Care Quality Commission

Royal Mencap Society

Royal Mencap Society - Drummond Court

Inspection report

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Ratings

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

Overall summary

We carried out this inspection on 3 and 10 December 2014. This was an unannounced inspection.

The service provides accommodation and support for up to 36 people with learning disabilities, some of whom also have autistic spectrum disorder. At the time of our inspection 33 people were living at the service in several shared bungalows and flats on the same site.

A registered manager was in post. 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.

At our last inspection which was carried out on 22 July 2014 we found that regulations relating to people's care and welfare and to the service's ability to maintain accurate records had been breached. The provider

Summary of findings

supplied us with an action plan to show us how they would make improvements by 12 September 2014. At this inspection we continued to have concerns in these areas with relation to the healthcare needs of people with high care needs and record keeping related to people's healthcare

We found that medicines were not being managed safely and people were placed at risk of not receiving their medicines when they needed them. Medication audits were not effective and no learning had taken place to reduce the chance of further errors in administering medicines.

Although staff were trained in safeguarding people from abuse we found that the service had not always made the appropriate referrals to the local authority safeguarding team. Staffing levels in some parts of the service meant some people's needs were not always met promptly.

The service did not always operate in line with the Mental Capacity Act 2005 (MCA) and 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.

People with complex healthcare needs were not always supported to access healthcare appointments and receive ongoing healthcare support.

Staff were caring and treated people with dignity and respect. Staff received a comprehensive induction and training to carry out their role and received ongoing support.

People who used the service, or their relatives, were involved in the assessment and planning of their care. People were supported to be independent but those whose care needs were greatest did not always have the same social opportunities.

Quality monitoring was not always effective and had not highlighted some issues of poor practice which we found. The service had not made all the required improvements to record keeping which we identified at our last inspection.

At this inspection we found that there were breaches of six regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

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 safe.

Medicines were not managed safely for all people who used the service.

Staff were trained in safeguarding people from abuse but referrals to the appropriate authorities were not always made.

Risks to people were managed and reviewed but staffing levels in some parts of the service made it difficult to meet people's needs.

Inadequate

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

Some people had not been supported to have access to healthcare appointments.

The service did not always operate in line with the MCA and DoLS. Some people were being deprived of their liberty without this being sanctioned by applying to the local authority.

Induction and training of staff was in place, although some staff were supporting people with conditions, about which they had received little or no training.

Requires improvement

Is the service caring?
The service was caring.

Staff were caring and patient.

People's preferences were documented in their support plans and were respected.

People were treated with respect and their information kept private.

Good

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

People who were more independent were able to be involved in the assessment and planning of their care and they were supported to live their own lives.

Those people with higher care needs did not always have the same opportunities to direct their lives.

Requires improvement

Is the service well-led?
The service was not well led.

Poor record keeping meant some people did not have their care needs met.

Requires improvement

Summary of findings

Quality monitoring systems did not always identify issues of poor practice.

Royal Mencap Society - Drummond Court

Detailed findings

Background to this inspection

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

This inspection took place on 3 and 10 December 2014 and was unannounced. The inspection team consisted of two inspectors and a pharmacist.

Before we carried out our inspection we reviewed the information we held on 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 by law. 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 10 people who used the service and observed others who were not able to communicate with us. We also spoke with two relatives, 12 care staff, the registered manager and the regional manager. We reviewed 10 care plans, eight people's medication records, two staff recruitment files, training records, staffing rotas for the preceding six weeks and records relating to the maintenance of the service and equipment. Following our inspection we spoke with staff from the local authority adult social care team and contracts department.

During the inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

We found that some people, whose medicines were administered by staff, did not receive their medicines safely. We saw from the service's own records that in the last 11 months there had been 43 medication errors, including 23 missed doses, four incorrect doses and one occasion when the wrong medicine was given.

Systems for ordering people's medicines did not ensure that medicines were available at the service when people needed them. During our inspection one person required Paracetamol which had been prescribed for them to take for pain relief as and when they needed it (PRN) but there was none available. We also noted that another person had seen the GP the day before our inspection and been prescribed antibiotics for an infection. The antibiotics had still not been collected for this person and therefore there had been a delay in commencing this person's treatment.

