Royal Mencap Society

Mencap York Domiciliary Care

Inspection report

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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?	Requires Improvement

Summary of findings

Overall summary

The announced inspection of Mencap York Domiciliary Care took place across several dates in December 2016 and January 2017. We visited the agency offices on 13 and 20 December. We visited some of the supported living schemes on 14, 15 and 20 December. Interviews with relatives of people that used the service took place on 13, 16 and 19 December and further interviews with relatives and other stakeholders took place on 3 January 2017.

Mencap York Domiciliary Care provides personal care and support to people with a learning disability and/or Autism spectrum living in and around York. At the time of our inspection, the service supported 50 adults, many living in twelve supported living schemes. People were tenants of housing association properties and Mencap York Domiciliary Care provided personal care to people within their home. The housing providers were responsible for the buildings and their maintenance. Mencap York Domiciliary Care ran a small 'community service', which provided domiciliary care and support to people living elsewhere in the community.

The registered provider is required to have a registered manager in post. On the day of the inspection there was a manager that had been registered and in post for the last nine months. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

At the last inspection on 10 November and 10 December 2015 the service did not meet all of the regulations we assessed under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider was in breach of four regulations. These related to Regulation 12: Safe care and treatment, Regulation 18: Staffing, Regulation 10: Dignity and respect and Regulation 17: Good governance.

This was because the registered provider had not managed risk safely, ensured staffing levels were adequate to meet people's needs, monitored staff training, respected privacy and dignity and identified concerns, which meant that service delivery was inconsistent.

At the last inspection we made three recommendations, because there were shortfalls with management of medicines, providing person centred care and managing complaints.

At this inspection the registered provider had made sufficient changes to demonstrate compliance with the regulations.

The registered provider had ensured risks to people that used the service were appropriately assessed and managed. Risks assessments were detailed, covered areas of risk and were regularly reviewed. They cross-referenced with the information held in people's support and health action plans, which also noted the risks

people might face.

Staffing numbers were sufficient in all of the supported living schemes we visited. Everyone we spoke with felt staffing levels were adequate and that vacancies were covered by other support workers when necessary. Rosters were adequately covered to meet the needs of people that used the service.

The registered provider ensured support worker training needs and updates were monitored. The service had a high proportion of employees and relief workers whose training was up to date. The training matrix (record) was well managed and colour coding enabled quick and easy identification of training gaps and when training updates were needed. Dates of completed training were clearly identified. Support worker training had improved and was being managed appropriately.

We found that people's privacy and dignity were respected.

The registered manager had implemented further audits and widened the range of safety checks to include people's environments. Quality assurance and monitoring systems were much improved and the service was becoming more consistent across the supported living schemes.

The service had addressed the recommendations we made. Medicines were managed safely. People that used the service experienced a person-centred approach to their care and support needs. Where people lacked capacity their support plans were develop, for example, to include a way of summoning support. This was because specialist equipment was arranged for people to use which informed support workers when they needed to attend them.

People and their relatives told us low-level complaints and niggles were addressed more appropriately and satisfactorily, but there was still room for further improvement. All complaints were centrally collated and the organisation was analysing trends so that greater effort could be made to resolve issues more effectively.

People were protected from the risk of harm because the registered provider had systems in place to detect, monitor and report potential or actual safeguarding concerns. Support workers were appropriately trained in safeguarding adults from abuse and understood their responsibilities in respect of managing potential and actual safeguarding concerns.

The premises at each supported living scheme were safely maintained and there was evidence in the form of maintenance certificates, contracts and records to show this. Recruitment policies, procedures and practices were carefully followed to ensure support workers were suitable to care for and support vulnerable people.

People were cared for and supported by workers that were regularly supervised and appraised regarding their personal performance. However, the registered provider was still embedding the new supervision system and had encountered some issues with staff understanding and use of the new format documentation.

People's mental capacity was appropriately assessed and their rights were protected. Employees of the service had knowledge and understanding of their roles and responsibilities in respect of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). They understood the importance of people being supported to make decisions for themselves.

The registered manager was knowledgeable on how the service worked with other health and social care professionals and family members to ensure decisions were made in people's best interests where they lacked capacity to make their own decisions.

People received adequate nutrition and hydration to maintain good levels of health and wellbeing. People received compassionate care from kind support workers that were knowledgeable about people's needs and preferences.

People and their relatives were supplied with information they needed with regard to their care and support when necessary. People were involved in all aspects of their care and were always asked for their consent before support workers undertook care and support tasks.

People had the opportunity to engage in pastimes and activities if they wished to. People were encouraged to maintain good family connections and support networks.

The service was not always well-led, because although people had the benefit of a positive and open management style, there were clear 'visions and values' for Mencap employees to follow and quality assurance and monitoring was carried out, there were minor concerns identified with record keeping.

Recording systems used in the service protected people's privacy and confidentiality and they were securely held. However, we made a recommendation to ensure all support workers completed records regarding people's information and for the running of the service, clearly, consistently and carefully.

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 protected from the risk of harm because the registered provider had systems in place to detect, monitor and report potential or actual safeguarding concerns. Risks were managed well so that people avoided injury or harm wherever possible.

