Royal Mencap Society

Taunton Deane Support Services

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Taunton Deane Support Services provides care and support to people with learning disabilities and autistic people who live in their own homes. The service supports people who live in Somerset, Bath and North East Somerset and Bristol. It is registered to provide personal care. At the time of the inspection the service was providing personal care to 21 people living in 9 separate settings. Some people lived in their own home; other people house shared. Where staff slept in to ensure people were safe overnight, they had a private space to do so in a spare bedroom.

In 'supported living' settings people's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

People's experience of using this service and what we found

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

The provider was not able to demonstrate how they were meeting all of the underpinning principles of Right support, Right care, Right culture.

Right Support
The quality of care and support people received across different settings was not consistent. In 2 settings, people had not always received the care they needed to live safe and happy lives. Staff did not always support people with their medicines in a safe and effective way and risks to people had not been fully considered and planned for.

Recruitment processes were safe, and the provider was taking active steps to recruit and retain staff. Some settings relied on high levels of temporary staff who did not always have the skills, experience or knowledge to meet people's needs and expectations.

Right Care
People were not always treated respectfully or with compassion. Staff did not always understand or respond to people's individual needs.

Staff had training on how to recognise and report abuse but had not always applied it. Staff had not protected people from poor care and abuse in 1 setting. The service was currently working with other agencies to do so.

People's care and support plans did not always accurately reflect their range of needs or risk and this had not promoted their wellbeing.

Right culture
The culture varied across the service. In 2 settings, people had not received high quality care and support. In 2 other settings we visited people felt engaged, listened to and were happy with their support.

People's quality of life was not enhanced by a culture of learning and improvement. Neither the provider nor the registered manager had effective oversight of practice in all people's care settings. This had led to people receiving poor or unsafe care.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 25 January 2019).

Why we inspected
We received concerns in relation to safeguarding, the safety of people's care and the management and oversight of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed to requires improvement following this inspection.

Enforcement
We have identified breaches in relation to protecting people from abuse, providing safe care, care planning and governance and oversight of the service. We have also made 1 recommendation in respect of medicine administration practice.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Taunton Deane Support Services

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was carried out by 2 inspectors and 1 Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service provides care and support to people living in 'supported living' settings, their own homes and flats, so that they can live as independently as possible. In 'supported living' settings, people's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure people had

the opportunity to agree to us visiting them and that the registered manager would be available to support the inspection.

Inspection activity started on 14 February 2023 and ended on 15 March 2023.

What we did before the inspection
We reviewed all the information we held about the service, including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We sought feedback from 2 local authorities who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

During the inspection
We visited 4 settings (where a total of 9 people who received personal care lived). We met all 9 people who received personal care and spoke with 8 of them about the care they received. The Expert by Experience spoke with 8 relatives on the phone. We met with the registered manager, the area operations manager, 3 service managers, 1 assistant manager and 5 care staff. We looked at records related to the care and support of 6 people.

After the inspection
We continued to seek clarification from the provider to validate evidence found. The registered manager, area operations manager and service managers sent us records relating to the management of the service including investigation reports, complaints and compliments, accidents and incident records, quality audits, service improvement plans, staff meeting minutes and staff training records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection we have rated this key question requires improvement.

This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
• One person told us how they had not been kept safe and the effect it had on them. Although they were happier now, they said, "I did have a very bad time a while ago but those people [meaning certain staff] have all gone now. I certainly wouldn't call them people [because of how they treated me]. All the staff I have now are excellent."
• Staff had training on how to recognise and report abuse. However, in 1 setting training completion had been poor and any training which had been completed had not been put into practice. Staff who had concerns had not always raised them or, if they had and felt no action was taken, had not escalated them or used whistle blowing procedures.
• There was one current safeguarding investigation ongoing when we inspected the service. The serious concerns leading to the investigation had been raised by another care provider's staff team, not by the provider's own staff. One allegation had been substantiated. Other allegations were concluded at staff disciplinary hearings as there were "sufficient concern that these be heard in a formal disciplinary process."
• Staff told us each setting was now a safe place to live and work in. No staff raised any current concerns about people's safety with us, but some staff spoke with us about recent events which had affected people's safety in 1 setting. One staff member said, "The atmosphere here has changed completely since [the incidents were investigated] and those staff have gone. They were very controlling; it was a very strange atmosphere. The way they treated [name] was horrible. They used to shout at [name] as well. It is now a really happy, welcoming place. Even people living here have said they know things will get much better now [so it must have had an effect on all of them]."

