered the service.

The head of business support and development showed us how the provider recorded quality monitoring and risk management information centrally. This demonstrated how the individual services were audited, who was involved, the actions required, and timescales for completion. The registered managers completed audits in areas such as medicines; health and safety, and care plans. The report then gave an automatic risk rating and services rated as high risk were monitored more closely. Where monthly spot checks had been carried out in services and concerns found the audit showed that more stringent checks were needed in respect of this. The provider was introducing new IT systems to improve the timeliness of management reporting and this had been identified as an issue.

Comprehensive annual service reviews had been carried out, these were collated and analysed for trends and themes and used to produce improvement plans. These plans highlighted what needed to be addressed and what was working well. For example, management of risks to staff at night had been considered, by looking at a possible speed dial to the on call service. An improvement plan also highlighted the importance of regular consultation with people using the service and their relatives, to invite their opinions and respond to these. The provider's board members had carried out a visit in one service so people were given the opportunity to express their opinions about the service and their report concluded that people were being treated with dignity and respect.

The registered managers ensured lessons were learnt from any incidents and accidents to protect people

from further harm. They used this information to identify any relevant trends and improve the service. One manager explained there are, "Many missing person's incidents." Reports outlined the incident type and provided a detailed description, the outcome of the incident, procedures to be followed, contributing factors, any similar incidents that were linked to this, and any changes to procedures to take place as a result. For example, two missing person's incidents had taken place due to the person being dropped off outside their home rather than escorted to the front door. The provider had worked with the person and relatives to devise a new procedure to ensure they returned safely, that included a signing in book which the person was happy to manage. Falls prevention work was to be undertaken in one service after the provider identified after two incidents that this was required. In another case, staff had liaised with the college to attend sessions with a person, when the incident analysis had shown when staff were told they were not to attend sessions with the person.

The service had four registered managers in post and one post vacant which was covered by an interim manager. They were based at the main office and were allocated localities to oversee. They were supervised by the head of care and support, who held monthly meetings with them to check on their performance. The scheme managers based at the services told us that the registered managers had an open door policy, maintained a visible presence and were always willing to step in and assist when needed. The registered managers had completed training that was reflective of the needs of the people who used the services. This included a higher national vocational qualification in health and social care, promoting independence and leadership programmes. Staff described the scheme managers as supportive and said they were treated liked valued members of the team. They were aware of the management structure within the provider's organisation and who they could contact if they needed to discuss any issues.

The staff working in the services that we visited spoke positively about the provider and told us they were proud to be part of an organisation that held a clear set of values and made them feel like a valued employee. Staff commented, "One of the best organisations I have worked for, they treat their staff well, the management have been great", "Good organisation, it has had a positive impact on me, they respect people and take them for what they are, as I would, I feel honoured to be working with them and being able to contribute", "Outward is a good organisation to work for, they involve customers and they really empower them" and "I have been supported when I had [time off] I came back and got all the support, staff have been supportive they inspired me, they are a great team."

Daily handovers were recorded by staff after each shift and included the handover of keys, medicines and finance checks, staff observation reports and tasks staff were allocated to complete during their shifts. Staff said that they were kept informed about matters that affected the service through team meetings and talking to the scheme managers frequently. They told us about staff meetings they attended and that the scheme manager fed back information to staff who did not attend the meetings. The most recent staff meeting minutes were available and agenda topics comprised of shift cover, security checks, cleaning duties, checks on medicines and finances and people's health and wellbeing, and property and maintenance, which had been identified as needing further improvement. However, we found in one service that the waking night staff had only attended one team meeting in 12 months. The manager explained that the minutes of the meeting were on the notice board for waking night staff but agreed to seek to resolve this.

Some people who used the service were involved in the process of improving the quality of care; they were called customer service representatives and quality checkers. In response to an executive report that was produced they had identified that the customer survey was not accessible in an easy read format and large print. Three people who used the service attended the customer committees and were involved with staff recruitment. In one service, feedback identified that people were happy with certain aspects of the service but inspection training was needed for the quality checkers who used the supported living REACH

standards. The REACH standards are used by people to check how good a service is, and what can be done to improve it.

People using the service and their relatives told us their overall view of the services and how they could be improved. They commented, "There is no evening life, night staff don't interact, there is a gap between 6.00pm and 10.00am until regular staff are back on duty", "To make [the person] feel less anxious", "The house is kept clean but the toilets could use some attention, "Three points, communication, training and more permanent staff" and "I believe it is service first, not happy about cost cutting. I can't comment outside of this issue but [the person] is positive and happy."

The provider worked closely with the local authority that conducted monitoring visits and provider concerns meetings to identify areas for improvement. The provider's improvement plans documented what was required by the registered managers to address any shortfalls. The registered managers were aware of the requirement to notify the Care Quality Commission of important events affecting people using the service. We had been promptly notified of these events when they occurred.