The premises were safely maintained, support worker numbers were sufficient to meet people's need and recruitment practices were carefully and safely followed. People's medicines were safely managed.

Is the service effective?

Good

The service was effective.

People were cared for and supported by qualified and competent support workers. Workers were regularly supervised and received an annual appraisal of their performance. People's mental capacity was appropriately assessed and their rights were protected.

People received adequate nutrition and hydration to maintain good levels of health and wellbeing. The premises in the supported living schemes were suitable for providing people with the support they needed, comfortable and adequately equipped.

Is the service caring?

Good

The service was caring.

People received sensitive and compassionate care from support workers. People and their relatives were involved in all aspects of their care.

People's wellbeing, privacy, dignity and independence were monitored and respected.

Is the service responsive?

Good

The service was responsive.

People were supported according to their person-centred care plans, which were regularly reviewed. They had the opportunity to engage in pastimes and activities and to lead individual lives. People were encouraged to maintain relationships with family and friends.

People and relatives' complaints were managed well. However, some relatives were frustrated by low level niggles reoccurring.

Is the service well-led?

Requires Improvement

The service was not always well led.

Records were generally well maintained and were held securely in the premises, but they were not always consistently completed and isolated documents sometimes had gaps. Recording systems in use protected people's privacy and confidentiality.

People had the benefit of a positive culture and management style.

Quality monitoring and assuring of the service was effective. People and relatives had opportunities to make their views known.

Mencap York Domiciliary Care

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.

The inspection of Mencap York Domiciliary Care took place across several dates in December 2016 and January 2017. We visited the agency offices on 13 and 20 December. We visited some of the supported living schemes on 14, 15 and 20 December. Interviews with relatives of people that used the service took place on 13, 16 and 19 December and further interviews with relatives and other stakeholders took place on 3 January 2017. The inspection was announced and we gave the service 24 hours' notice because we wanted to be sure there would be someone at the offices to answer our queries.

Five Adult Social Care inspectors and one expert-by-experience carried out the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The area of expertise for this expert-by-experience was in learning disability services and principles/practice of equality and diversity. The expert-by-experience spoke with relatives of the people that used the service on the telephone on 21 December 2016.

Information had been gathered before the inspection from notifications that had been sent to the Care Quality Commission (CQC). Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also requested feedback from local authorities that contracted services with Mencap York Domiciliary Care and reviewed information from people who had contacted CQC to make their views known about the service.

We spoke with six people that used the service and fourteen relatives. We spoke with the registered manager and thirteen support workers that worked at Mencap York Domiciliary Care. We looked at care files

belonging to ten people that used the service, including records relating to medicines. We viewed records and documentation relating to the running of the service, including recruitment files and training records for seven support workers, quality assurance and monitoring, equipment maintenance records, staffing rosters and records held in respect of complaints and compliments.

We observed support workers providing support to people in their homes with permission to do so and we observed the interactions between twelve people that used the service and their support workers.

Good

Is the service safe?

Our findings

At the last inspection in November and December 2015 the registered provider was in breach of Regulation 12(2)(a)(b) with regard to risk management and reduction. This was because the registered provider had not ensured consistency across all of its supported living schemes in managing and reducing risk for everyone that used the service.

Examples used as evidence that the registered provider was in breach of the regulation on risk management, included poor management of risk due to mobility issues, sometimes no support plan to instruct support workers on how to reduce risk, no measures in place to reduce a person's risk of being cold and no prevention of harm from an unsafe environment in a support worker's bedroom, which was unlocked.

There were insufficient health and safety and fire safety checks to identify risks and monitor the supported living scheme environments. Issues regarding environment safety were the registered provider's responsibility as, although they did not provide the accommodation, they had a duty of care to identify environmental risks and take reasonable steps to minimise them.

At this inspection the registered provider had made sufficient improvement and was compliant with Regulation 12.

Risks assessments contained sufficient detail, covered all areas of risk and were regularly reviewed. They were cross-referenced with the information held in people's support and health action plans that also noted risks people might face. People had risk assessments in place for a wide variety of areas including, for example, personal care, support with independent living skills, activities, environment, accessing the community, nutrition, moving and handling, skin integrity and personal safety. Each person had a risk assessment register in their care file and all risk assessments listed were reviewed at least annually. Records showed what happened, the action taken by support workers and if any health care professional was contacted for advice.

People had individual personal emergency evacuation plans for evacuating from their homes in an emergency, which were very detailed in their assessment of risk. They included a quick-read one page instruction for support workers to assist people quickly. This page was kept by the front door of each supported living scheme for easy access.

The supported living schemes we visited had general emergency evacuation plans in place, which contained details of contact numbers as well as the procedures for supporting people in specific emergencies, for example, flood, electricity failure or structural damage.

Regular checks were carried out to ensure the environments in which people lived were safe and free from risks. These were completed by the supported living scheme managers on a monthly basis and were recorded. Any work required to repair damaged and unsafe property or furniture was placed on an action

plan and carried out as soon as possible.

At the last inspection the registered provider was in breach of Regulation 18(1) with regard to insufficient support workers to meet people's needs at some of the supported living schemes. Some one-to-one care hours were unclearly allocated and sometimes the care hours provided were less than the hours needed to meet people's needs. We acknowledged that the need for care hours was 'fluid'. However, testimonies from support workers, relatives and people that used the service indicated that staffing was insufficient in some supported living schemes to meet people's needs. Therefore not all people had their needs met.

