Nottingham Mencap

Nottingham Mencap Short Breaks Service

Inspection report

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Date of inspection visit:
20 October 2020
02 November 2020

Date of publication:
20 November 2020

Ratings

Overall rating for this service	Inspected but not rated

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

Summary of findings

Overall summary

About the service
Nottingham Mencap Short Break Services is a domiciliary home care service providing care to children and adults with personal care needs. The children and adults they care for have a learning disability and/or communication needs. They care for children and adults for an agreed time period within their own homes and out in the community. The service provides short breaks from caring responsibilities for relatives and carers. They were providing a service to three people at the time of the inspection.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care within their own home. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, 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 providing support to people with a learning disability and/or autistic people.

The service was able to demonstrate how they were meeting some of the underpinning principles of right support, right care, right culture. People were supported to make their own decisions where able maximising their independence. People received care that promoted their dignity, was person-centred and respected their human rights. The ethos and values of the provider and the behaviour of care staff and management resulted in people leading confident and inclusive lives.

People's experience of using this service and what we found
The risks to people's safety were assessed and recorded. However, we did find that some risks such as how to evacuate a person in case of a fire were not individualised to that person's needs. Guidance was in place for staff to support people that presented behaviours that may challenge; however, formal training had not been provided for staff.

We have made a recommendation about this in the full report.

People were protected from the risk of abuse. Separate safeguarding polices were in place for children and adults and staff had completed safeguarding training for both. We did note the policies did not include the external reporting process to other authorities should a reportable incident arise. A process was in place to ensure accidents and incidents were investigated and reported. There was not currently a process in place to ensure the CQC were notified of reportable incidents. The provider is acting to address this. Records showed there were not currently any incidents to report.

Improvements were needed in some aspects of the overall governance of this service. The complaints policy and whistleblowing procedures did not include guidance for how to report concerns externally. The

registered manager and nominated individual had limited knowledge of CQC regulations and processes and were not fully aware of the requirements to report notifiable incidents to the CQC. They both have assured us they will improve their knowledge and understanding of these processes in order to ensure people continued to receive safe care.

We have made a recommendation about this in the full report.

Robust infection control procedures were in place. This included how to reduce the risk of the spread of COVID-19. People did not currently require assistance with their medicines.

People, relatives and staff spoke highly of the registered manager. They praised their caring approach and felt confident they or their relatives received the highest possible quality of care. This view was reflected during the inspection. Both the registered manager and the nominated individual spoke with passion about improving the lives of the people they and their staff cared for.

People and staff felt well supported during the height of the COVID-19 pandemic. Staff wellbeing was actively supported and monitored. All felt able to discuss any issues with the registered manager and were confident they would be acted on.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
This is the first inspection of this service since 25 July 2013. The service ceased providing the regulated activity of personal care following this inspection and therefore was not inspected. We were informed by the provider in October 2019 that they had recommenced providing the regulated activity of personal care.

Why we inspected
We inspected this service due to the provider recommencing the provision of the regulated activity of personal care. We have found evidence that the provider needs to make improvements. Please see the 'Is the service Safe?' and 'Is the service Well-led?' sections of this full report. We found no evidence during this inspection that people were at risk of harm from these concerns.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

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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 Care Act 2014.

Inspection team
The inspection was carried out by one inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service did not have a manager registered with the Care Quality Commission; however, an application to become registered has been received. We will monitor the progress of this application.

Notice of inspection
We gave the provider 48 hours' notice of the inspection. This was because we wanted to ensure the provider could provide a safe environment for their staff and our inspector to work whilst adhering to COVID-19 safety precautions and guidelines.

Inspection activity started on 20 October 2020 and ended on 2 November 2020. We visited the office location on 20 October 2020.

What we did before the inspection
We reviewed information we had received about the service since registration. We sought feedback from the

local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

On this occasion, we had not asked the provider to send us a provider Information return (PIR). A PIR is a form that asks the provider to give some key information about the service. This includes what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt was relevant.

During the inspection
We spoke with one person who used the service and two relatives. We spoke with two members of the care staff, the registered manager, the chief executive officer and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included three people's care records, risk assessments and other records relevant to the care they received.

After the inspection
We asked the registered manager to provide us with a variety of policies and procedures and additional information after the inspection. All information was sent within the required timeframe. We used all this information to help form our judgements detailed within this report.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection of this service since 25 July 2013. The service ceased providing the regulated activity of personal care following this inspection. We were informed by the provider in October 2019 that they had recommenced providing the regulated activity of personal care.