Another person had been advised by the GP on 28 November 2014 to begin putting olive oil drops in their ears so that they could be syringed in one week's time. We saw that the drops had been collected and opened but there was no record of any drops being administered and some staff were unaware that this person had any ear drops. The person had received Paracetamol for ear pain on five occasions between 25 November and 1 December. They had still not had their ears syringed on 10 December 2014. A third person had not received their epilepsy medicine on 28 November due to insufficient stock.

We saw in one person's medication administration record that they had been prescribed an anxiety relieving medicine to be taken before specific personal care procedures and blood tests which distressed them. We noted that an influenza vaccination had been carried out on 4 October 2014 but they had not received this medicine beforehand. Staff described the person as being, "not too happy about it" and daily notes for that day described them as 'quite agitated'. In addition the care plan relating to how to give this person their medicine did not match how staff told us they actually administered it. This meant the person was not receiving their medicine as prescribed.

Arrangements for people who managed their own medicines were good and two people told us that they received the support they required to continue to do this independently. The service had risk assessments relating to this and these were regularly reviewed.

Stocktaking and auditing procedures of medication were not effective. Stocks of medicines were incorrectly recorded in seven cases which could have placed people at risk of receiving too much or not enough of their prescribed medicines.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Most people who used the service told us that they felt safe and would speak to a member of staff if they did not. One person said, "I would speak to staff". We saw from one person's daily notes that they had recently expressed that they felt bullied by staff and wanted to talk about it to someone. It was not clear what action had been taken in response to this. We saw that the person had been referred to an advocacy service a few days later but staff were not aware who had made this referral or why. There was no information about when the advocacy service might begin to work with this person and no investigation had taken place to establish why the person felt they were being bullied. There had been no referral to the Adult Protection Team.

Staff had received training in keeping people safe and reporting concerns about possible abuse. They were able to tell us about the signs and symptoms a person might display if they were being harmed. However not all staff were able to tell us when referrals should be made to the local Adult Protection Team.

We found that the manager did not always fulfil her responsibility to report safeguarding concerns to the commission or to the local safeguarding team. As part of the local authority's review of the service they told us that they had discovered some safeguarding issues which should have been notified to the commission as they related to a person being inappropriately restrained on more than one occasion. The high number of errors administering medicines had also not been referred to the local safeguarding team for investigation.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2010).

Inadequate

Is the service safe?

Staff employed at the service had been through a thorough recruitment process. Permanent and agency staff had Disclosure and Barring Service checks in place to establish if they had any criminal record which would exclude them from working in this setting. We looked at two staff recruitment files and found that all appropriate checks had taken place before people started work. There was a basic induction for agency staff to help them become familiar with the needs of the people who use the service and the general routines.

We were concerned that although staffing levels for those more independent people who used the service were acceptable, in some areas of the service there were not always enough staff. We found that staffing levels for people who had complex needs did not always keep them safe. We noted that there had only been one member of staff on duty in one bungalow the previous evening instead of two. The member of staff on duty had been an agency worker who had not worked an evening shift before and was not familiar with people's needs. The on call manager had not been alerted and the registered manager was not able to tell us why staff had not taken steps to address this issue. We saw that one person had not had a particular care need met which meant that there was a delay in them receiving some medical treatment they needed. Staff told us this may have been because the agency worker was not familiar with the person's needs and there was no permanent member of staff to help them.

We observed a person being left unsupervised for a period of 25 minutes and saw that they were continually falling asleep and hitting their head, near their eye, on a table that had been placed in front of them. They also kept trying to drink from an empty cup for 20 minutes before staff, who were assisting someone else during this time, noticed and brought them a drink. We noted across the site that healthcare appointments were sometimes missed and the reason given was noted as a lack of staffing to support people. Staff told us that social outings and access to the community was also difficult to arrange with the current staffing levels. This meant that people's needs for social interaction were not always met. The manager was not able to show us an analysis of people's needs which could be used to determine how many staff were needed to support people safely.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us that they were involved in risk assessments and were supported to take risks. Records confirmed this. One person had a risk assessment about using their bicycle to go and visit friends. They told us they knew how to keep themselves safe and said, "I need to wear a helmet". Risk assessments were regularly reviewed and we saw that the risk assessment process supported people to increase their independence. Where people did not have the capacity to be involved in risk assessment we saw that their families or legal representatives had been consulted.

We saw records which showed that the service was maintained and equipment such as the fire system and equipment to help people with their mobility were regularly checked and maintained.