At this inspection staffing numbers were sufficient in all of the supported living schemes we visited and therefore the registered provider was compliant with Regulation 18.

We saw that staffing levels were still fluid, but the registered provider managed a complex staffing situation well so that staffing levels remained adequate. Support workers and relatives we spoke with felt staffing levels were adequate and that vacancies were covered by other support workers when necessary. One support worker said, "Occasionally we don't have enough staff to do activities, but that is very rare. There has usually been plenty of staff around, at least three and we can ask for relief support, or as a last resort look for agency staff." Another support worker in one of the supported living schemes explained, "We don't have enough staff for the number of hours needed to support people at the moment which is why we are using agency staff at present." All support workers stated that sufficient staff were deployed in the supported living schemes and people's needs were being met.

Relatives expressed a variety of views about staffing levels and said, "There are always two or three staff available", "[Name] gets a lot of support", "Staffing levels are sometimes hit and miss", "If there is any support [Name] needs, it is provided" and "A lot of the staff have been there long-term and [Name] gets lots of support from them." Relatives also said, "There seems to be enough staff to look after [Name]" and "I have had no concerns about staffing." Only one relative said, "There are a few staffing problems. They (Mencap) don't always ensure enough staff are on duty."

Support workers said, "We are short by one or two staff, but recruitment is taking place at the moment", "We cover vacancies ourselves when needed and take the time back when we can, so all shifts are covered" and "Sometimes we juggle staff around to accommodate extra tasks, like collecting a person's wheelchair, but we are flexible and accept that rosters change according to people's needs." Support workers said that where agency workers were used the service managers tried to keep the same personnel to maintain consistency for people they supported.

We found the service now had an electronic means of identifying the requested and actual hours worked by support workers and this was aided by supported living scheme managers inputting all of the data for each support worker on a weekly basis. This enabled the registered manager to monitor staffing levels to ensure there were sufficient numbers in each supported living scheme to meet people's needs.

At the last inspection medicines were not always stored safely because keys to medicine cupboards were found readily available to anyone and medicines with a limited time in which to be used were not dated when opened to ensure they would be used before that time expired. A recommendation was made regarding these issues.

At this inspection we found that medicines were appropriately managed. The registered manager had ensured that any concerns regarding medicines had been identified and resolved. For example, there were ten occasions in the last year when a dose of medicine was not administered to people as prescribed. These

incidents were quickly reported and action was taken to respond to the missed doses to ensure people's safety. Measures were put in place to re-train the support workers concerned. Messages were issued to all workers regarding the importance of medicines being taken by people. Systems were in place to ensure there was one nominated support worker per shift in each of the supported living schemes to administer people's medicines. Greater care was being taken to prevent further errors occurring.

Support workers were trained in the administration of specialist medicines like insulin and seizure rescue medicine. Support workers had their competence checked after each training session or training update and records of these competence checks confirmed this. District nurses supported workers with advice and information if required.

We were told that occasionally people might need to have their medicines administered covertly because they may be reluctant to take medicine that was essential for their health. This only took place following full assessment of needs and risks and after obtaining a best interests decision in line with the Mental Capacity Act 2005. We saw one such decision was recorded. We also saw that controlled drugs, those required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001, were held in individual locked containers in the communal medicine cupboard of one of the supported living schemes we visited. Support workers explained this had been approved by the local pharmacist who supplied medicines to people that used the service.

The service had systems in place to manage safeguarding incidents and support workers were trained in safeguarding people from abuse. They demonstrated knowledge of what constituted abuse, what the signs and symptoms of abuse might be and how to refer suspected or actual incidents to York City Council (CYC). Evidence in training records showed that support workers were trained in safeguarding adults from abuse.

Some of the people we met had profound disabilities, which affected their ability to communicate verbally. We saw that they were comfortable in the company of support workers and each other. They demonstrated contentment in their demeanour and showed fondness for the workers that supported them. They were relaxed and made requests of workers for support and engagement in their own preferred way of communicating. One person agreed, when asked, that they were happy and comfortable in the presence of the support workers.

Relatives we spoke with said, "Yes we feel [Name] is safe there (at the supported living scheme)", "[Name] is safe. They (staff) are very good. Mencap has a family atmosphere", "Safe, [Name] is very safe. Staff have to deal with their mood swings and quirkiness. They are the most active in the house", "I think [Name] is safe, they laugh a lot are happy and are putting on weight" and "One hundred percent safe. We (meaning relatives and staff) all work as a team. We're open minded and we talk. Everyone involved, it's transparent and if there's any problems they (staff)go overboard to sort it."

Records were held in respect of handling incidents and four referrals that had been made to the local authority safeguarding team in the last year. We discussed the need to inform us about all safeguarding referrals made to CYC, as we found that we had been informed about those that were investigated by CYC but not about those that were left with Mencap to investigate. The registered manager had been a little unclear about which incidents needed to be notified to us. Systems in place, support workers being trained in safeguarding people from abuse and actions taken to handle safeguarding incidents ensured that people who used the service were protected from the risk of harm and abuse.