The provider had failed to protect people from abuse and improper treatment. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People, who could express a view, said they currently felt safe. One person said, "Everything is really good here." Relatives were confident about people being protected from abuse or mistreatment; they told us staff helped keep people safe. One relative said, "Oh yes, he is safe definitely. He's happy. Staff are very attentive and the property is secure."
• The service worked with other agencies, such as the local authority safeguarding team, when issues arose.

Assessing risk, safety monitoring and management
• Three relatives had some concerns about risks to people. These had been or were being discussed with the

relevant service managers to try to resolve the issues. One relative said, "[One service manager] is pushing to have 24 hours support as [name] is vulnerable at night; she fell. We had an online meeting with stakeholders from the NHS regarding learning for the future." Another relative told us, "[Name's] not safe with his eating [due to significant weight gain]. I'm not happy with it at the moment and I need to get things sorted out." The person this affected told us, "I am needing to lose weight as I have put on a lot of weight since living here. I am on a healthy eating plan now."

• There were 2 recent serious incidents in 2 settings where people had choked. Both had come to significant harm. Both people were known to be at risk of choking and had eating and drinking plans in place designed to enable them to eat and drink safely. The provider was investigating both incidents; one investigation had recently been completed. This had raised 6 learning points for staff to try to improve care in this area and prevent this type of event happening again. It was not clear if/how this learning had been shared with staff. The second investigation was still in progress.

• Risks to people and to staff should be assessed and reviewed regularly and plans put in place to reduce or eliminate risks where possible. This was not being done consistently. For example, staff were transcribing eating and drinking plans written by speech and language therapists into people's care plans. We found staff had omitted key information for 1 person whilst doing this. For another person, the most recent eating and drinking plan had not been shared with staff. This was in computer records which staff had no access to. One person had choked on a tablet. A speech and language therapist had therefore recommended liquid medicines, but this person still had 6 medicines in tablet form. It was not clear why this recommendation had not been acted upon. This placed these people at increased risk of choking.

• Risks to people's health were not consistently considered and planned for. For example, one person had been admitted to hospital due to recurring infections. This increased risk had not been reflected in the person's care plan. Another person was at risk of losing weight. They had gained weight and their risk assessment said staff were only to be concerned if their weight fell below a certain level. However, this person was not being weighed so this plan was ineffective.

• Both local authority quality teams had raised concerns in their reports about the poor quality of risk management by the provider. These concerns included risk assessments not completed for all areas of risk, a lack of detail in risk assessments which were in place and a lack of evidence staff had read and understood them.

Learning lessons when things go wrong

• People did not always receive safe care because learning from accidents, incidents or 'near misses' was inconsistent or ineffective. Staff reported incidents and the organisation collated details of incidents at a senior level, but it was not clear if or how any lessons learned were fed back to staff working on shift supporting people.

• We found settings where staff teams did not have regular team meetings, so key information was therefore not shared with staff as a group. Also, in some settings staff supervisions (a staff 1:1 meeting with their line manager) were also not taking place so information could not be shared individually. There were no other formal methods of sharing any learning which staff could describe to us or they were aware of.

• Both local authority quality teams raised concerns with us about learning from accidents, incidents or 'near misses'. Neither felt there were any effective systems in place to share learning with staff or across services more widely. They had raised this concern with the provider.

• Relatives had mixed views about this issue. Relatives who were very involved in their family member's care did have confidence. One told us, "Incidents we would be very much on top of, as we're hands-on, and we do reports and are as aware as much as we can be." Relatives less involved were less confident. Comments included: "They don't say anything regarding incidents. [Name] had [an injury] and I still don't know what happened. [Name] wouldn't tell me, and they [staff] fobbed it off" and "Incidents, I'm not sure about [them]. No one tells you anything. I hope they'd ring if there was an incident, but I'm not 100% sure they would. There's a 'suspicion' sometimes if you ask anything."

The provider had failed to provide people with safe care. This was a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Environmental risks to people were minimised because risk assessments had been carried out, to help to keep people and staff safe in each setting.