Requires improvement

Is the service effective?

Our findings

When we last inspected the service on 22 July 2014 we found that there was a breach of Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010. This was because people with complex health needs were spending long periods of time without meaningful things to do, and opportunities for social outings were very limited. There had also been conflicting and incomplete information in support plans which meant that some staff were unclear about some people's needs. The registered manager sent us an action plan stating that support plans had been reviewed and that each person would have a daily activity planner.

At this inspection we saw that some improvements had been made in these areas. However we remain concerned about the opportunities for people with complex needs to be supported to have their healthcare needs met.

We found that several people with complex healthcare needs were not always supported to have appropriate access to healthcare services such as GPs and dentists. As documented previously in another part of this report we found that two people had not received prompt treatment for their health conditions. We also found that a further four people had not been supported to have regular and follow up appointments with the dentist. This resulted in one person ultimately requiring emergency dental treatment having been in a significant amount of pain for several days. Another person's record showed a six week gap between the first record of their healthcare condition and them being taken to see an appropriate medical professional. A lack of effective recording in all these cases had contributed to people's healthcare needs being overlooked by staff. Where a shortage of staff had been given as a reason for initial appointments being cancelled this was often further compounded by poor recording which meant new appointments were not scheduled.

One person with Diabetes was identified by a healthcare professional as needing their toenails cut as a matter of urgency. This was not arranged for a month. We found that another person, whose epileptic seizures had increased, had not attended an epilepsy clinic appointment on 2 November 2014 as the clinic had cancelled it. However staff had not been proactive about rearranging the appointment or chasing it up even though the person's condition had deteriorated in the meantime. A GP had requested an epilepsy review for this person on 2 December 2014 but no appointment for this had been made by the time we came to inspect the service on 10 December 2014.

One person's Diabetes was not being effectively managed. A support plan relating to their Diabetes referred to following advice from professionals but this advice was not present in their plan. The person had their blood glucose levels tested daily but we could not see from the records which medical professional had asked for this. The registered manager told us that the service was carrying this out as a matter of good practice. We also noted that records of daily blood glucose levels were kept in a variety of locations and a few were missing. It was not clear to staff what would constitute a high reading and what should happen in response to it. Staff gave us conflicting information about what a high reading would be. This placed the person at risk

This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager did not demonstrate a good understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) and had not made appropriate referrals . Some decisions, such as the decision to use a lap belt for one person, had been made in accordance with the MCA and DoLS. However we also found that others, such as the decision to carry out daily blood glucose level tests for one person with Diabetes, had not been made according to the MCA. The capacity of this person to agree to this daily invasive procedure had not been assessed.

In addition we found that several people had received an influenza vaccination without their capacity to consent to this being assessed. The MCA process had not been followed and the vaccination had not been identified as being in their best interests. We were aware that this was an issue which also concerned the local GP surgery but the management of the service had a responsibility to ensure that the rights of the people who used their service were protected. We asked one member of staff how they knew that a particular person had consented to receive an influenza vaccination and they told us that, "[They] always have it". This demonstrated to us that this member of staff did not have a clear understanding of the MCA process.

Requires improvement

Is the service effective?

One bungalow had an electronic keypad fitted to prevent people leaving the service. This was being used to keep them safe but the service had not made the necessary applications to the local authority which meant they were not acting in accordance with the Deprivation of Liberty Safeguards. The team leader in this bungalow told us that those people who were able to access the community independently could use the keypad but we observed some people ringing the bell and being let in and out by staff.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People who used the service were positive about how they were supported. One person told us, "I am quite happy living here. I can do mostly what I want. I do a lot of things on my own". A relative of a person who used the service told us how pleased they were with the way the staff cared for their relative. They said, "We can't fault [my relative's] care and I'd be the first one to say".

People's needs were assessed and preferences and choices were documented in their support plans. Care plans were very person centred and provided staff with some detailed information about how to meet people's needs. We observed staff providing care and support to people and it was clear that staff knew those they were supporting well. Staff told us they had noticed a change in one person's routines and behaviours recently which might be linked to a particular health condition. Although they were able to tell us about the changes this person was displaying there was as yet no change to their care plan related to how staff should help them to manage this. Staff had also received no training related to this health condition.

