Care Quality Commission

Royal Mencap Society

Royal Mencap Society - Lombardy Park

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on 31 March 2015 and was unannounced.

The service provides care and support for people with learning disabilities who live in six bungalows on the same site. Some people are quite independent while others have significant care needs and require more support and care. The service is registered to provide care for 28 people and at the time of our inspection 26 people were resident.

The service had a registered manager in place. 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.

Summary of findings

We found that the high number of staff vacancies meant that there was a lack of continuity with regard to staffing. The registered manager had put measures in place to address the staffing issues but poor records meant that it was not always clear how shifts were covered.

People told us they felt safe at the service and staff had completed training in safeguarding people from abuse. Safeguarding issues had been referred to the local authority and internal investigations had been carried out when required.

People were supported to take risks and these risks were assessed and measures taken to reduce them as much as possible. Risks were regularly reviewed and it was recognised that as people's conditions changed their risks might increase or reduce and the service responded to this promptly.

Medicines were managed well and staff were trained to administer medicines safely. Staff practice was checked through formal observations to ensure continued best practice.

Staff received an induction, on-going supervision and annual appraisal to support them in their roles. A wide variety of training was provided but we found that training related to some specific health conditions had not been made available to staff. Staff knowledge regarding supporting people with diabetes and high cholesterol was not robust and some care records for people living with diabetes were incomplete.

The service operated in line with the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards. The MCA ensures that, where people lack capacity to make decisions for themselves, decisions are made in their best interests according to a structured process. DoLS ensure that people are not unlawfully deprived of their liberty and where restrictions are required to protect people, this is done in line with legislation.

People were supported to have a balanced diet and were appropriately referred to dieticians if they needed this. People were encouraged to take part in choosing their meals and cooking. Staff did not demonstrate a clear understanding of the dietary requirements of a person with diabetes. People were supported to access healthcare services and the service worked in partnership with other healthcare professionals, such as district nurses, to maintain people's health.

Staff were kind, caring and patient and treated people with respect. They showed a real interest in the people they were supporting and several staff remarked on how much they enjoyed their jobs.

Care plans were drawn up with the involvement of the people they concerned and reflected people's care needs as well as their choices and preferences. Staff respected people's choices and supported them in the way they chose. People were able to engage in a wide range of hobbies and interests and went out regularly into the local community to shop and attend social events.

People knew how to make a complaint and we saw that formal and informal complaints were managed well.

Quality monitoring at the service was carried out by the registered manager and their line manager. The registered manager had oversight of the way the service was performing and communicated well with the team managers in each of the individual bungalows.

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?
The service was not always safe.

There was a lack of continuity with regard to staffing and records relating to staffing were unclear.

Staff were trained in safeguarding people from abuse and safeguarding concerns had been appropriately referred and investigated.

Risks were assessed and managed well and medicines were managed safely.

Requires improvement

Is the service effective?
The service was not always effective.

Staff received training to assist them to carry out their roles but some had not received training related to specific healthcare conditions.

The service established people's consent in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were supported with their eating, drinking and most healthcare needs but staff did not demonstrate a good understanding of care for people with diabetes.

Requires improvement

Is the service caring?
The service was caring.

Staff had built good relationships with people and were kind and caring.

People were supported to be involved in decisions about their care and their privacy and dignity were respected.

Staff promoted people's independence.

Good

Is the service responsive?
The service was responsive.

People had been involved in developing care plans which met their needs and reflected their choices and preferences.

People followed their own interests and hobbies and were supported to take an active part in their community.

Formal and informal complaints were managed well and to people's satisfaction in most cases

Good

Is the service well-led?
The service was well led.

Good

Summary of findings

People who used the service, relatives and staff were able to help develop the service.

Staff were well supported by the management of the service.

There was a comprehensive system of audits in place to monitor the quality of the service.

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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 took place on 31 March 2014 and was unannounced. The inspection team consisted of two inspectors.

