Royal Mencap Society

Mencap Respite Service Liverpool

Inspection report

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

This inspection took place on 11 and 13 December 2018. The first day of inspection was unannounced.

This was our first inspection of the service under its new registration.

Mencap Respite Service Liverpool is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Mencap Respite Service Liverpool is situated in a residential area of Belle Vale in Liverpool, with nearby shops and public transport. The service is based in a terrace of houses and consists of separate bedrooms and shared bathrooms over two floors. The service provides temporary accommodation for up to five people at the same time. People come and stay for short periods of time, ranging from a few days to several weeks.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service, particularly those staying for longer periods of time, were supported to live as ordinary a life as any citizen.

People's needs within the service varied and usually impacted upon the length of time that they were at the service. The staff team showed us good examples of how they adapted their support to people based on individual needs.

There was a service manager in post and a registered manager oversaw the service. 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.

When we inspected, staff, people using the service and their relatives were enthusiastic about sharing with us how highly they thought of the service. It was clear from our conversations that the service manager and their team were passionate about creating a caring, person-centred service that involved people and their relatives.

We found that there were some areas in which the service needed to improve, which mainly related to the safety of the service. In other aspects, we found and heard of very good examples of the way in which the service cared for and supported people and their relatives.

The service's management and storage of medicines, particularly controlled drugs, needed to be improved ,

to ensure people and their medicines were kept safe.

We made a recommendation regarding this.

People had risk assessments and care plans in place to guide staff. We found that at times information about people's risks and how the service had learned from incidents needed to be clearer.

We discussed with managers how some service safety aspects may benefit from review , such as the use of window restrictors.

Staff were aware of safeguarding responsibilities and had confidence in managers to address any concerns. Managers recorded and investigated concerns appropriately.

There were enough staff to meet people's needs and they had been recruited appropriately.

The service was clean and bright and all relatives commented on this positively.

The service was working with the local authority to review their practice of following the principles of the Mental Capacity Act 2005. We saw good examples of how people's rights regarding decision-making were supported.

Staff felt well supported. Staff had access to regular training and supervision. We considered with managers that some further specialist training would be useful.

The service was adaptable to people's needs. We considered with managers how some specialist considerations may help to give a more rounded assessment of people's requirements.

The service showed us good examples of meeting people's different dietary needs, including those based on people's cultural backgrounds.

People had access to health professionals if they needed them while they stayed at the service.

Staff treated people with dignity, respect and kindness. People and relatives spoke highly of the service and its team.

We heard very good examples of how the service had supported people to develop skills, to promote their independence and control over their lives.

The service involved people and their relatives in the planning of care. Information and support were person-centred. Plans were reviewed before each time an individual came to stay, to promote up-to-date knowledge.

Activities for people varied, but we heard that people and relatives valued the way in which the service helped people to connect with others.

The service listened to and involved people and their relatives in different ways, to support ongoing development.

We discussed a few record-keeping issues with managers, which needed to be improved to reflect the

person-centred care of the service.

The service and provider used a variety of checks and audits to help improve the service. The service listened to and acted on external feedback.

We observed an enthusiastic team of staff who were passionate about the care they provided. Team meetings took place regularly and staff used these to make improvements.

There was an inclusive culture at the service that welcomed and celebrated people's uniqueness. Through events and regular communication, the service was maintaining a good relationship with people and relatives and developing community links.

Managers had submitted statutory notifications to CQC in line with their legal obligations.

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.

The service needed to improve the storage and management of people's medicines.

Risk assessments at times required further review or more detail to protect people robustly.

There were enough staff to meet people's needs and staff had been recruited appropriately.

Staff were clear about safeguarding responsibilities and had confidence managers would address any concerns.

Is the service effective?

Good

The service was effective.

Staff worked with the local authority to support people's choice and decision-making under the Mental Capacity Act.

Staff felt well supported in their role through regular training and supervision.

There was a good focus on outcomes for people. We considered additional training could develop the service's specialism and assessments further.

Staff worked with people and their relatives to support specific nutritional needs.

Is the service caring?

Good

The service was caring.

People and their relatives spoke highly of the service and the staff's kind, caring and respectful support.

People and their relatives were involved in the planning of care.

We considered with the team a few areas for further

personalisation.

Staff handled discussions about people's sensitive issues in a respectful and dignified way.

Is the service responsive?

Good

The service was responsive.

People's care was personalised to their needs.

Staff worked with people and families to update person-centred information.

The service listened to and acted on feedback and complaints.

People and relatives felt there were enough activities on offer, but made suggestions for further development.

