Care Quality Commission

Royal Mencap Society

Royal Mencap Society - Domiciliary Care Services - South London

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**

Overall summary

This inspection took place on 27 January 2015 and was announced. This was the first inspection since this service registered with CQC on 17 September 2014.

Royal Mencap Society - Domiciliary Care Services - South London provides personal care for people with a learning disability and/ or autism. At the time of the inspection the service supported 40 people in seven supported living

Summary of findings

schemes with staff available day and night, and two other people in their own home. The supported living schemes were in the London boroughs of Croydon, Hounslow, Richmond and Islington.

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

Risks that people faced whilst they received care were generally managed well, except in one case where a person's risks in relation to malnutrition were not addressed appropriately. Accidents and incidents were reviewed to identify patterns and provide the right support to people.

People were supported to understand how to stay safe. Staff had a good understanding of how to recognise abuse and how to help protect people from the risk of abuse. Safeguarding procedures were followed to keep people safe.

Recruitment procedures were safe ensuring only staff who were suitable worked with people using the service. There were enough staff to support people effectively. Staff were supported in their role through induction, supervision and training.

Only staff assessed as competent administered medicines. Appropriate procedures were in place to ensure people received their medicines as prescribed.

Staff understood the Mental Capacity Act 2005 and where people could not make decisions these were made in people's best interests, and were recorded where necessary.

People were able to eat the foods they chose. Staff understood people's individual preferences and supported people with specialist dietary needs. Staff also supported people to attend regular health appointments.

Staff were kind and treated people with dignity and respect. People were supported to be as independent as they wanted to be and they were involved in planning their own care, with some support from advocates. Care plans reflected people's views on how they wanted their care to be delivered.

Systems were in place to investigate and respond to complaints and suggestions, ensuring learning took place.

People using the service and staff felt listened to and were involved in the running of the service, for example with people sitting on the panel to interview new staff. The service encouraged open communication with people and their relatives, staff and outside professionals.

The registered manager and staff understood their roles well and a range of audits were in place to monitor the quality of service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. A person had not been weighed regularly, in line with their risk assessment, to monitor known risks. However, other risks, including weight loss for other people, were managed well. Accidents and incidents were recorded and reports analysed to look for patterns and ensure people received the right support.

At one scheme although medicines management had improved, an action plan was in place to achieve further improvements to make systems more robust. Systems were in place to promote safe medicines management, such as only staff assessed as competent administered medicines.

When allegations of abuse were made action was taken in line with procedures to keep people safe. Staff understood how to recognise abuse and report this.

There were enough staff to meet people's needs and recruitment procedures were robust in ensuring that only people deemed suitable worked in the service.

Is the service effective?

Good

The service was effective. Staff were supported by effective induction, training and supervision. They understood the Mental Capacity Act 2005 and decisions were made in people's best interests where necessary.

People were supported to meet their day to day health needs, accessing health services. People ate the food they liked and staff understood people's special dietary needs.

Is the service caring?

Good

The service was caring. People were treated with kindness, compassion, dignity and respect. Staff knew the people they cared for, including their backgrounds and preferences. People were supported to be as independent as they wanted to be and were involved in planning their own care, with some people receiving advocacy support.

Is the service responsive?

Good

The service was responsive. People were supported to follow their interests, take part in social activities and develop relationships. There was an effective complaints system in place with a central team ensuring complaints were investigated and responded to within defined timescales.

Is the service well-led?

Good

The service was well-led. The organisation had a clear vision and values focusing on equality for people with learning disabilities, which staff were

Summary of findings

aware of. People and staff were involved in running the service, and communication with relatives and professionals was open. The registered manager and staff understood their responsibilities. Systems to monitor the quality of service were in place.

Royal Mencap Society - Domiciliary Care Services - South London

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.

This inspection took place on 27 January 2015 and was announced. We gave the provider 48 hour notice of the inspection to ensure the manager would be present. It was undertaken by a single inspector.

Before the inspection we reviewed information we held about the service and the provider. We also contacted a learning disabilities social work manager and a commissioning and lead placement officer to ask them about their views of the service provided to people.

During the inspection we visited two supported living schemes. We observed how staff interacted with the people. We spoke with four people who used the service, the registered manager, two scheme managers (a scheme manager were in charge of the day to day running of each supported living scheme) and three support workers. We looked at four people's care records, three staff files and records relating to the management of the service.

After the inspection we spoke with health and social care professionals associated with people using the service to ask them about their views of the service provided to people. These were a local authority contracts officer and a quality assurance manager, two social workers, a psychiatrist and a learning disabilities pharmacist, a general advocate and an occupational therapist (OT). We also spoke with five relatives.