Before we carried out our inspection we reviewed the information we held about the service. This included statutory notifications that had been sent to us in the last year. A notification is information about important events which the service is required to send us. Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used the information provided to us in statutory notifications and the PIR to focus our inspection.

We spoke with six people who used the service and observed others who were not able to communicate with us. We spoke with three relatives, six care staff, two team managers and the registered manager. We reviewed nine care plans, five medication records, two fire evacuation records, four staff files, training records, staffing rotas for a period of three weeks and records relating to the maintenance of the service and of equipment.

Requires improvement

Is the service safe?

Our findings

People who used the service told us they felt safe and would speak to a member of staff if they did not. One person said, "I do feel safe here, yes". We saw that staff were trained in keeping people safe and knew what signs might indicate if a person was being abused. All the staff we spoke with were knowledgeable about safeguarding issues and knew how to make a safeguarding referral. Some staff told us that they had done this in the course of their duties.

The service had experienced a number of recent safeguarding concerns and these were being investigated. Safeguarding matters had been appropriately notified to CQC and the local authority adult protection team. When required the manager had undertaken internal investigations of safeguarding matters and had reported back promptly. The findings of these investigations were made available to us. We could see that the systems and training in place helped to protect people who used the service.

We saw that risks were assessed and actions taken in order to minimise these risks. People were supported to take risks as part of the service's commitment to increasing people's independence. We saw that the risks faced by one person when accessing the community had been assessed due to their severe epilepsy. We saw that they continued to go out socially but measures, such as ensuring staff accompanied them and took the person's medicines with them, were in place to help keep them safe.

People were involved in risk assessment if they were able and we saw that people had signed their risk assessments. Risk assessments were regularly reviewed and where a change in someone's condition had taken place we saw that assessments were updated. One risk assessment had been reviewed after a person had had a fall which resulted in a hospital admission. Additional staffing had been put in place for them as a temporary measure. The service had an Emergency Contingency plan which had assessed various risks to the service and outlined actions staff should take in the event of an emergency such as a flood or loss of heating for example.

The service had a number of staff vacancies which totalled 180 vacant hours each week. In the three week rota we viewed this meant that staff were sometimes doing additional shifts, staff training was cancelled on two occasions and there was a high use of agency staff. This meant there was a lack of continuity with regard to staffing and people were not always clear who would be supporting them. We received a mixed picture about the impact of this from the people who used the service, their relatives and staff. Some told us that it put pressure on the staff and curtailed opportunities for social outings while others felt that the impact was not significant and did not compromise the safety of the service.

We saw that the management of the service worked hard to use staff as flexibly as they could to cover vacant hours and those which needed cover due to staff sickness. On the rota supplied to us it appeared that some shifts, including one to one shifts, had not been staffed with the assessed number of staff. We discussed this with the manager who assured us that this had not been the case and was a matter of poor recording. They agreed that they needed a better way to document when one to one hours had been provided to ensure that people who used the service were seen to receive the staff support they required.

We saw that the service had completed a very detailed risk assessment with regard to the occasional low staffing which set out the threshold for team leaders to come off their office based duties and work a shift. It documented various staffing scenarios in each of the bungalows and gave guidance to staff. It was clear from the risk assessment what levels would be considered unsafe and what hours must be covered, such as mealtimes on one unit where people were at risk of choking.

The service had a comprehensive recruitment procedure in place. We saw that permanent and agency staff had received a Disclosure and Barring Service check to make sure that staff did not have any criminal record which would exclude them from working in this type of setting. Staff records confirmed that appropriate checks had taken place before people started to work at the service in most cases although we did find one instance where there was no record of the person's identity being checked.

We found that medicines were managed well. Staff received training before they administered medicines and this training was refreshed every three years and a structured observation of their practice was carried out annually. We found that staff were knowledgeable about the medicines they were giving to people. Additional information about the medicines people were taking was available for staff to refer to.

Requires improvement

Is the service safe?