The supported living schemes we visited had maintenance safety certificates in place for utilities and equipment used by people and these were all up-to-date. These included, for example, fire systems,

electrical installations, gas appliances, hot water temperatures at outlets and lifting equipment. There were maintenance contract in place to ensure the premises and equipment were safe at all times. Safety measures and checks in place meant that people were kept safe from the risks of harm or injury.

The supported living schemes had accident and incident policies in place, which support workers used should anyone living or working in the schemes have an accident or be involved in an incident. Records were maintained by the service using a critical incident reporting procedure, which was on-line and showed that accidents/incidents were recorded thoroughly. Systems showed that action which had been taken to treat injured persons and prevent them re-occurring, was also recorded. The supported living scheme managers could analyse the accidents/incidents in their schemes on a local level, as they received each incident (Menac) report. These were discussed in accountability meetings with area managers and with teams in team meetings. Evidence of this was seen in one supported living scheme in the form of an environmental audit which addressed two concerns that were reviewed with an area manager and fed back to the team.

The registered manager told us they used thorough recruitment procedures to ensure support workers were right for the job. Job applications were completed, references requested and Disclosure and Barring Service (DBS) checks were carried out before job candidates started working. A DBS check is a legal requirement for anyone applying for a job or to work voluntarily with children or vulnerable adults, which checks if they have a criminal record that would bar them from working with these people. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. We saw this was the case in all six support workers' recruitment files we looked at. Recruitment practices were safe.

Good

Is the service effective?

Our findings

At the last inspection the registered provider was in breach of Regulation 12(2)(c) because they had not ensured support workers' identified training needs were completed. The system in use to record this was insufficiently robust to identify there were gaps in workers' training or to ensure training had been completed.

At this inspection sufficient improvements had been made and the registered provider was compliant with regulation 12. Staff training needs and updates were monitored centrally.

The service had a training matrix (record), which showed 152 workers were employed and 32 relief workers were active with Mencap York Domiciliary Care. Only a small percentage of these had training that required updating and fourteen employees were in the process of completing their induction, so not all of their training had been completed yet. The service had a high proportion of employees and relief workers whose training was up to date. The matrix enabled quick and easy identification of training gaps and training updates needed. The dates of when training was completed could also be easily determined.

We saw some of the training information packages that were delivered to workers, for example, on the difference between mental capacity and mental health legislation and how these impacted on people without capacity or good mental health. Both legislations were tied in with the legislation on people's human rights: article 5 the right to liberty.

Specialist training was completed according to people's individual support needs. For example, administering insulin, rescue medicines or supporting a person with percutaneous endoscopic gastronomy (PEG). Support workers confirmed this. One support worker told us that where necessary an occupational therapist or district nurse might attend a staff meeting to provide support workers with instruction on these and other procedures or care/treatment. They also told us that they had completed mental capacity training with CYC and moving and handling training while being observed.

Support workers told us they had completed mandatory training (minimum training as required of them by the registered provider to ensure their competence) and had the opportunity to study for qualifications in health care. One worker expressed a preference for attending classroom-based training over e-learning, as they learnt more from interacting with other learners, but they said this was not usually the training on offer.

Relatives told us "The staff are marvellous with [Name], who has used the service now for three years. Staff seem to know what [Name] likes and what helps them to be happy", "The support that [Name] gets is fantastic" and "I feel 90% of the time [Name] is well looked after and it is only little things that could be better."

The registered provider had an induction programme in place, which involved working through three training booklets on the Mental Capacity Act, Mencap policies and procedures, equality and inclusion, fire safety, first aid and health and safety. Also on information about the Mencap organisation, case studies on

how people that used the service were supported and safeguarding adults. When this was completed, new workers shadowed support workers and senior staff, to get to know people that used the service and their needs.

Induction followed the guidelines and format of the Care Certificate, which is a set of standards that social care and health workers follow in their daily working life. The Care Certificate covers the new minimum standards that should be learned by new care workers, as identified by Skills For Care. Skills For Care are part of the National Skills Academy for Social Care and help create a better-led, skilled and valued adult social care workforce.

The registered provider reviewed support worker performance via one-to-one supervision and the implementation of an appraisal scheme. Support workers had received supervision, but the regularity of use of the new system 'Shape Your Future' (SYF) was not fully understood by all workers. This new system was yet to be embedded because some support workers SYF records were completed differently according to support workers' understanding of the system. Most support workers had received two of the four supervisions expected between April 2016 and the end of March 2017.

Best practice was followed by researching advancements in learning disability care, seeking support from specialists in their fields and applying programmes and interventions to help people improve their quality of life. An example of best practice was explained to us, where positive intervention was used with a person to improve their wellbeing. Positive reinforcement of routine and behaviour was used to assist a person so that they no longer depended on continence aids at night. This meant they were more comfortable, less prone to skin conditions and required less support with personal hygiene.

Communication within the service was good. Support workers had daily handover sheets on which they recorded household tasks completed, checks made on cash tins, important information on individuals and appointments to attend/attended. A second sheet showed maintenance requests and when any repairs were completed.

