Royal Mencap Society

Royal Mencap Society - North Suffolk and Coastal Domiciliary Care Agency

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Royal Mencap Society - North Suffolk and Coastal Domiciliary Care Agency is a care agency providing personal care to people living in the community. People received support in their own individual houses or in shared supported living services for small groups of people. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time of our inspection 26 people were using the service.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This service was able to demonstrate how they were meeting the underpinning principles of right support, right care, right culture.

Right support:
The model of care maximised people's choice, control and independence. People were included in decisions about their care and support and were supported to access and be part of their local community. During lockdown this access had understandably decreased but alternative daily activities had been put in place as a substitute.

Right care and right culture:
Care was person-centred and promoted people's dignity, privacy and human rights. However, decisions about how to carry out night checks to keep people safe whilst ensuring their privacy needed review. Care plans were written in a person-centred way which was fully focussed on the person's needs. The language in care plans was inclusive and oversight from service managers and the registered manager monitored this closely.

Risks relating to people living with epilepsy required further review to ensure people were kept safe and their privacy and dignity maintained. The provider gave us assurances that this review process was already underway.

Other risks to people's health, safety and welfare had been assessed and actions needed to mitigate these risks were mostly well documented and managed.

There were enough staff to keep people safe. However, one of the supported living services, where people's

mobility needs had recently increased, needed further review of staffing levels to ensure people's needs could be met over a 24 hour period.

Other aspects of the service were safe. Staff were clear about how to safeguard people from abuse and the service managed people's medicines well. Staff were safely recruited and well trained and there were robust infection control procedures in place. Feedback from relatives was very positive about the skills and expertise of the staff.

The provider's oversight and monitoring of the service was structured. Despite this, the concerns we have noted relating to staffing and the management of people's epilepsy had not been identified and fully explored. The registered manager's auditing of individual care records, although detailed, did not ensure comprehensive oversight of each person's care and support needs. However, there was a strong emphasis throughout the service on being inclusive and person-centred.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 3 September 2019.)

Why we inspected
The inspection was prompted in part by notification of a specific incident, following which a person using the service died. This incident is subject to ongoing investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received as part of the investigation into this incident gave us some concerns. We were concerned about the management of people's epilepsy, especially at night. We also had questions about how the service keeps people's needs under review. This inspection examined those risks.

We undertook this focused inspection to review the key questions of safe and well-led only. We reviewed additional information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to review some of their procedures for monitoring people at night, especially those living with epilepsy. We noted that although the provider had begun to review the needs of people living with epilepsy, this review was not complete. The provider kept people's other needs under appropriate review, although the COVID-19 pandemic has resulted in some reviews being delayed.

We have made a recommendation relating to the management of people's epilepsy needs.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Royal Mencap Society – North Suffolk and Coastal District Domiciliary Care Agency on our website at www.cqc.org.uk. This report is listed under the provider's previous name.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-

inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe.	**Requires Improvement**
Is the service well-led? The service was not always well-led.	**Requires Improvement**

Royal Mencap Society - North Suffolk and Coastal Domiciliary Care Agency

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector.

Service and service type
This service provides care and support to people living in the community, either in their own flats or houses or in one of the six supported living services. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was on an extended period of leave at the time of our inspection and oversight of the service had been shared between two other registered managers.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider would be in the office to support the inspection. Inspection activity started on 1 March 2021 when

we visited the office location and ended on 19 March 2021 when we gave the provider feedback about our inspection.

What we did before the inspection
We reviewed the notifications of significant incidents which the provider is required to send us by law. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
The inspection visit to the offices was a formality as no records were kept there and the provider had closed the offices at the start of the COVID-19 pandemic. This meant that our inspection activity was carried out over the phone, through video calls and through e mail in the period following the inspection visit to the office on 1 March 2021. We spoke with three relatives of people who used the service about their experience of the care provided. We also spoke with eight members of staff including two area operations managers, three service managers and four care staff, two of whom worked as waking night staff.

We reviewed a range of records. This included ten people's care and medication records and two staff recruitment files. We also viewed a variety of other records relating to the safety and quality of the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- This inspection was prompted, in part, by concerns about how risks relating to supporting people living with epilepsy were managed. During our inspection we identified some people's records relating to their epilepsy had not been reviewed regularly. For example, one person's risk assessment was due for a six monthly review but had been left for 11 months. Another person's protocol about their emergency epilepsy medicine was incomplete, although information was documented elsewhere in their care plan.
- Some people who used the service had been provided with an alarm to alert night staff of possible seizure activity. Their capacity to consent to this had been assessed and documented. Other people had no record of this equipment being considered as part of their epilepsy management. Staff told us this was because it had been considered an invasion of their privacy.
- We asked staff how they check people are safe at night. They told us they check them hourly, in some cases by going into a person's room and feeling for their breath on the staff member's cheek. Care plans did not instruct staff to check in this way. Risk assessments stated staff should check people each hour, but did not specify how.
- We discussed the management of people's epilepsy with the area operations manager who told us that the provider had begun to review people's epilepsy needs, especially at night.

We recommend the provider continues to review all the risks relating to the management of people's epilepsy needs whilst continuing to be mindful of people's privacy and dignity.

- One risk assessment relating to a person's risk of choking should have been reviewed after six months but had been left for 11 months. The service manager explained that this was in part due to a backlog caused by the COVID-19 pandemic.
- Other risks, such as the risk of falling, were identified in care plans, documented and reviewed, giving clear guidance to staff. Guidance from other healthcare professionals was recorded and incorporated into care plans. Staff we spoke with demonstrated a good knowledge of people's individual risks and how to try to reduce them.