Requires Improvement

Is the service safe?

Our findings

Risks to people were generally managed appropriately, but we found one case where risks to a person were not being managed well. One person's risk assessment relating to nutrition and hydration said they must be weighed weekly with instructions to update the dietician on a monthly basis. However, they had not been weighed for around three months. The scheme manager told us their weight was monitored during GP appointments. Although records showed regular visits to the GP, we could not evidence weight monitoring was taking place there and these did not take place weekly. After the inspection the scheme manager forwarded us communication from the dietician showing weekly weighing was not necessary, although this confirmed the person should be weighed monthly. The scheme manager told us they would ensure the person's weight was monitored monthly and they would review the risk assessment. Where there were concerns about other people's weight we saw staff were monitoring their weight regularly.

A learning disabilities pharmacist recently audited medicines at one scheme. They told us medicines management had improved at the scheme since their previous visit and was safer. However, a number of actions they recommended previously were still outstanding, such as updating a list of staff signatures to identify who had signed medicines records, and ensuring there was a medicines 'pen picture' for all people that was updated with each medicines change. This meant the service had not fully completed the actions necessary to ensure medicines management was safe at this scheme.

We checked medicines management at a different scheme and found it to be safe. Only staff who had completed training and passed a competency assessment administered medicines. We checked stocks and Medicines Administration Records (MAR) and confirmed medicines had been given to people as prescribed. Each time staff administered medicines they audited and recorded the remaining balance. In this way systems were in place to check the right quantities of medicines were administered. Medicines were stored safely in locked cabinets in people's rooms.

Arrangements were in place for reviewing accidents and incidents. Accident and injury reports were reviewed by the relevant scheme manager. The registered manager reviewed accident and injury reports for the whole service during monthly meetings with other registered managers to ensure the right action had been taken to support people. A staff member centrally also analysed all reports across the organisation to look for patterns and trends, informing the regional managers of their findings. A pattern of increased incidents of behaviour which challenged had been identified at one scheme recently. The scheme manager then received more support from an internal specialist, a Mencap quality compliance officer. The specialist met with the scheme manager, people using the service and staff. Together they reviewed systems to meet people's complex needs and agreed on what improvements would be made.

One person told us, "I feel safe here, staff look after me." We asked them what they would do if they felt unsafe and they responded they would tell the manager, although this had never happened. Records showed people were supported to understand what keeping safe means through discussions with staff. Guidance on how to stay safe had been produced in a pictorial format to help some people understand this better.

People were safeguarded because the service responded appropriately to allegations of abuse. There had been several safeguarding's referrals at the supported living schemes over the last 12 months. The service had identified these incidents and referred them to the local authority safeguarding teams for further investigation, according to procedure. CQC had also been notified as required by law. Where necessary staff had been removed from the workplace to protect people and themselves while investigations were carried out. The service followed clear staff disciplinary procedures when it identified staff were responsible for unsafe practice. Staff received regular training on how to safeguard people as part of their induction with on-going training, and were familiar with the process to report allegations or suspicions of abuse.

Social workers told us the provider had been co-operative with safeguarding investigations. They told us the managers communicated progress on internal investigations, attended meetings and took on board recommendations made to keep people safe. Safeguarding issues were reviewed by registered managers at their monthly meetings so learning and best practice could be shared.

Requires Improvement

Is the service safe?

When staff vacancies arose a central recruitment team liaised with the scheme managers. Together they determined the skills, competencies, qualifications, experience and knowledge required by new staff. A recent care worker advert reflected the identified need for a female, preferably with experience of working with people with behaviours that challenged and with a “fun and imaginative approach”. The managers looked for the necessary attributes during the recruitment process to ensure staff were a good match for the people they supported.

Recruitment practices were safe as necessary checks were carried out so only people deemed suitable were recruited to work with people using the service. These checks included proof of identity , a full work history, references, criminal records checks, health checks and proof of the right to work in the UK.

People using the service, staff and relatives told us there were enough staff to meet people’s needs. Staff confirmed , and we observed, they were not rushed and had time to carry out their duties while spending quality time with people. Scheme managers told us, and rotas showed staffing levels were increased when necessary, such as when people needed to accompanied for appointments.

Good

Is the service effective?

Our findings

One person showed us their weekly pictorial menu and told us, "I choose what I want to eat. Today it's salmon. I eat pork chops and curries as well and I cook it." Another person said, "I like chips…staff cook it." Food was usually cooked from fresh ingredients. People had individual menus reflecting their own food preferences. Our discussions with staff showed they had a good understanding of people's individual preferences including particular ways they liked their food and drink to be presented.