We saw that there were effective systems in place for the ordering, booking in, storing and disposing of medicines. Records contained information on how people liked to take their medicines. There were clear protocols for staff to follow when giving people medicines which they only needed occasionally or in response to a specific health condition, such as recurring epileptic seizures. We noted that some of these protocols were overdue for review. Most medication administration record (MAR) charts had been fully completed and indicated that people received their prescribed medicines correctly. We did note that there were some gaps in one person's chart where staff had failed to sign when they had administered medicines. People were supported to have their medicines reviewed regularly.

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Requires improvement

Is the service effective?

Our findings

People were positive about the skills and competence of the staff. One person told us, "I am well looked after. I have no complaints". A relative praised the staff and told us, "They take [my relative] out. They have increased [their] independence. [My relative] is very happy there".

Staff told us that they felt they had the training they needed to carry out their roles. One member of staff told us, "The training is really good here". Records confirmed that staff received appropriate training and we saw that this was refreshed regularly. We noted that some staff had received specific training such as supporting people with Down's Syndrome who were living with dementia. One member of staff told us that they had subsequently raised the issue that the colours of the living room in one bungalow were not 'dementia friendly'. This was being taken forward by the manager. Another staff member told us that they had received training relating to mental health conditions and had found it very useful. They told us, "This helped me understand we were doing the right things".

We saw that when staff first started working at the service they received an induction which covered all aspects of delivering care and support. New staff spent time shadowing permanent staff as part of their induction as well as receiving training. One person, who had recently completed their induction said, "I had an action folder to complete. I feel supported – teamwork is good".

Agency staff received an induction before they began working and one agency staff member told us that they felt staff had given them the information they needed to carry out their role. Records confirmed that a structured induction was provided for new agency staff. We saw that the service tried to use the same agency staff as much as they could to give some continuity to the people who used the service. Checks were carried out on any new agency staff member to confirm that they had received the required training.

Staff received regular support and supervision from their managers. An annual appraisal took place and as part of this each member of staff gave feedback on the other members of their team. This was aimed to give the staff member a more complete picture of how they were carrying out their roles and identify any additional improvements they might need to consider or training they required.

We observed that people's consent was asked for before care and treatment was provided. We saw that staff were patient when establishing a person's consent and went over the options several times if needed.

The management and care staff demonstrated an understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS), although some staff were yet to complete this training. We saw that some decisions had been taken appropriately in people's best interests. We saw that people's capacity to understand had been assessed and where they had been assessed as lacking this capacity the appropriate legal measures had been put in place. Appropriate applications had been made when the manager felt that a person's liberty might need to be restricted in order to keep them safe.

We saw staff supporting people to prepare and eat their meals and ensure they had appropriate access to food and drink. People were encouraged to make their own choices about food and drink. Care plans documented people's food likes and dislikes and staff demonstrated to us that they knew and respected people's preferences. Where a person refused to eat a particular meal records showed that an alternative was supplied to them.

We asked one member of staff to tell us about one person's needs related to their eating and drinking and they were able to tell us how staff supported them on a daily basis. They told us that they knew when the person, who did not communicate verbally, was unwilling to eat or drink that something was really wrong. We saw that this person had been unwell the previous week and this had been quickly noted by staff who had monitored them closely.

People were supported with their healthcare needs and staff worked in partnership with healthcare professionals to maintain people's good health. We saw that people were referred to appropriate healthcare professionals such as GPs and physiotherapists if needed. People were supported to attend dentist and optician appointments regularly and an electronic record identified if someone was due for a routine appointment. Where an aspect of a person's health needed to be monitored, such as their food intake or weight, we saw that records were fully completed.

Requires improvement

Is the service effective?

Each person had a health passport which contained important information which would be needed by hospital staff in the event of an admission to hospital. We noted that one person's passport did not include the information that they had diabetes.

Although staff had received training into certain health conditions we saw that no staff had undergone training in the management of diabetes or high cholesterol. We noted that one person who used the service had these conditions and care plans did not contain a lot of guidance for staff. We noted that there were few low cholesterol or low sugar foods in the kitchen and staff could not tell us in detail about the dietary support the person needed.