Support workers were fully aware of the importance of good communication with people and tried hard to learn to understand people expressing their needs and personal communication methods. Communication methods used included picture books, Makaton (sign language), facial expression/body language and face-to-face discussions. Support workers were trained in Makaton and intensive interaction techniques if appropriate to the people they supported. We observed support workers using Makaton.

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 interest 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 interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). For people living in their own home, this would be authorised via an application to the Court of Protection.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We were told that an ADASS (Association of Directors of Adult Social Services) tool was used to determine the potential for the need of an

authorisation. Several Court of Protection authorisations had been applied for via CYC. Two of these were not completed yet: regarding use of bed safety rails and non-use of an electric wheelchair while in the supported living scheme.

When necessary, if people were assessed as having no capacity to decide for themselves, a best interests meeting and decision was made on their behalf. One person's file had no best interests decisions in place and contained a signed declaration that they understood some communications with people, but were unable to make complex decisions. Another person had a best interests decision recorded by the CYC to live where they lived and be supported by Mencap York Domiciliary Care workers.

One person's decision to have a general anaesthetic in order to obtain a blood sample and have a dental check at the same time was decided using the best interests process. This was being coordinated between the relevant health care professionals to ensure the least restrictive method was to be used. They had introduced a de-sensitivity session to seek acceptance of a blood sample taken without anaesthetic. Consent to care and treatment was recorded with regard to MCA and DoLS, but detail was not always comprehensive and this has been addressed in the section on 'well-led'.

There was clear evidence that people's capacity was being considered and DoLS were being identified but the local authority was not always being made aware of the potential for further assessments to be made. The registered manager was made aware of this and undertook to ensure the managers in supported living schemes informed the local authority of all potential DoLS.

People's nutritional needs were met by the service. People and their relatives had been consulted about their dietary likes and dislikes, allergies and medical conditions. Support workers sought the advice of a Speech and Language Therapist (SALT) when needed, where people had problems eating or swallowing. People had nutritional risk assessments in place where they had difficulty swallowing or needed support to eat and drink. Mostly people chose their menus, went shopping for their provisions and helped to prepare meals if they were able to.

People's health care needs were met with the help of support workers because people and their relatives were consulted about their medical conditions and information was collated and reviewed with changes in their conditions. Support workers told us that people saw their GP on request and when needed. Services of the district nurse, chiropodist, dentist and optician were obtained whenever necessary.

Health care records held in people's files confirmed when they had seen a professional, the reason why and what the instruction or the outcome of the consultation was. We saw that diary notes recorded where people had been assisted with their health care needs. For example, with personal hygiene, posture, mobility. One person required specialist mouth care, which was recorded in a mouth care support plan.

People were monitored with regards to their weight, food and fluid intake, skin integrity, seizure activity, physical exercise, mobility and social activity, so that the best possible care could be provided. Support plans showed clear instructions for these areas of need.

Good

Is the service caring?

Our findings

At the last inspection the registered provider was in breach of Regulation 10 (1) because they had not always ensured people's privacy and dignity was promoted. Sometimes relatives had visited and found that people were inappropriately attired to ensure their dignity.

At this inspection sufficient improvements had been made and the registered provider was compliant with Regulation 10.

We discussed privacy and dignity with people, relatives and staff. People indicated to us that they were treated respectfully regarding their privacy. Privacy and dignity was seen as important by support workers who explained when and how they ensured these were upheld. Workers explained that when people used the bathroom independently they might still need support with dressing, hand washing and maintaining their dignity. People were supported with these discreetly. When people were independent with their meals they might need support with keeping clean and tidy. Again this was done discreetly. For those people that needed full support, support workers were mindful and ensured privacy and dignity were upheld.

Support workers understood the need to maintain confidentiality at all times, with regard to personal care or support needs and the sharing of people's information or financial arrangements. We saw that people were appropriately attired when we visited the supported living schemes and were treated respectfully and with dignity.

We heard respectful conversations taking place between support workers about people's individual needs, their behaviour, what they had been receptive to recently and what might be good to try out with them. We heard respectful conversations about people's family members and their commitment to supporting and loving those that lived in the supported living schemes. Support workers talked about how they included people in choosing colours for their bedrooms when decorating them. Support workers demonstrated they understood about and acknowledged people and their family members' differences in lifestyle choices.

We observed that support workers respected people's space, especially where they required specific support and supervision. Where people needed support with personal hygiene, support workers told us they ensured they promoted peoples independence and supported them to do as much as possible for themselves.

We saw one person who usually preferred everyone to remain at a distance, enjoy a moment of closeness with a support worker when they laid their head on the worker's shoulder and smiled. People were comfortable in the company of each other and support workers. We saw that support workers were positive when they approached people and invoked trust and reliability, so that people had confidence in them and found them dependable. Workers knew people's needs well. Support workers interactions were warm, positive and caring.

Relatives told us, "They (staff) have gone the extra mile and are very kind to us. We work together for my

relative's care", "Very Caring know what [Name] needs", "Caring yes. [Name] can tell me the one or two staff they don't like." Other relatives said, "Very happy with the care. Staff are very caring", "Staff are great, they offer me a cup of tea when I visit and are very caring to [Name]" and "The standards of care are second to none."