We found that staff had received training to carry out their roles but found that training in some key areas, such as diabetes, dementia, infection control and supporting people's nutrition, had not been provided for all staff. Care staff received a comprehensive induction and spent a period of time working with experienced staff in order to become familiar with people's needs. One member of staff said, "[The] training was good, with lots of practical stuff". Some staff had gone on to achieve further qualifications such as the NVQ or Diploma in Health and Social Care. Staff were also given regular supervision with their line manager and an annual appraisal system was in operation. Staff told us that they felt supported but several expressed a desire for some further training to help them carry out their roles more successfully.

This lack of training and understanding was clear in relation to how one person's Diabetes was being managed, although this was not the case for all people with Diabetes. We noted that care staff had not been provided with training in the management of Diabetes, even though several people across the site had this condition.

We found that people were supported to have a healthy diet and a variety of fresh food was available to them. We noted in the flats that there was a notice reminding people to help themselves to fruit to add to their breakfasts or make a smoothie. People were involved in meal planning, food shopping and care plans documented people's likes and dislikes and staff were aware of them. In one bungalow there was a pictorial menu on the kitchen wall to show people what the next meal would be. However we noted that the photographs there did not match what was being cooked and so did not enable people to understand what they were going to eat.

Some people had been identified as being at risk of not eating or drinking enough and we saw that relevant healthcare professionals, such as dieticians, had been involved to advise staff. We saw that only seven staff had received additional training in supporting people's needs with regard to their eating and drinking. We spoke with two staff about the steps they took to increase the calorie intake of one person who was significantly underweight. Staff demonstrated a good knowledge of nutrition but we did not see them proactively offering this person high calorie snacks between meals and there were hardly any snacks of this kind recorded in the person's daily food chart. It was also documented in this person's plan that they liked beef and we saw that they got very excited when we were discussing this but they had not had any in the last few weeks.

Good

Is the service caring?

Our findings

People who used the service, and their relatives, told us they were happy with the way staff provided care and support. We observed caring interactions between staff and the people they were supporting. Staff were able to tell us about people's life histories and knew what was important to them. Small details about things that make people feel happy and are important to them were noted in their support plans and staff were aware of them.

We saw that where people had expressed a wish to follow a particular religion this was noted in their support plan and they told us that they had the opportunity to go. One person told us that they used to go but now were happy just to listen to religious music and daily notes stated that they were supported to do this regularly. Another person told us that they had a lot of friends at the local church and were able to go regularly.

We spoke with one person who was hoping to move on to more independent living. We saw each staff member who interacted with them spent some time chatting this through with them as they needed reassurance about such a big step. We noted that they felt more relaxed after each of these conversations. Staff sometimes had the same conversation and gave the same reassurance several times to this person.

We saw that thought had been given to achieving consistent support for people and the same group of staff worked in each bungalow. People who were supported to live more independently also had consistent staffing and had been involved in choosing their staff. We observed one person who was not able to communicate with us verbally. It was clear that the member of staff supporting them knew them well and was able to quickly respond when they showed signs of distress and managed to distract them by talking about their family and forthcoming outings which calmed them.

An advocacy service was available for people if they needed one and we saw that the manager had recently referred one person to this service. There were posters promoting advocacy throughout the service and groups were being set up to promote people speaking up for themselves.

We observed staff speaking respectfully to the people they were supporting and, when offering them choices, we saw that they waited for their response without rushing them. It was clear from people's care plans that they had been asked what information it was important for staff to know in order to support and care for them successfully. We saw that plans included information about what made people happy, sad or upset. We noted one person's plan state that it was important to them that they had a shower each morning and we saw that they had had one that day.

We chatted with three people living more independently in the service and they had all contributed to their support plans and knew about them. One person said, "Yes I know all about that". They fetched their plan for us and described how staff supported them to be independent and to visit friends and family in the local area as well as to attend church. Another person told us how much they enjoyed their regular visits to the local cinema and we saw that this was clearly documented in their plan

Those residents who had capacity to understand their support plans knew where they were kept and were able to go and get them and go through them with us. We observed staff filling in people's daily records with them and asking them about their day. Staff took time to ensure people's information was kept private and treated people's information with respect. Staff also showed an awareness that people should be able to be as independent as they could. One staff member explained that some people they supported liked staff to keep their money when they go out shopping but prefer to actually hand the money over in the shops themselves. They explained that this helps to promote people's independence and dignity.