We also saw that in two cases people with diabetes had not had their blood sugars tested in line with their care plan. One person's blood sugar levels should have been tested four times a week but had only been recorded once in March and seven times in February. Staff told us that the person's diabetes was stable so it may be that the care plan needed to be reviewed. A second person's care plan documented the blood sugar level that the person should have and what constituted a high reading. Staff on this unit were not able to tell us accurately what these levels were and so we were not assured that they would be alerted quickly to a deterioration in the person's condition. Although this person's diabetes was primarily managed by the district nursing team, staff at the service also supported them with their condition.

Good

Is the service caring?

Our findings

People we spoke with were happy with the way staff provided care and support. One person told us, “The staff are really kind. I have a keyworker and I really like her”. A relative of a person who used the service said, “The staff members treat [my relative] as an individual. [My relative] is always well turned out and staff make sure her hair is in the modern style and nails are done”.

We observed that staff knew the people they were supporting and caring for well and had built good relationships with them. Staff mainly worked in the same bungalow which helped them get to know the needs and preferences of the people living there. In addition to staff having a detailed knowledge of the people they were caring for, care plans documented how people would express pain or anxiety and gave staff guidance on how to relieve this. For example one plan said, “If I am in pain my face is pale and I will not engage”. This information helped to ensure that those people who did not communicate with words had their needs met.

Staff were patient and kind and did not rush people. Staff took time to establish the wishes of people who could not communicate verbally. Staff used a mixture of Makaton (signing) and some basic communication techniques to find out if one person would like something to play with and gave the person time to respond.

Care plans contained information on people’s likes and dislikes as well as their personal histories and backgrounds. Things that were important in a person’s life were clearly identified. We noted that staff were aware of people’s preferences and their life histories before they came to Lombardy Park. Staff were seen to take a real interest in people’s lives and we observed them chatting to people at length about their families and hobbies. Staff were particularly aware of the needs of those people who did not have family members in their life.

People were able to discuss their care needs informally with their keyworker in their regular meetings as well as in a more formal way at their care plan review. It was clear that people had the opportunity to direct their own care if they were able and people told us that staff listened to them. Some people used an advocacy service to help them make their wishes known. One person spoke very positively about their advocate who visited them regularly.

Information was given to people in a suitable format, whether this was easy read, verbally, Makaton or photographs. We noted that in some bungalows there were pictorial menus displayed. People told us they helped choose the food and the photos helped to remind them. On one unit the photo did not match the meal that staff were preparing which meant people would not be informed about their next meal.

People were treated with respect and their dignity maintained. Staff asked people discretely if they needed support with their personal care and we saw that people’s private information was kept confidential. Staff did not discuss people’s private business in public areas. We saw that several staff had received training in equality, diversity and human rights and spoke positively about this.

People were encouraged to maintain and increase their independence. One relative of a person who used the service told us that their relative liked to help out with the cooking and felt that this had increased their self esteem.

Good

Is the service responsive?

Our findings

People who used the service, or their relatives, had been involved in developing their care plans. One person told us that they liked to make choices about their life. They said, "I like it here….I can have my TV and CD player on when I want. I don't go to church. I used to go but I don't want to anymore". A relative commented, "[My relative] goes out by [themselves] locally. [They] would not have done that years ago. [They] help out in the house, making sandwiches and things like that".

People's needs were assessed before they moved into the service and this initial assessment helped to formulate their care plan. Care plans documented people's choices and preferences and made clear what people's skills and abilities were as well as the things they needed help with. We noted that one plan documented that the person did not really like routines while for other people the opposite was the case. People had been asked about whether they wished to receive personal care from a staff member of the same gender and where they expressed a preference we saw that this had been recorded. Care plans were subject to on-going review and reflected any changes in people's needs promptly.