People that used the service had differing needs and faced many challenges in their lives. Some became anxious if unable to express their needs or displayed this in their behaviour. Support workers were fully aware that for some people consistency was very important, while for others routine should be avoided to prevent reinforcing unhealthy habits. Support workers had to read and understand information about people's needs, beliefs and routines, understand their diagnosed learning disability and/or Autism spectrum disorder, so that they provided the right care and support to people at the right time.

Support workers provided people with individual time to go out, but one worker questioned whether group living was helpful in this, as often people saw a person getting ready to go out and thought they too would be going out. The worker said this often unsettled people unnecessarily.

Discussion with the support workers revealed people using the service had one or more particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010: age, disability, gender, marital status, race, religion and sexual orientation. We were told that everyone had diverse disability needs, which support workers worked hard to meet so that no one was discriminated against. Workers challenged situations where people faced discrimination in the community or while receiving a community-based service.

People had useful and important information held in their files concerning their tenancy agreement, compliment and complaint forms, end of life wishes and funeral plans, best interests meeting notes, mental capacity assessments, family member details, authorisation documents, correspondence and local authority assessments and support plans.

Files also held information about what people could expect from the service (a statement of purpose). The statement of purpose was issued in an information pack that told people about their rights, choices, learning opportunities, safety and what they could expect with regard to support with health, happiness, money, friendships and inclusion in the service. All of this enabled people and their family members to understand what the service of support would be and to maintain a check on their needs and support networks.

We saw that people who used the service had their general well-being considered and monitored by support workers who knew what incidents or events would upset their mental health, or affect their physical ability and health. We found that people were experiencing a satisfactory level of well-being and were generally quite positive about their lives.

We were told by support workers that no person using the service was without relatives or friends to represent them, but that advocacy services were available if required through Cloverleaf. Advocacy services provide independent support and encouragement that is impartial and therefore seeks the person's best interests in advising or representing them. Information about advocacy was provided to people in leaflets in their files and on notices around the supported living schemes. We were told several people that used the service were supported by advocates to ensure they were given impartial advice and assisted to make impartial decisions about their lifestyle choices and support needs.

Good

Is the service responsive?

Our findings

At the last inspection we made a recommendation that the registered provider should seek guidance from a reputable source about person-centred care, because some people did not have adequate means of summoning the support they needed. There was insufficient Tele-care equipment in use for those people that were unable to use a call bell system.

We also recommended that the registered provider sought guidance from a reputable source about the management and recording of low-level concerns to ensure they were effectively dealt with. This was because some relatives had expressed the view that the registered provider had not dealt with these concerns effectively (particularly regarding communication inefficiencies) and they were still on-going.

At this inspection we found that the registered manager had made improvements with people's means of communication and with the management of low-level concerns.

The registered provider sought information about person-centred care and support plans and risk assessments. They had instructed supported living scheme managers to implement new format support plans and risk assessments for everyone that used the service. Those we looked at contained a wide variety of person-centred information obtained from stakeholders: relatives, friends, carers and health care professionals involved with or interested in the person, to enable support workers to meet people's needs. Information included what people liked, how they communicated, instruction to workers on how to support people with personal care and nutrition and ensure privacy.

One page profiles were also seen, as well as one page profiles specifically for agency workers, who may know nothing about the people they were supporting. Risk assessments were in place to match any areas of support where potential or actual risk was evident. The registered provider ensured that people's environment was risk assessed and made safe. Support plans and risk assessments were reviewed regularly.

Some people had been issued with Tele-care products, such as sensor mats to alert support workers that they were out of bed or had left their bedrooms. These were in place where people needed supervision throughout the day and night. Tele-care products, for which people were assessed, aided independence or ensured their safety.

People's care files contained personal information and details, a support agreement, health action plan, medicines list, personal care support needs, nutritional, mobility and financial needs, tenancy agreement, housework required and general behaviour information. Files held copies of local authority assessments and support plans with outcomes.

Information about one person's health needs and the help they required with cooking, cleaning, laundry, finances, taking part in activities or going to church was very detailed. Files for other people were just as detailed in their content. Only one person's support plan agreement was not signed and details were

missing with regards contacts, their GP, physical and mental health and allergies. This was discussed with the registered manager who explained that new format support plans were on-going regarding the streamlining of these documents, their indexing and uniformity. Supported living scheme managers were monitoring progress.

Following any changes in need the service was responsive and sought advice from relevant professionals, where possible. Needs were responded to in a person-centred way. For example, one person's tendency to self-harm prompted a request for specific training to aid support workers when supporting them to keep them safe. A series of isolated incidents where medicines had been missed prompted additional medicines administration training for some support workers and where a person had experienced some falls their equipment and falls risk assessment were reviewed. Following another person's falls a physiotherapist was consulted to improve their personal strength and balance. All of these interventions were appropriately recorded by supported living scheme managers and signed off by the registered manager.

Some behaviour charts we looked at for one person indicated that a support worker could have exercised a more responsive approach to the person's needs, as a list in their support plan clearly indicated the order in which their care was to be given. The chart noted that the support worker had assisted the person in a different order and this had resulted in inappropriate behaviour, which then needed to be managed to reduce the person's anxiety and prevent potential injury to themselves and others. There was no information on the chart or in other records to show whether or not this situation had been addressed with the support worker. When we asked the supported living scheme manager about this, they told us and showed us evidence in the support worker's supervision record that the support worker had been asked to explain their actions. The support worker was instructed to follow people's support plans at all times.