Is the service well-led?

Good

The service was well-led.

The service and its team were led by a manager who was well respected by people, relatives and staff.

The service had an open, transparent and inclusive culture.

Team meetings took place regularly and these helped the service to develop.

The service involved people and relatives and was exploring further connections with the community.

Mencap Respite Service Liverpool

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 11 and 13 December 2018 and was unannounced.

The inspection was carried out by one adult social care inspector.

Before our inspection we reviewed information we held about the service. This included the statutory notifications sent to us by the registered provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the commissioners of the service to gather their views.

We used all of this information to plan how the inspection should be conducted.

As this is a 'respite' service, there were not always people living at it. On the days of our visit, nobody was staying. However, we spoke with one person who had used the service and another person wrote us a letter to let us know about their experience whilst they were there. We spoke with the relatives of six of the people who regularly used the service. Relatives shared with us their own thoughts, as well as how their loved ones described the service in their own words.

During the inspection we spoke with three out of the eight regular support workers, the service manager and the registered manager.

We looked at the care files of seven people receiving support from the service. We sampled two staff recruitment files, checked communications, records and charts relating to people's care, as well as medicine administration records and audits. We also looked at the service's incident and accident forms, safeguarding records, regular safety and maintenance checks, quality assurance processes, meeting minutes, as well as training and supervision information.

Requires Improvement

Is the service safe?

Our findings

The service needed to improve the management and storage of people's medicines. This was to ensure that people's medicines were kept safe and information about risks related to their medicines were up to date.

For example, we found an issue with the recording of one person's medicine stock level. Spaces for controlled drugs were not securely fixed into place. The storage of controlled drugs are subject to legal requirements to prevent these from being misused. One person was in receipt of a controlled drug, but the information around this was not updated until after we had pointed this out to the team. This included potentially very harmful side effects associated with this medicine.

We recommend that the service refers to appropriate best practice guidance to ensure people's medicines, including controlled drugs, are managed and stored safely.

We found that staff had signed for medicines they had given people and that, overall, detailed medicines overviews were in use. People who administered their own medicines were supported to do so through appropriate risk assessments.

We found that some information about people's risks and conditions needed to be clearer, to ensure staff could respond appropriately and timely. For example, we found that information about what types of epileptic seizures one person was likely to experience was missing. This was important, as staff also had to give medicines if the person became unwell following seizures. However, for other people we found that this information was detailed and clear. Staff also obtained the missing seizure information for the one person, who had never experienced a seizure while at the service, from their family.

When we walked around the service with managers, we considered together how aspects of the safety would benefit from review to keep different people safe. All windows either had a restrictor or a restricting mechanism in place. Not all of these were tamper proof. We understood that where there had previously been no restrictors at all, the service had installed these. We considered with the team how they could review their risk assessments, to ensure suitable window restrictors were in place for different people who may use the service in the future.

A relative told us, "[My relative] feels safe there. They make [my relative] comfortable, [they miss] us but they interact with [my relative] and occupy [my relative]. I have no concerns."

We found that the team had developed personalised risk assessments for people who used the service, to guide staff on how to keep people safe. Staff had reviewed people's risk assessments before each time they had come to stay at the service and following incidents and accidents. This included personal emergency evacuation plans that described individualised support, for example in the event of a fire.

Significant incidents had been reviewed and investigated at senior manager level. The staff team had received 'debriefs', which were conversations with senior managers. These supported the team and helped

to prevent reoccurrence. We considered with the team and managers, with regards to some other examples, how they could ensure they reflected on underlying causes of accidents and incidents in other ways going forward, to demonstrate lessons learned clearly.

Staff were clear about their responsibilities to keep people safe and protect them from abuse. Staff were aware of safeguarding procedures and had confidence that managers would address any concerns. There was an open and transparent culture in the service that supported this. Staff also told us they would feel confident to whistle-blow to external organisations, such as CQC or the local authority, if they felt concerns had not been addressed. We found the service had recorded and investigated concerns appropriately.

There were enough staff to meet people's needs and keep them safe. Staff were able to develop and make changes to the rota to meet demand within the service, for example during periods when it became busier. This meant there were staff available at different times, to welcome and settle people into the service in an unrushed way. Staff had been recruited using appropriate checks. This helped to ensure they were suitable to work with people who may be vulnerable as a result of their circumstances.

When we visited the service, we found it to be clean, bright and well-presented. All of the relatives we spoke with confirmed this. A relative said, "It is always spotless. I was really delighted." The service had recently had an external infection control audit and achieved a very good score of above 90%. They had since introduced further measures to improve their infection control to help protect people.