Using medicines safely
• People were supported by staff to take their medicines. When people had medicines 'as and when required', protocols were not always in place to guide staff when it would be appropriate to give a dose. This meant people may not always have the right medicines at the right time.
• People were not always supported by staff who followed systems to record medicines accurately. For example, we found gaps on people's medicine records in 1 setting we visited. These had not been investigated by staff. It was therefore not possible to confirm if people had their medicines as prescribed.
• Staff should receive training in how to give medicines safely and have their competence checked. We found in 2 services relevant staff training had not been carried out in line with the provider's policy. This meant that some staff had been administering medicines without either up to date training or a competency check being carried out. This had placed people at risk. The provider's current action plans showed medicines training and staff competency checks had been a priority area for improvement during the last 3 months.
• Relatives told us their family members were supported by care staff with the medicines they needed. Most relatives thought support was satisfactory; some relatives were much more involved than others. A relative said, "I have full oversight of [name's] medication and I'm in touch with the doctor." One relative did have some concerns. They told us, "I suspect [1 medicine] is too high a dose. I phoned this morning to discuss this with his doctor. Do they [staff] know what they're giving the tablets for? How would agency staff know? These are the questions I've got."
• The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured that people's medicines were reviewed by prescribers in line with these principles.

We recommend the provider carries out a thorough medicines audit for each person supported with medicines. This should include reference to nationally recognised best practice guidance.

Staffing and recruitment
• Staff recruitment processes promoted safety, including checks to ensure staff were suitable to work with vulnerable people. The recruitment processes involved people wherever possible. One person told us, "I helped with the staff interviews. I enjoyed it, it was fine no problem at all."
• The service had experienced the national care sector challenges in both recruiting and retaining care staff. Recruitment was ongoing. Relatives generally had confidence in the provider's own staff. People told us they liked the staff who supported them. One person said, "The staff are great, all of them." One relative told us, "The main staff I'm really pleased with….who are all Mencap staff."
• Relatives did comment about the use of agency staff which had caused them some concern. Comments included: "I'd like to say the shortage of staff who really know [name] is worrying" and "The only time I sense a bump [staff not providing the right care] is with the temporary staff or agency, but it's hard to tell how often they're coming."

Preventing and controlling infection
• There were systems to help prevent and control infection. These included policies, procedures and training for staff.
• People told us staff wore personal protective equipment (PPE) such as gloves and masks when necessary,

and had good hygiene practices, such as hand washing.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection we have rated this key question inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements. Continuous learning and improving care.

• The quality assurance systems in place were not effective. They did not identify issues within services, reduction in the quality of services, poor practice or any other areas of concern. This led to a reactive quality assurance process rather than a proactive system.

• Where individual services were well managed by service managers, the lack of any effective provider or registered manager oversight was compensated by the competence of the individual service manager. Where services were poorly managed and provided poor or unsafe care they had not been identified by the provider. This meant people had not been protected from abuse, poor care or harm.

• The registered manager told us their quality assurance systems were "very thorough". This was not borne out by the evidence at this inspection, discussions with local authority quality assurance teams and particularly in the poor outcomes people had experienced. Service managers completed their own audit on services they were responsible for. The registered manager told us, "On a monthly basis [service manager's reports] are rolled-up into a report that is provided to each area manager and regional manager. The reports summarise compliance against all the measures on the [report] and enables operational managers to drill-down into areas of low-compliance. This process was not effective. We were not assured these were checked for accuracy or if any evidence was ever requested to determine if each audit accurately reflected the service.

• This lack of registered manager and provider oversight had resulted in two settings (accommodating 7 people who received personal care) becoming poor services over a significant period of time. There had been serious incidents in both settings which had adversely affected people. These were now under formal quality assurance processes instigated by two separate local authorities. One staff member said, "I'm not sure what [Mencap staff who visited the service] looked at because most things we should have been doing were not being done. This has been going on for ages."

•The provider did not have clear and effective processes in place to ensure learning was shared across services or within staff teams. Information was collated within the organisation but there was no learning shared at staff level so incidents could recur.