At this inspection we saw that the service and each supported living scheme had a complaint policy for anyone to follow and records showed that complaints and concerns were handled within timescales. Each supported living scheme also had a local procedure, which was available in an accessible format for people to understand. Mencap York Domiciliary Care had a centrally organised electronic system (Menac) for logging and managing complaints. The registered manager was aware of the low-level complaints that relatives made and was working on improved communications with relatives.

Two complaints had been received since the last inspection and both issues were addressed by the registered manager. Both were addressed by liaising with the complainants to discuss issues and making a referral to the occupational therapist to re-assess one person's needs. While appropriate action had been taken by the registered provider and information had been given about action taken, we understood that one complainant did not consider their complaint fully resolved. The registered manager continued to liaise with the complainant.

Relatives we spoke with told us they knew how to complain to represent their family member that used the service. They said, "I know how to complain and know that the (scheme) manager is always available" and "I sometimes have issues with the place, niggles really, and pass these on to the staff. They have tried hard over the past two years to improve things" and "I do make my niggles known, but sometimes it gets frustrating saying the same things over and over." Everyone acknowledged that relatives just wanted the best possible care and support for the people that used the service. The registered manager was personally liaising with relatives regarding continued dissatisfaction and instructed all supported living scheme managers to monitor people's care more closely when relatives made comments.

Compliments were also received and recorded at the supported living schemes in the form of letters and cards and many had been received since the last inspection.

Activities that people engaged in were entirely according to their individual assessed needs, preferences and choices. People attended hydrotherapy, 'dance-ability', youth clubs, night clubs, swimming, gym, trampoline, art, baking, plant-potting, bowls, drama, trips out and celebrated seasonal events. Some supported living schemes had light or sensory rooms for people to use when they were anxious or needed to relax.

Relatives told us that people had opportunities to engage in pastimes, activities and social events and that the service was responsive to people's needs. They said, "[Name] goes out with staff all the time to museums and swimming, which is one thing I could never get them to do. They have visits to Newcastle, Leeds and Scarborough on the train", "[Name] has plenty of personal hours to use and sometimes does a lot with other people that use the service, when they could go out more on a one-to-one basis with staff" and "[Name] goes out more or less every day."

Relatives said, "Staff take [Name] out to Movers and Shakers drama and music group. They go to the theatre, panto and have meals in restaurants" and "[Name] goes to Pastimes, four days a week. Funding is the problem, as at weekends there is limited staff. [Name] goes to Weight Watchers as they are a compulsive eater. They lost a stone and staff altered everyone else's menus to healthy eating following the weight loss programme."

We were told by support workers that two people used to attend church each week, at the request of relatives, because they both enjoyed singing. However, one of them made it clear they did not like going to church because they had to rise so early, although they still wanted to join in with a group of people singing and liked having tea with people. Support workers responded to this and ensured both people were able to sing at home and take tea elsewhere in the community. Another person liked to be in spaces where their voice echoed so support workers often arranged for them to visit such spaces.

Most of the supported living schemes had equipment for assisting people to move around their homes. People were assessed for its use and there were risk assessments in place to ensure no one used it incorrectly. Support workers understood that people had their own hoist slings to avoid cross infection and these were kept in people's bedrooms. Bed rail safety equipment was in place on people's beds and these had also been risk assessed for safe use.

Where it was considered appropriate people were asked if they would like the use of adaptive cutlery and crockery aids so that they could maintain their independence. One person's support plan clearly described the tools they used and why it was important they used them. All equipment in place was there to aid people in their daily lives to ensure independence and fulfilment, but only if people wanted to use them and they had been risk assessed to do so.

Staff told us that it was important to provide people with choice wherever possible, so that they made decisions for themselves and stayed in control of their lives. People had choice in what they ate, where they went and who with, when they got up from and went to bed, and what they wore each day. They had the choice to join in with entertainment and activities with others or to enjoy pastimes on their own. People's needs and choices were therefore respected.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection the registered provider was in breach of Regulation 17(2)(a) because although they had a quality assurance system in place the scope and breadth of the system was insufficient to identify the areas of concern that we highlighted during the inspection. For example monitoring of risks, staffing shortages, support workers' training needs and maintaining dignity and privacy. This had led to overall variation and inconsistencies in the quality of support and care people received from the service.

At this inspection we found that the registered provider had improved and was compliant with Regulation 17.

The scope and breadth of the quality assurance auditing systems had been improved by introducing quality audits in all areas of service provision. These included audits on support plans, risk assessments, medicines, daily recording, accidents/incidents, health and safety and people's living environments. We looked at the system in three of the supported living schemes we visited. We saw that where issues were identified they were recorded in an action plan, action was taken to remedy them and the record was signed off when completed.

We saw that staffing hours were monitored using audit tools, where concerns had been identified, changes had been made to resolve them and other action taken (discussion in team meetings) to ensure all support workers were aware of the changes that resulted. A workforce development plan was produced, which detailed the pro-active response taken by the registered provider when recruiting new workers.