Good

Is the service effective?

Our findings

The service was working together with the local authority to use the Mental Capacity Act in lawful, yet practical ways, to ensure people's rights were protected. 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.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

Staff were developing with the local authority a practical way of applying in an effective, yet person-specific way, to obtain authorisation to restrict people's liberty. In respite settings this can be challenging, because often people only stay at the service for short periods of time. We saw that the service had completed such applications and the service manager had attended a briefing session with the local authority to develop best practice.

Staff supported people's rights to make important decisions. We saw that staff had assessed people's capacity regarding the decision whether they wished to stay at the respite service. People's capacity to consent to care, treatment and supervision had also been considered. We saw good examples of staff taking practical steps to maximise people's understanding of these decisions. This included considering how to support the person's communication or when the best time of the day would be to ask them. Where staff assessed people not to have the capacity to make such decisions, they recorded personalised observations. For example, how the person, in their own way, indicated that they were relaxed and happy to stay at the service.

All of the people and relatives we heard from told us how much they or their loved ones enjoyed coming to the service to stay. All of the family members we spoke with felt staff had the necessary skills to care for their relatives who used the service.

One family member said, "My overall impression of the support workers is that they do a good job. I have noticed [my relative] is well looked after and cared for. It is more like a family home."

Staff felt well supported in their role and received regular training and supervision. It was clear from our conversations that the service manager supported the team in an ongoing way, outside of formal meetings. Staff received a comprehensive induction to guide them in their role. New staff worked alongside experienced colleagues, while they got to know people and the service. Staff induction followed the Care

Certificate, which is a recognised induction standard for staff working in health and social care. Staff were encouraged to develop further through the completion of National Vocational Qualifications, also now referred to as apprenticeships.

Staff training covered a variety of 'mandatory' subjects and completion levels were good. Courses included those on Safeguarding, fire safety, food hygiene, emergency first aid, infection control, eating and drinking safely and the Mental Capacity Act. Managers regularly observed staff competency around assisting people to move and giving them medicines.

There were more person-specific training sessions available, based on people's individual needs. This included training in giving people rescue medication in a safe way, as well as training in Positive Behaviour Support. We considered with the team how other courses could be useful to gain insight on how best to support people who may experience the world differently. For example, staff at the service had currently not received specific training in understanding autism or sensory differences.

We found there was a positive focus on good outcomes for people. We discussed with managers how considering people's different needs around how they experienced the environment could also make a difference to their assessment and stay at the service.
Managers based their initial assessment of people on the information they received from social services. Staff then developed a more detailed assessment, working in partnership with people and their families, to get a more complete understanding of people's needs. As the service provided temporary accommodation, the environment was adaptable to individual people's requirements at the time of their stay. The ground floor bedrooms and bathroom were accessible for people with reduced mobility.

We discussed with the team how thinking about people's sensory differences could help the service to develop further. We considered this in particular with regards to their assessment of outcomes and adaptations for people. We recognised that the service had done this in parts, for example staff had made changes for one person regarding the lighting of the service. We discussed how additional considerations and further specialist training could strengthen this. For example, there were strong air freshener smells present in the service, which may affect some people. We considered it would be an important part of assessment to check whether people were sensitive to certain smells. From conversations we also considered that further insight may help staff to effectively support people and teach skills around sensory differences linked to balancing, touch or orientation.

People had enough to eat and drink and the service supported people's dietary needs effectively. The service worked well with people and their families to support people's different diets. This included meeting people's cultural and religious needs regarding meals and food preparation, as well as supporting people with diabetes to eat well. Staff ensured that people had access to health professionals when they needed them.

A relative told us, "I am sure [my relative] would love to just go and have a [fast food meal] when [they stay] at the respite and it would be easy for the staff to take [my relative] to such places. But the staff make sure that [my relative] eats well." They also said, "[My relative] loves a Sunday roast and they go out of their way to make sure [my relative] has this."

People told us the food at the service was good and that staff looked after them well. A person wrote to us, "They take me out for food and we [bake] cakes."

Good

Is the service caring?

Our findings

People and their relatives spoke highly of the service and the staff's kind, caring and respectful support. All felt that the staff made sure that the service provided "a break" for both the person, as well as their loved ones, but that it was more than that.

A person said, "I enjoy coming here … and I like spending time with other people that stay." Another person confirmed staff treated them with kindness and they felt well looked after at the service.