When people had complex needs in relation to eating and drinking they had been referred for specialist advice. Specialist cutlery had been obtained for some people and staff followed the specialist advice when supporting people, such as offering more of particular foods. Where one person had recently been diagnosed with a particular condition affecting what they could eat, staff had a good knowledge of the type of food the person should eat. A range of literature and specialist advice was available for staff to learn more about the condition so they could reflect this in the way they met the person's needs. Staff were in the process of creating a support plan and risk assessment in relation to this and the completed care plan was forwarded to us after the inspection.

Staff supported people to meet their day-to-day health needs. One person told us, "Staff take me to the doctors and dentist when I need to go, and to the foot clinic, they sort out my problems." A relative told us after their family member had returned from a stay in hospital to their scheme in poorer health than usual they had "got better" as the staff took care of their health needs. A commissioning and lead placement officer told us their client was doing much better than they had with a different provider and they were pleased with how staff were supporting them.

Records showed people regularly attended health appointments with health professionals such as their GP, dentist and optician and other specialists. The scheme manager and registered manager kept track of when people were due for reviews on an electronic spread sheet which they reviewed each month. People had health action plans in place in the schemes we visited. These are plans about how people can remain healthy and who they need to see to do this. They are created and reviewed by a learning disability nurse. When the registered manager identified people did not have health action plans in place in one scheme he had recently begun to oversee, he liaised with the scheme manager to ensure these were implemented.

The psychiatrist told us staff at one scheme were well trained. All staff we spoke with told us the training was of good quality and helped them to do their roles. All staff completed an induction before they started to work at the service. The first five days of the induction included five full days of training, including safeguarding, fire safety, medicines management, communication skills and understanding people's behaviour when this challenged others. The on-going staff training plan included safeguarding adults, health and safety and training in how to manage people's finances safely. Staff completed competency assessments as part of the training courses to ensure they had the expected skills and the knowledge from the training.

Staff had electronic training profiles which were colour coded to show when training was due. A central department regularly sent the scheme managers spread sheets showing which staff would soon be overdue for training, or were overdue. Scheme managers booked staff on training when it was due for renewal which meant staff received regular training updates.

Staff told us they received regular supervision and annual appraisal from their line manager and they felt well supported. They told us at supervision they received support in relation to meeting people's needs as well as their personal development. One staff member told us, "I feel well supported. The manager is always available when they're here or on the phone. I can discuss any problem and he always listens." A contracts officer told us at one scheme there were a number of incidents due to people's particular needs. They explained how staff had a standard de-brief after incidents of behaviour which challenged so they felt supported.

Staff understood the Mental Capacity Act (2005) and this was discussed with staff at team meetings. People's capacity to consent to care or treatment was assessed and recorded where necessary. Recently mental capacity assessments had been carried out to assess whether people had capacity to sign their support plans and to

Good

Is the service effective?

choose to purchase sugary foods when they wanted to when this had been in doubt. Best interests decisions were made when people were assessed to lack capacity to make certain decisions and these were recorded.

The registered manager understood that some people could be deprived of their liberty unlawfully in a supported living setting and the action they needed to take to prevent this from happening. They and the scheme managers we spoke with were aware of the recent court judgements in relation to people in supported living being deprived of their liberty. They had considered what potential restrictions to people's freedom were in place within the service. They had then contacted the local authority to alert them and to request the necessary support where people might have been deprived of their liberty to make an application to the Court of Protection, which oversees cases where people's liberty is being deprived in a home setting.

Good

Is the service caring?

Our findings

Two people told us, “Staff are kind” and another told us the names of all the staff they liked. One relative told us, “I call [my family member] and he seems quite happy, he tells me what he’s been doing.” Another relative said, “[My family member] seems happy there…the staff are really lovely.” Another relative said, “The care is excellent.” We observed people were treated with kindness and compassion. The psychiatrist told us staff were caring. An advocate told us staff were attentive to people’s welfare and built a good rapport with people. An OT told us they had no concerns about the relationships staff were building with people. When a person returned from the shops staff spent time admiring the items they had purchased which the person responded well to.

Staff had the right skills to communicate effectively with people. There were individual communication plans for each person, reflecting advice from specialists where this was available. We observed staff varied the way they communicated depending on the person and their preferred way of communicating. For some people staff used more repetition and fewer words, for others staff used some Makaton signs while speaking slowly (Makaton is a form of sign language adapted for people with learning disabilities). Staff understood the importance of pictorial signs to help some people’s understanding. We observed a pictorial weekly schedule on the wall in one person’s bedroom. They told us, “I choose the pictures myself, it helps me.” When a non-verbal person led staff into their room and began biting their hand, staff recognised they wanted help to turn on their TV and did this for them.