Monthly accountability reports were now being sent from Mencap York Domiciliary Care to the registered provider. We saw the one for November 2016, which showed that risks, recruitment, quality, vacancies, training and high use of agency staff were being accounted for. It also showed that support worker grievance and disciplinary issues were addressed.

The registered provider's quality team looked at trends in areas of concern, for example, safeguarding adult's issues, the outcome of training provided to supported living scheme managers around CQC's Key Lines of Enquiry and 'Menac' reports. The findings from their analyses were now communicated via emails to the service and discussed in manager's meetings to look at ways to continuously improve.

Relatives of people that used the service told us there was a lovely atmosphere to the supported living schemes. They said, "I can talk to the registered manager, as she's been there at the scheme", "I think the service is well-led, all the staff know what they are doing and so they look after people well and sometimes can't do enough for them" and "Things have definitely been getting better and I think the (scheme) manager and staff are trying harder to ensure the scheme is well run."

The registered provider was required to have a registered manager in post and on the day of the inspection there was a manager in post, who had been the registered manager for six months. They were still new to their role but had undertaken to address all of the breaches identified at the last inspection and assured us

that continuous development would be seen in the next six months.

The registered manager and registered provider were fully aware of the need to maintain their 'duty of candour' (responsibility to be honest and to apologise for any mistake made) under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We saw that notifications had been sent to us over the last year and so the service had fulfilled its responsibility to ensure any required notifications were notified under the Care Quality Commission (Registration) Regulations 2009. We clarified with the registered manager when safeguarding alerts (made to CYC) needed to be sent to the Commission as notifications, as most but not all had been sent to us.

Support workers told us they thought one supported living scheme manager was not 'brilliant' at disciplining workers individually, as they tended to tackle issues with the whole support worker team, but they were approachable and supportive in other ways. Other support workers said about their supported living scheme managers, that they listened and helped them with work related or personal problems.

Not all support workers told us they had confidence in the registered provider's management structure. One support worker gave an example of when they and people that used the service had not had input into a decision about who lived in one of the supported living schemes. They said this meant people were not compatible on that occasion with regard to their individual needs and so people had been cared for on a group basis rather than individually. This was an isolated situation, which was not reflected in other supported living schemes. Support workers talked about challenges with relationships that sometimes made it difficult to reduce risks to people. They explained that strategies were put in place to manage these challenges wherever possible.

Support worker meetings were held in supported living schemes so that people who used the service could join in and these were recorded. Support workers were able to discuss people that used the service and their needs. They signed the meeting records after reading them so that everyone was fully aware of the issues discussed. People that used the service were invited to these meetings and some of them attended, so that they could be included in discussions about the strategies proposed to meet their needs. Other topics for discussion included training needs, medicines management, mental capacity implications and people's choice. Monthly supported living scheme managers' meetings were also held and these were evidenced by meeting minutes.

The service had written visions and values, which were 'inclusive, trustworthy, caring, challenge and positive'. These were written in the organisation's 'Our Big Plan' which was a five year organisation development plan. Support workers described the visions of the service as being progressive and challenging, but putting the best interests of people that used the service at the heart of the service. They said individual's lives were fulfilled and one-to-one support was provided to people where necessary.

We were told that the service had achieved the Investors in People award, the report of which stated all staff 'Have strong foundations for inspirational leadership, clear vision for the future, shared values and good access to high quality learning and development' and the service has 'A passion for getting the best out of people.' Some recommendations were made regarding leadership and management practices, for example, to embed and monitor the organisation's development for managers, increase leadership visibility, address work-life balance, improve internal communications and information sharing, develop recognition and reward, encourage collaboration, consult earlier about planning and changes and introduce progression across all levels in the organisation.

The service maintained records on people that used the service, support workers and other employees.

There were records kept for the running of the business that met the requirements of regulation. We saw that records were generally appropriately maintained, up-to-date and securely held. There were a few exceptions to this; isolated records that were not completely filled in (one person's health action plan, another person's best interest meeting notes and key worker notes), not consistently maintained (fridge temperatures in one supported living scheme and continence charts in another) and a few isolated documents not dated or signed.

Information on fluid charts seen at one supported living scheme did not show the totals for the daily amounts that people had consumed, but individual amounts were recorded, so essential information was recorded. Instructions and advice provided by, for example, an occupational therapist were followed but not recorded in one person's diary notes to evidence that action had been taken to adhere to them. Some hand written medication administration record sheets were not counter-signed, but others were. Most people's mental capacity assessments were clearly recorded but isolated assessments were not always consistently completed.

We recommend the registered provider ensures all support workers know their responsibilities regarding consistent and clear record keeping.

Other record keeping was consistent and meticulous. People's care files were detailed in their content; support action plans in particular. These were detailed in the care and support people needed and stated exactly how these needs should be met; particularly with regard to medicines, observing health concerns, monitoring blood sugar levels and people's states of wellbeing (anxiety and mood), keeping appointments and recording symbols for communication.

Other detailed records and documentation included the service user handbook, support worker rosters, daily diaries for people that used the service and activities people took part in. There were clear handover sheets showing who was responsible for designated tasks and actions: with regard to money checks, administering medicines and completing stock checks and health and safety checks.