Two relatives independently from another told us that their family member "loves the staff and they love [my family member]." It was clear from the way staff talked to us about people that they cared about those who came to stay at the respite service.

A relative told us, "[My relative] loves it, they are all very outgoing, [my relative] adores it. [My relative] is very happy, the staff are very lovely. I have met them on many occasions, everyone has been nice to us, so caring."

When we visited, staff came in on their days off to talk to us. They were supportive of their managers and shared with us the passion for their service and the people using it. Staff spoke warmly about people, in personalised ways that showed they knew about individual likes, dislikes and preferences. We considered that it was evidence of a particularly caring service that staff were able to develop close relationships with people even during their short stays.

When people used the service for weekend breaks, we heard they enjoyed relaxing and engaging with staff and others. However, we also heard that for people who had lived at the service for longer, staff had achieved empowerment and support to make important life decisions.

Staff told us about a person who had used the service and how they were proud to have made a difference to that person's life. Staff explained how they had worked in partnership with the person to identify what life skills they needed to learn, to live more independently. Staff gave us examples of how they had then supported the person to learn these skills, increased this person's self-worth and improved their quality of life.

We found that people and their relatives were involved in the planning of their care.

A relative said, "Oh yes, they sent us information to fill in to create a plan together and they always stay in touch to keep up to date."

A staff member told us, "If a person prefers male or female support, we make sure we arrange that on the rota. We are all very flexible here."

People brought things important to them to personalise their bedrooms during their stays and staff

encouraged this.

When people needed someone independent to speak up on their behalf, the service gave us examples of engaging with local advocacy services.

We discussed with managers that at times abbreviations used on signs or in people's care plans did not reflect the person-centred culture of the service. For example, on signs and in people's care plans, staff used the abbreviation "PWS", meaning "people (or person) we support". We considered with the team that for example the use of people's name in their plan would show greater personalisation.

People's records were locked away in a cupboard to protect their confidentiality. We heard examples of how the team had handled discussions about people's sensitive issues in a respectful and dignified way.

Good

Is the service responsive?

Our findings

People's care was personalised and responsive to their needs. The service worked in partnership with people and their families to develop individual support and to keep information up to date.

The service developed initial care plans based on assessments they had received, for example from the local authority. We saw that staff updated people's care plans before each time the person used the respite service. Staff completed a form based on any new information they had received from people or relatives. This indicated if the person's needs had changed. Staff then updated care plans and the information was communicated to those supporting the person.

In the care plans we viewed, we saw a good level of detail that had developed further each time the person had used the respite service. Relatives also told us that the service involved them in the development and update of plans.

A relative said, "They always take notes about changes and communicate any changes or if something is wrong." Another family member told us, "We wrote a plan and we do review it together regularly. If there was anything they did not know they would call me and ask."

In people's care plans we saw person-centred information. For example, care plans described how the person communicated in their own way. Staff were also able to give us examples of this. Staff described how people let them know how they felt or if there was something they wanted or did not want, through gestures, signs or facial expressions.

As part of daily notes, staff recorded how the person had felt on the day and whether there was anything that needed to improve. There were good examples of what people had said or shown. We considered with the team how they could develop this further, to reflect the thoughts and wishes of those who may for example not use words to communicate.

The service gave us examples of how they had listened to people and their relatives, to make changes to their care and support. For example, the service had listened to feedback from relatives about what their loved one liked and did not like to eat. As a result, staff knowledge had become more detailed and support for the person more responsive to their needs.

The service let families know how their loved one's stay at the respite service had been and if there was any information. The manager also spoke to relatives following stays, to check if there was anything that needed to be improved. The service kept in touch with people and relatives regularly to find out what could be done differently. We also saw that there had been a survey for people and their relatives, to comment on their experience of the service.

There had been a couple of recorded complaints and the service had investigated these appropriately. We heard of an example of how the service had met with the person that had made the complaint. This helped

to make improvements and ensured the person was happy with the care and support provided. A complaints procedure was displayed and available in different formats for people, including an 'easy-read' version. The service also considered how such information could be made available to people in different, individualised ways.

Relatives told us that the service kept them up-to-date with information and that staff were good at communicating with them. People and relatives we spoke with had no concerns about the service at the moment and told us they had no reason to complain. They also told us they had confidence that the manager would address any concerns they had promptly.

A relative told us, "It is really lovely and we never had a reason to complain and if it continues as it is, we never will need to."

Another family member told us, "[My relative] has a favourite room and they make sure it is available when [my relative] comes and stays. [My relative] does not communicate very much, but [my relative] does let them know when things are not right and they do listen to [my relative]."