• The PIR stated, "We regularly review with staff the core values via performance observations, training as well as 1:1 meetings" and "Staff are also encouraged to report negative behaviours so we can continually maintain positive staff culture which is for the best interests of the people we support. Managers discuss at staff meetings and at supervisions to ensure all staff understand." We found that in 2 services staff training

completion rates had been very low and regular 1:1 meetings or performance observations had not been taking place for some time. One staff member said, "I have worked here for over 3 years and I have only had 3 supervisions in all of that time. I have never had an observation and there are no real discussions here." Their personal records confirmed what they had told us.
• Staff had mixed views about the quality of the service they worked in and whether they felt valued and supported by their managers. Comments included: "When I first came here I couldn't believe it was a Mencap service. I was shocked at how bad it was", "There was very little opportunity to discuss issues here [as there were no regular team meetings or supervisions] and anyway, you wouldn't really bother as nothing you took to the manager ever went anywhere. So, you lose all trust in them [managers and those above them]" and "Overall it's quite good here. We are now having more regular meetings which is a good thing. Things are improving slowly."

The provider had failed to ensure effective governance and oversight of the service. This was a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support.
• People did not receive consistently high quality care and support. People's care plans and risk assessments did not always reflect the care being delivered or the risks people faced. There were errors and omissions found in eating and drinking plans, medicine plans, in risk assessments and behaviour support plans.
• Some care plans were not dated so it was not possible to determine when they were written or when they were last reviewed.
• Two local authority quality teams shared significant concerns with us about the quality and accuracy of care plans and risk assessments in use in 2 settings. They had both asked for significant improvements to be made.

The provider had failed to develop a clear and up to date care plan for each person. This was a breach of Regulation 9 (Person-centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
• The service worked in partnership with a number of different health and social care professionals including local authorities and various healthcare services. Two local authority quality teams shared significant concerns with us about people's care in 2 settings; these related to the care and support 7 people received. We visited both settings during this inspection.
• Both had been visited at least twice by staff from these teams. They identified numerous improvements needed to be made so people were safe, received the care they needed and were supported by the right number of staff who had been trained.
• Areas of concern raised by these teams included, poor service management, lack of 1:1 staffing, lack of meaningful activities for people, poor care plans, risk assessments and daily records, low staff morale, lack of staff training and supervision, poor staff practice, poor channels of communication for staff and poor medicine management.
• Both quality teams followed up their initial visits with numerous recommendations. Staff from both teams told us when they carried out their next follow up visit things had not improved. They have therefore visited again and both services are starting to improve, but there is much to be done. We have continued to work closely with both local authority quality teams before, during and following our inspection visits to ensure services are supported to improve and that improvements are monitored and sustained.
Engaging and involving people using the service, the public and staff
• People had mixed views about their involvement in their service. People said they spoke with staff or

people gave feedback in ways that were meaningful to them about the service they received. Comments included, "I have no problems. If there's anything I need I just go down and ask the staff", "I quite like living here. If I have any problems I talk to staff. I get on with most people here, not everyone though so it's just ok" and "I really want to move. I have asked before to move but nothing has come of it." We did follow this up and this was correct. No one had pursued this for the person and now the process had to be started again.
• Relatives told us communication and engagement with them was mixed. Most thought it could be improved; some thought it was poor. One relative said, "Feedback? We don't normally do forms, but we are constantly in contact. We've got access to the manager." Other comments included: "Feedback? No one has ever asked me about [name's service]", "There's no feedback, not that I can remember. If something went wrong, I'm not convinced I've been told about it unless the authorities were involved" and "Feedback has fallen by the wayside."
• Staff told us their opinions had not always been listened to or valued, but things were improving. One staff member said, "The atmosphere is good now, improving. We had a team meeting last week, these are regular now. They are helpful." Another staff member told us, "Things are changing slowly. You can talk about things and things then happen. They are followed up; nothing used to happen before."
• Staff were aware of the importance of working alongside other agencies to meet people's needs and liaised with other healthcare professionals such as the GP, speech and language therapist, and pharmacy when required.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager understood their responsibilities to be open, honest and apologise if things went wrong.
● The management teams in each setting had made sure we received notifications about all important events so we could check appropriate action had been taken.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to develop a clear and up to date care plan for each person. This was a breach of Regulation 9 (Person-centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to provide people with safe care. This was a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to protect people from abuse and improper treatment.

This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.