A number of relatives were visiting during our inspection and we saw that there were no restrictions on this. People told us that their relatives were able to visit them whenever they wanted. One person told us that it was very important to them that their relative visits them regularly and confirmed that this happened. Each person had their own room which they could use if they wanted to talk privately with their relative.

We noted that personal care was offered to people discretely in order to maintain their dignity. Staff showed an awareness of people's need for their own space and we saw in support plans and daily notes that thought had been given to some people's need for time on their own.

Requires improvement

Is the service responsive?

Our findings

We found that people who used the service, or their relatives, had been involved in the assessment and planning of their care and that plans were regularly reviewed. We saw that people had routinely signed their care plans or their relatives had if the person did not have capacity to sign for themselves. The registered manager told us that people who used the service met with their keyworker each month to set goals and decide what they wanted to do.

People's preferences were clear in the records and particular information about what was important for staff to know was captured. For example one person's plan stated, 'It is important there are spare batteries for my [communication device]'. We spoke with this person and we saw how important this device was for their independence and ability to make choices about their care. We asked staff where the stock of spare batteries was but they were not sure. This presented a risk of the person becoming distressed if they were unable to communicate in the way they wanted. This person was not able to shop independently.

We noted that a female staff team were supporting a group of male service users in one particular bungalow. Staff told us that they are aiming to recruit a male member of staff for this bungalow. We discussed this issue with one person who used the service and they did not express any concern but staff were aware that this might not be the case for all the others.

We saw that while people living more independently had plenty of opportunity for social activities, those with higher care needs had fewer opportunities to mix socially with other people or follow their own interests and hobbies. We asked staff in one bungalow when two people we had been speaking with had last been out socially in the evening or at a weekend but staff were not able to tell us and admitted that staffing levels in that particular bungalow made this difficult. Records showed that people spent most of their time in the service. We spoke to the registered manager about how they involved people with complex needs in their local community and they told us this was difficult and an area they wanted to improve.

We saw that there was a focus on increasing people's independence and people's goals for more independent living were widely known by staff and documented in people's support plans.. One person told us about their plan to get a job on a farm. Another person had a cleaning job and told us they were saving their wages to treat themselves. People were proud of their independence and their achievements.

Although some people were supported and encouraged to increase their independent living skills this did not apply to all of the people who needed a higher degree of support. We noted that some people were not supported to be take part in daily living tasks at the service and we did not see anybody using any specialist equipment to enable them to be involved.

We saw that, within each bungalow, decisions about communal living had been reached in house meetings. In one bungalow we observed people chatting to staff about arranging a meeting to discuss the possibility of getting some chickens and guinea pigs. Elsewhere in the service people were given the opportunity to share their views in house meetings and in one to one meetings with their keyworkers. One person told us that they might be going to be supported in a different way as some changes had been suggested. They told us, "I will have my own money and pay for my own things". The registered manager told us that an advocacy service would be working with any person who might wish to move on to a more independent way of living and meetings would take place with relatives or legal representatives before any decisions were taken.

The service had an accessible complaints procedure which some people were aware of. One person told us that they were not familiar with the complaints procedure, although there was a copy in their support plan, but said, "I have not got anything to complain about". All the people we spoke with told us they would tell the staff if they had a complaint. Although an advocacy service was used by the service it was not clear how those with more complex needs would be supported to a make a complaint.

We saw that the service had received three complaints since our last inspection and these had been investigated, recorded and responded to appropriately by the service. None of the complaints we saw related to the provision of care at the service. The last set of surveys asking for feedback from people who used the service, their relatives and healthcare professionals had been sent out in June

Requires improvement

Is the service responsive?

2014 and responses had been broadly positive. In addition regular newsletters informed people about the action that had been taken in response to feedback the service had been given.

Requires improvement

Is the service well-led?

Our findings

When we last inspected the service we found a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because records were duplicated and inconsistent which could have placed people at risk of receiving unsafe care. The service was required to take action to make improvements to the way record keeping supports the delivery of care.