People and their family members felt there were enough things for people to do. We saw that there were individual activity plans for people in their care files. Staff explained that these were basic to start with, but then developed with the person. People told us they enjoyed the opportunities for social interaction staying at the respite service provided. This was a good example of how the service was working to avoid social insolation for people.

A person told us about what they liked doing at the service, "I get a break [here], the staff make me happy. They play football [with me] and I [also] like watching football."

A relative told us, "[My relative] is very outgoing, one of [my relative's] problems is socialising, so from that side of it they are brilliant at it. For [my relative] it is like a holiday. [My relative] goes to some clubs, they make sure [they] can go to [their] clubs." We heard that staff supported people on walks, trips to the shops or for meals out. Relatives told us how much people enjoyed the service's decorations and celebrations at Halloween and Christmas.

One relative commented, "It would be good if they could have a minibus, to take people out for a drive." However, the relative told us they understood this was a question of funding. Staff gave us examples of how they were creative when it came to engaging people, for example through a variety of board games. A games console was also available for people to use.

Good

Is the service well-led?

Our findings

The service and its team were led by a manager who was well respected by people, relatives and staff. A senior manager was in post as the registered manager for Mencap Respite Service Liverpool and they maintained oversight of the service. We met with both managers and staff during our visits and found them to be welcoming, engaging, open and responsive to our feedback.

A person who used the service told us, "Staff are nice to me and listen to me. I would not want them to do anything differently."

The relatives we spoke with knew the manager and spoke highly of her. A family member's comment summarised this, "The manager is a lovely, caring person."

Relatives told us that the manager was very supportive. A relative explained, "You can only get the referral or funding a few weeks before the stay, which makes it difficult to plan for holidays." Relatives told us that the service manager was very accommodating and helped people and their families to plan stays at the respite service in advance.

The service had an open, transparent and inclusive culture. Team meetings took place regularly. Staff talked about a positive culture, were enthusiastic and engaged with service development. For example, staff agreed at team meetings with the service manager on ways to improve shift patterns and records, so that people's needs could be met better.

A member of staff told us, "We have regular team meetings and [service manager] makes sure they are arranged so they accommodate staff needs." Staff felt listened to and supported by the service manager when they needed it. Staff had access to a range of polices to guide them in their role and we saw they signed them after reading.

We asked staff how the service supported the diverse needs of people and the team, to recognise and celebrate individuality. In an inclusive service, we expect that people are free from discrimination based on things such as their age, disability, gender, gender reassignment, race, religion or faith, sex, sexual orientation, maternity or pregnancy, marital status or civil partnership.

Staff gave us positive descriptions of how equality and diversity were promoted both within the team, as well as for people using the service. Examples included the empowerment of people, as well as the adaptation of meals to meet people's faith needs.

People' s relatives we spoke with praised how the service communicated with them and staff's efforts to engage people and relatives. This included regular contact before or after people stayed at the service, as well as flyers to keep people and relatives up to date. The service had recently arranged a Christmas party and people who used the service and relatives had been invited. This was regardless of whether they were staying at the service at the time of the party or not.

A relative told us, "They are easy to contact, we really like the personal contact. I am very, very pleased. They sent letters out about the Christmas party, they were delighted that [my relative] was staying at the time, but [my relative] would have gone anyway."

Another family member said, "[My relative] went to the Christmas party and staff were pleased to see [them] as if [they were] a family member."

The manager told us that at times people who often stayed at the service may "Just come around for tea if [they are] in the neighbourhood."

Staff also told us that they had tried to connect with the surrounding community more. The manager told us, "We held a 'Macmillan's coffee morning'. [People who use the service] and staff enjoyed preparing this, baking and setting up. We sent out invitations to neighbours and a couple of them came." We considered with the team how the service could develop its integration into the community further, to maximise people's inclusion as valued citizens.

The manager and staff carried out regular checks and audits to promote the safety and quality of the service. This included health and safety checks, as well as record checks. We found that maintenance certificates were up to date. The manager used different audits, for example of care plans, medicines and finances, to identify improvement needs. We discussed a few record-keeping issues with the team, which we considered under the question whether the service was safe.

The service had responded to input and feedback from external organisations, such as the local authority or fire services. Where internal audits identified issues, these carried timely actions and these had been marked as completed. In addition, there was a Manager Assurance Tool, to aide oversight at provider level. Unfortunately, this was not working on the day of our visit and we were unable to check this part of the service's quality assurance.

Managers had sent statutory notifications about specific events to CQC, in line with their legal obligations.