Staffing and recruitment

- One of the supported living services supported people who needed help with their mobility. We noted that, despite two staff being needed to support one person with their mobility needs, there were parts of the day when only one staff member was on duty. We also noted that only one member of staff was on duty overnight. We asked how staff would meet people's needs at night. One staff member told us, "It can be tricky – the ones who have a walking aid need you to push the bathroom door open for them. If the other

[person]needs help at the same time, how can I choose who should go to the toilet?"
●We asked the area operations manager if they had reviewed the staffing needs at this supported living service following an increase in people's needs. They had not done so and had not approached the local authority to raise the issue of people's additional staffing needs.
●Staff also told us that the on-call procedure at this service was more of an advice line to co-ordinate support. In reality, staff called the service manager out of hours even though they were not actually supposed to be on call. Asked who they would call for help in the middle of the night, one staff member said, ""I would call [service manager – they have their] phone on. We do have an on-call system, but they are in Peterborough"
●In other areas of the service there were enough staff and relatives praised their skills and expertise. One relative told us, "They look after [my relative] like I do. Their caring is excellent. They understand [my relative.]…. I totally trust them"
●Staff were recruited safely using a robust recruitment process. New staff received a comprehensive induction and they spoke very highly of this, confirming they were not rushed into taking on roles and responsibilities they were not ready for. New night staff told us they had been given a lot of time on day shifts to get to know the needs of the people they were supporting and caring for.

Systems and processes to safeguard people from the risk of abuse
●Staff demonstrated a good understanding of how to recognise and act on the signs that someone might be being abused. They understood how to raise a concern both within Mencap and externally and had received appropriate training.
●Care plans identified how staff should positively support people who used the service to manage their own stress and anxiety without putting others at risk.

Using medicines safely
●Medicines were managed safely. Staff received appropriate training and their competence to administer people's medicines was checked by service managers.

Preventing and controlling infection
●People were protected by the safe use of infection control procedures and practices. Staff and relatives told us that the provider had taken robust action to control the risks associated with COVID-19.
● Staff were able to outline the additional cleaning tasks which had been put in place to keep people safe. They also explained how they helped people who used the service understand the many changes to their daily life such as social distancing and the need for facemasks.
●Staff were clear about the use of personal protective equipment (PPE) and had received appropriate infection prevention and control training.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as outstanding. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There was a registered manager in post, but they were absent on a period of extended leave. Two other area operations managers had taken over the monitoring and oversight of the service during the registered manager's absence. We found them to be knowledgeable and feedback about the registered manager and those covering for them was positive. Each individual supported living service had its own service manager who had daily oversight.
- There was a system of audits and checks in place. Audits monitored aspects of the service such as medicines, health and safety and the environment. Service managers submitted audits to the registered manager who, in turn, audited care plans on a rotational basis. This meant that, across the whole service, each person's care plan would be reviewed in depth by the registered manager at least once a year. In the intervening time the service managers carried out this monitoring. Given that we identified some care plans had not been reviewed in accordance with the provider's own procedure, we questioned how effective this oversight was.
- The issues we raised about the management of people's epilepsy and the staffing of one of the supported living services had not been proactively explored by the registered manager. We fed this back to the provider who assured us they would be taking this forward.
- The service demonstrated a willingness to learn and reflect in order to improve the service for the people supported and cared for. The provider assured us the issues we raised in feedback around staffing and care for people living with epilepsy would be immediately taken forward.
- The service had submitted the required notifications to CQC when they had a significant incident to tell us about.

Learning lessons when things go wrong

- Staff filled out the provider's incident and accident forms when things went wrong, and these were analysed to see if lessons could be learned. Any learning was shared with staff.
- The provider had begun a review of the care needs of people living with epilepsy. This had been prompted by the incident at one of the supported living services. Although this was an appropriate response, we questioned the lack of timeliness in carrying out a thorough review of all plans and all risks relating to epilepsy

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good

outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Staff and relatives were positive about the open and transparent way the service was run. Mencap's focus on being person-centred and inclusive was clear in conversations with staff and relatives and in records. Records were written in an accessible way and it was clear that people who used the service had been included as much as possible in drawing up their own care plans. Care plans identified how staff should involve people in daily decisions about their care and support and staff gave us examples of how they put this into practice.

●Staff felt well supported and able to raise any concerns or ideas they might have and told us they were listened to. One commented, "If training was not adequate and I wasn't happy and there was an issue, I would raise it with [service manager.] [They have] been very supportive"

●Relatives told us they had good relationships with the staff and service managers. They said they were kept informed during the COVID-19 pandemic, with the staff supporting people to use a variety of ways to keep in touch.

●Relatives confirmed that they were involved in drawing up and reviewing care plans. However, one person commented they had not attended a formal review of their relative's care for two years. We fed this back to the provider.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

●The area operations managers and service managers for each of the supported living services, had a good understanding of their legal responsibilities relating to being honest and open with people when something went wrong. The good relationships staff had built with people's families helped to facilitate this.

Working in partnership with others

●The service worked well in partnership with many other health and social care professionals. Care records demonstrated close working with a variety of specialist health professionals including psychiatrists, psychologists, speech and language therapists and neurologists. Staff worked as effective advocates when supporting people to access the healthcare they needed.