At this inspection we found a very mixed picture with regard to recording and whilst there were clear improvements in some bungalows which led to consistent care being delivered to people, in others this was not the case. We found that care records relating to people's access to healthcare and healthcare appointments were poor in some cases and contributed to people not receiving the care they required promptly, if at all. Appointments for dentists and some hospital clinics were found stapled in the diary but no corresponding record was in the daily notes. Staff were not able to tell us if the person had missed the appointment or if they had attended and staff had not recorded the outcome. This meant that the person had either missed out on their appointment altogether or risked that staff were not aware of the latest information following attendance at a healthcare appointment.

In one bungalow we found that handover records between shifts were not effective. We saw that there had been no structured way of recording information to be handed over from one shift to another between 30 November and 8 December. Staff told us that information had been handed over verbally during this time as they had not had a handover book. We saw that it was during this time period that two people's health care needs had not been met because staff did not have the correct written information to refer to.

This was a continued breach of Regulation 20 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010.

Throughout our inspection we found that the service was providing support and care more successfully to those who were more able to be independent. We saw people were supported to increase their independence and to contribute to developing the service. This was not so evident for the people who required more care and were more dependent on staff. We did not see evidence of a management strategy in place to empower those with higher care needs to have a role in developing the service.

We found that the various bungalows often operated in isolation and opportunities for staff to share ideas and support each other were limited. Although team leaders in each individual bungalow and flats had an amount of autonomy about how their particular service was run one told us they would like to be able to arrange the training that they felt their team needed. We raised this with the regional manager who told us that the expectation was that they did have the authority to arrange this. However this was not understood by the staff we spoke with.

We did see, however, that each individual bungalow enabled people to be involved in daily decisions about the way the service was delivered. People were involved in planning their own care and regular meetings were held in each of the different bungalows and flats. One person told us that it had recently been decided that everyone should take a turn to cook dinner each week. The group in this particular setting had also decided on a colour scheme for a particular room which was to be decorated. Those who were more independent were involved in their local community and many played an active part. Again it was not easy to see how those with higher care needs were supported to take part in their local community, if they were happy to do this.

Mencap's values were known by staff and throughout the service we observed staff demonstrating the values of inclusiveness and caring. We saw that good and caring relationships between the staff and those they were supporting had developed from this value base.

The registered manager is required to submit formal notifications to the Care Quality Commission in certain circumstances. The service notified the commission appropriately in most cases, but we were not made aware of the fact that such a high number of medication errors had taken place since our last inspection and no referral to the local Adult Protection Team had taken place relating to this issue. We did not see evidence that learning had taken place following the large number of medication errors or following some of the safeguarding matters which had

Requires improvement

Is the service well-led?

been referred to the local authority. We saw from records that over the last year medication errors had not reduced significantly despite investigations taking place and some staff receiving additional training.

People who used the service knew the registered manager well and we saw the manager chatting with people throughout the service. The manager told us that people and staff were able to raise issues directly with her or through the feedback surveys which we viewed at our last inspection .Staff meetings were also held regularly within each individual setting which gave staff the chance to give feedback. The manager was not able to give us any examples of when this had happened and had led to a change being made to the way the service was run.

The registered manager, who has left the service since this inspection, told us that they met each week with the team leaders from each bungalow and the flats for an accountability meeting. Team leaders were asked to confirm that monitoring of their individual services had taken place via a series of audits, and the registered manager would review a sample of these audits. In practice we found that the sampling carried out was not sufficient for the manager to uncover the issues relating to medicines and healthcare appointments which we identified during our inspection. Ineffective monitoring of the service led to some people failing to receive care which met their needs. No action had been taken to analyse why some people had repeatedly missed appointments in order to prevent further repeats

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not protected from the risks of unsafe care because the provider did not deliver care which ensured their welfare and safety. Regulation 9 (1) (b) (ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The provider failed to safeguard people from abuse because they did not always respond appropriately to allegations of abuse. Regulation 11 (1) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not protected against the risks associated with the unsafe use of medicines because the provider did not have appropriate arrangements for the obtaining, recording and safe administration of medicines. Regulation 13.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The provider did not have suitable arrangements for obtaining, and acting in accordance with, the consent of the people who use the service. Regulation 18.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People who use services were not protected against the risk of unsafe or inappropriate care because accurate records in respect of their care and treatment were not maintained or could not be located promptly when required. Regulation 20 (1) (a) and (b) (i).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The provider did not safeguard the health, safety and welfare of people who used the service because there were not sufficient numbers of suitably qualified, skilled and experienced staff available at all times. Regulation 22