Plans contained detailed information to help care staff provide person centred care. For example one plan documented that the person' liked swimming but does not like most other physical activities'. Another plan outlined exactly what the person would do to indicate that they had had enough to eat. We spoke with staff about another person's care plan which stated that they liked to have regular foot spas. The person became excited when we mentioned the foot spa and it was clear to us how much they enjoyed it. We saw from records that they were often supported to enjoy the foot spa.

People told us about their hobbies and we saw that people were supported to attend social events and follow their interests both within the service and in the local community. One person was very enthusiastic about their interest in Wales and Welsh culture and language. We saw that there were notices up in Welsh in their room and staff chatted very knowledgably with them about their interest. Another person told us how they follow football and like to attend local games. People enjoyed cooking, music and sensory activities as well as the more usual interests of films and television. We noted that where the television was on this was the expressed choice of a person who lived in that bungalow – often a favourite film was on. On the day of our inspection several people had gone out to visit a museum and many people who used the service remarked on how regularly they are able to attend social events and activities away from Lombardy Park.

The service had a complaints policy and each person who used the service had been given information about how to make a complaint. It was clear that some people would need advocacy to make a complaint. A system was in place for logging issues that were not formal complaints. There was evidence that the service responded appropriately to informal concerns and issues raised by the people who used the service and their relatives were followed up and resolved.

The service had received five formal complaints in the last year. Each one had been promptly responded to in writing, investigated and, in all but one case, resolved to the satisfaction of the person making the complaint. Where the person making the complaint remained unhappy we saw that a thorough investigation had taken place and were satisfied that the manager had responded appropriately.

Good

Is the service well-led?

Our findings

People who used the service, their relatives and staff were given the opportunity to help develop the service. Surveys were given out to people who used the service and were facilitated by staff. We saw that the most recent surveys were broadly positive. The registered manager told us that they were working on a better format for these surveys in the hope of receiving more targeted information. Surveys also went out to families and we saw that some issues raised had been addressed by the provider. For example, following negative feedback about a change the provider had made to the staffing complement, a particular staffing role was reinstated.

Staff were offered the chance to provide feedback via staff meetings which were held regularly within the individual teams attached to each bungalow. Staff also had the chance to provide 360 degree feedback as part of the annual appraisal process. Staff told us that they found the registered manager approachable and were happy to raise any concerns with her or with their individual team managers. Information about whistle blowing was prominently displayed and staff told us they would be confident to do this were they to have any concerns about another staff member's care practice.

The culture of the service was based on a set of values based on inclusion and caring which aimed to improve the lives of people with learning disabilities. We found that staff demonstrated these values in the way they delivered care and support to people who used the service.

There was a clear management structure in place, with the registered manager being supported by team managers within each bungalow. Team managers were responsible for the day to day management of their bungalow and met regularly together and with the registered manager to ensure they had oversight of the issues throughout the service.

The registered manager understood their responsibilities and sent the statutory notifications that were required to be submitted to us for any incidents or changes that affected the service. We saw that where the local adult protection team had asked the manager to complete investigations into safeguarding concerns these had been carried out thoroughly and professionally. We saw that the manager had a range of actions they were putting in place to tackle the shortage of staff which they felt was the biggest threat to the service at this time.

The registered manager's line manager visited every quarter and carried out a quality assurance monitoring visit. In addition to this the registered manager carried out a monthly quality monitoring exercise in which she also sampled records across the service. The aim was for the registered manager to sample all the records during the course of a year. Some care plans were being rewritten and updated as part of this exercise. The findings of the quarterly monitoring and that carried out by the registered manager fed into a service improvement plan.

We found that record keeping at the service was mostly good and that records could be located promptly when we asked for them. Some records were duplicated with staff recording the same information in various places. This made the task of recording information more onerous for staff and increased the risk of information becoming confused. Records relating to staffing were not always clear and the manager is addressing this as a priority.

Staff competencies were checked with regard to moving and handling and the administration of medicines. This helped to ensure that best practice was followed in between formal training sessions. We saw records to confirm that these checks had taken place. We also saw that spot checks were carried out on night staff and any issues highlighted were dealt with promptly by the management of the service.