Staff took practical action to reduce distress. When one person became agitated about contacting a friend staff reassured them about when they would be able to contact the person. The person told us, “I call my friend from the office when I want to.” When they became anxious about finding their hat and scarf to go outside, staff immediately supported them to find the items and put them on, reassuring the person throughout. The person appeared relieved, smiling and joking with staff. Staff also understood triggers which were likely to cause people to act out and knew ways to reduce these triggers, avoiding incidents of behaviours which challenged.

People felt listened to and had their views acted upon. One person using the service told us, “The staff are very good, they listen”. Another person told us they liked living at the scheme but were going to leave soon. They explained this had been their decision so they could move closer to family and the staff had supported them in planning this. Some people were supported by advocates who helped people’s views to be understood so that care was provided how they wanted. A general advocate told us staff at one scheme were proactive at getting in touch when people needed support with particular issues.

Staff treated people with dignity and respect. We observed staff interactions with people and saw they spoke respectfully to people, yet with affection. Before a person left the house staff discreetly told them they had some food around their mouth and supported them to wipe it away. When a person expressed they did not want another person to enter their room staff supported them by respectfully asking the person to go to a different area of the house. Staff recognised when people required time alone in their own rooms and respected this.

People were encouraged to be as independent as they wanted to be. An advocate told us they could see at one scheme there was a focus on maximising people’s independence. He explained how people had their own keys and could come and go as they pleased. We saw care plans and risk assessments addressed how people should be supported to build and retain their skills, such as ironing and cooking. In one scheme we observed people being encouraged to be involved in their meal preparation. One person was supported to prick their potatoes before they were cooked. Another received minimal supervision from staff and led their meal preparation. Staff told us how another person enjoyed ensuring the rubbish was taken care of for the scheme and the person confirmed this.

Good

Is the service responsive?

Our findings

People were supported to follow their interests and take part in social activities. One person told us, "Staff take me out a lot, I like it. We go to the cinema and into London." A relative told us, "[My family member] seems to be doing a lot, they always tell me what they've been doing." People had individual activity programmes in place, with several people going to day centres and spending time doing activities of interest, such as shopping. The organisation ran some social events for people to make new friends and maybe find a partner. A valentines ball was held last year as well as events based around music and food.

People were encouraged and supported to develop and maintain relationships with people that matter to them. One person told us they could phone their friend from the staff office any time." One relative told us, "[My family member] listens to us on the phone and staff support her to visit often."

At the schemes we visited staff knew the people they were caring for and supporting, including their preferences and personal histories. One person told us, "Staff know everything about me, I've told them everything." A relative told us, "The regular staff understand [our family member]." Our discussions with staff showed they knew people's backgrounds, likes and dislikes.

People were involved in making decisions and planning their own care. People kept their care plans in their rooms when they choose to. People told us they knew what was in their care plan because they were involved in reviewing them, they signed care plans where they were assessed as having the mental capacity to do so.

People's care and support needs were assessed with care plans developed to address specific needs, such as nutrition and hydration. Care plans reflected how people preferred to be supported, with information gained from background information, relatives and staff observations where people were not able to communicate their views. One relative told us, "They ask our opinions about the care plans." Care plans also reflected people's backgrounds, and preferences, as well as areas of their care they could do themselves and areas where they needed support. With this information staff were then able to provide care as people preferred.

Each person had a keyworker who they met with at least monthly. A keyworker is a member of staff who works closely with a person, ensuring their needs are met in different areas of their life. Staff encouraged people to talk about what made them happy or unhappy in the past month and how staff could support them better. They talked about activities they had done, set goals and made plans for things they wanted to do soon. Records showed one person had wanted to go to a pantomime at Christmas as well as have a Christmas meal. The next month records showed these activities had taken place. This keyworking processes meant people's views about their quality of life were taken into account and acted upon.

People told us if they wanted to complain they would speak to the manager. Recently a scheme manager supported one person to make a complaint about another person within a scheme. They had passed the complaint on to the organisation's central complaints team who investigated the matter and responded to the person promptly. As a result of the complaint a number of actions were taken to improve the quality of life of the person who complained. The complainant told us things had improved and they did not have anything to complain about now.

A relative who complained recently told us their complaint had not yet been resolved to their satisfaction. However, the managers had listened to their views and produced a response to the issues raised and the issues were still being dealt with.

Good

Is the service well-led?

Our findings

At one scheme a person told us, "The [scheme manager] is very good." The advocate told us how one scheme in particular was well-led as the scheme manager was motivated and interested in people and this cascaded down to staff. Managers had suitable support systems in place involving regular supervision and peer support with monthly meetings. Staff felt the provider listened to any issues they raised and took appropriate action.

For most schemes feedback from professionals was positive. However, for one scheme several professionals raised concerns. A contracts officer told us they were concerned last year and while improvements were being made some concerns remained. An OT told us there were sometimes delays or vagueness in responses to queries and they were not confident information they provided to the scheme managers was passed on to staff. A brokerage and quality assurance manager told us it was not clear what the senior management were contributing to the scheme. There had been a relatively high turnover of scheme managers and a relative and psychiatrist commented this had affected continuity of systems. The contracts officer explained how they had implemented a joint improvement plan with the service and were working closely with the service to monitor this. They told us the service had invested a lot of time and resources to improve. However, they said there was scope to accelerate improvements and a recent audit highlighted some concerns in financial management and recording systems.

When we contacted the registered manager regarding this feedback they told us they had just been made aware and were putting in place processes to improve with immediate effect. They strengthened management resources by drafting in a quality and compliance lead to support the scheme manager closely, with a view to facilitating the speed of progress with the action plan. The regional operations manager also changed their role to have more oversight and leadership at the scheme. However, it is too soon to verify whether these changes have resulted in improvements to the scheme.

Royal Mencap has a clear vision for a world where people with a learning disability are valued equally, listened to and included. The Mencap manifesto, developed by people using the service and their families, includes being treated as equal citizens, having control over their lives and opportunities to lead fulfilling lives. Staff were aware of the provider's vision and values and confirmed they received class-based training on these as part of their induction. They promoted these values in their day-to-day work. One staff member told us, "We're here to give as much quality of life to people as we can" and gave examples of how they supported people to have as much control in their lives as possible.

People were actively involved in developing the service. People were consulted with regarding their views in monthly meetings with their keyworker as well as in house meetings in some schemes. The views of people on employing new staff were gathered as part of the recruitment process as they were involved in interview panels. In addition, an annual survey of people using the service, staff and relatives was carried out and the results analysed.

Staff felt they influenced the management at the schemes they worked at because scheme managers listened to them. One staff member told us they had raised concerns about the speed the landlord carried out repairs at the scheme. The scheme manager had taken this feedback on-board and set up a meeting with the landlord to which the staff member was asked to attend to air their views.

Staff members told us the service communicated well with them. One staff member said, "Generally communication from the organisation is brilliant." Staff told us they were well informed about issues affecting the service through team meetings, supervision, shift handovers, the communication book, a monthly newsletter e-mail and regular contact with the scheme manager. Staff were invited to regular team meetings where their feedback was encouraged.

The service had improved the way they communicated with people's relatives in the last twelve months. For one scheme a relative told us how staff recently started telling them straight away when incidents occurred whereas before they had to remind them. For a different scheme a contracts officer told us they had responded well to concerns over communication with families, setting up regular meetings with family members.

Resources were in place for scheme managers to develop their teams and drive improvement with management training and internal resources such as HR. One scheme manager told us they had attended training on managing

Good

Is the service well-led?

difficult conversations. They told us how this had been useful when supporting a staff member who was not meeting the requirements of their role. The training and support they received from their manager, HR enabled them to follow processes to manage the situation, resulting in the person being offered alternative, more suitable work. Managers also completed other management level courses, including in health and safety, safeguarding for managers, managing finances and medicines management for managers.

Audits were regularly carried out to check quality. Each month, scheme managers checked various aspects of the scheme and updated a spread sheet with their findings. For example they reviewed the dates people last visited various healthcare professionals and when they last had a medicines review. They checked whether MAR were accurate and the medicines procedure was being followed. Scheme managers checked all monetary transactions staff supported people with each month and that balances were as expected. The registered manager reviewed these spread sheets monthly and ensured the necessary action was taken were improvements were indicated. For example, through this system the registered manager identified health action plans were not in place for people at one scheme they recently began overseeing. This meant they were able to make arrangements for them to be implemented.

The registered manager visited each scheme at least quarterly to monitor the quality of service provided. They checked some people's support plans checking information was up-to-date and reflected people's views. They observed support such as at mealtime or medicines administration. They checked the scheme manager carried out their own audits, such as of medicines processes and supporting people to manage their finances.