During this inspection we found some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
•People's care needs were assessed and recorded within their care records. However, the recorded risk assessments were not always comprehensive enough to advise staff how to support a person to reduce the risk to their safety.
•We noted plans to evacuate people from their homes in case of a fire were not individualised and did not consider their ability to understand the danger. The three people who received support with personal care had varying communication needs and learning disabilities. This was not considered when the fire evacuation plans were put in place. This could place people at risk of harm.
•Care records stated that all three people had 'learning difficulties'. There was guidance in place for staff to follow to help them to communicate with people for day to day decisions, such as meal choices and clothing. We also noted there was guidance for staff to follow should the person present behaviours that may challenge.
•However, training records stated that staff had not received formal training to assist them with safely managing these situations This could place people's safety at risk.
•We had no current concerns that people were at immediate risk of harm. Staff were knowledgeable about people's needs and feedback from the relative and person we spoke with was positive.

We recommend the provider carries out a review of the risks associated with people's care and updates relevant care records and risk assessments where needed. We also recommend specific training is provided for all staff where they provide care for people who may present behaviours that may challenge.

Systems and processes to safeguard people from the risk of abuse
•People were protected from the risk of harm or abuse.
•People felt safe when staff provided care for them within their homes. A person said, "The staff help me stay safe which I like. Everything they do makes me feel safe."
•The provider had the policies and processes in place to act on any concerns raised about people's safety. However, we did note that the policies did not include reference to ensuring the CQC were notified of concerns. This could mean the CQC would not be made aware of issues that could be affecting people's safety. The manager told us they would address this.
•Staff spoken with felt confident raising any concerns about people's safety with the manager and were assured they would act on those concerns.

Learning lessons when things go wrong
•The provider had processes in place to record when an accident or incident had occurred. Records showed there had been no accidents or incidents.
•The form used to record incidents if they did occur was detailed. However, it did lack space for the manager to record whether a recommendation they had made had been effective in reducing the risk of recurrence. It also included a reminder to report incidents to the Health and Safety Executive. However, it did not include a reminder to inform the CQC of a notifiable incident. The registered manager told us they would amend the form to include these areas.

Staffing and recruitment
•There were enough suitably experienced and qualified staff in place to keep people safe.
•People had a small, consistent team of staff providing care for them. A relative said, "[Name's] carer always arrives on time and does the hours set."
•The manager told us they ensured that the right staff member(s) with the appropriate set of skills was assigned to each person. This helped people receive suitable, consistent and safe care.
•Staff were recruited safely. Appropriate checks of their suitability to work were completed prior to them commencing care for people. This helped to keep people safe.

Using medicines safely
•Staff currently provide no support with people's medicines. This is because people either manage their own medicines or have support from family members to do so.
•A medication policy was in place to ensure if needed, people could receive safe support with their medicines.

Preventing and controlling infection
•The provider has robust infection control procedures in place.
•Staff were aware of how to reduce the risk of the spread of infection.
•Infection control policies and procedures had been adapted to address COVID-19 concerns. The manager was providing care in accordance with government guidelines and ensured they implemented any changes quickly. This helped to reduce the risk of the spread of infection within the provider's office and people's homes.

Requires Improvement

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.

This is the first inspection of this service since 25 July 2013. The service ceased providing the regulated activity of personal care following this inspection. We were informed by the provider in October 2019 that they had recommenced providing the regulated activity of personal care.

During this inspection we found some concerns with the way the service was managed. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.
•The nominated individual and manager did not always have a thorough understanding of the regulatory requirements of their role.
•Knowledge of the requirement to report incidents to the CQC was limited. Although records showed that no incidents had occurred that required reporting. Neither the nominated individual nor the manager, had a thorough enough understanding of how to report an incident to the CQC.
•The manager and nominated individual acknowledged that a more detailed and thorough understanding of the regulatory requirements of their role was needed to ensure people continued to receive safe care. It was noted that only three of over 100 people received the regulated activity of personal care and represented a very small part of the overall service provided.
•As reported in the 'Safe' section of this report there were some gaps in the assessment of the risks to people's safety. The provider stated they would ensure that quality assurance processes and governance were amended to include reviews of all risks associated with people's care.
•Staff had a good understanding of their role and how they contributed to people receiving safe care. Staff spoken with praised the approach of the manager and they found her to be supportive.

How the provider understands and acts on duty of candour responsibility which is their legal responsibility to be open and honest with people when something goes wrong
•The provider had the processes in place that ensured if mistakes occurred, they investigated them fully and apologised to the people affected.
•We did note the provider's complaint policy did not contain details of The Local Government and Social Care Ombudsman whom people could refer their complaint if they were not satisfied with the outcome/response to a formal complaint. The manager told us they would amend this.
•The provider had a Whistleblowing policy in place. This informed staff how they should report concerns about the conduct of other staff members. We noted the policy only referred to internal reporting procedures and did not include how staff could report concerns to other agencies such as the Local Authority, CQC or Police. The manager told us they would amend this policy to reflect external reporting procedures.

We recommend the provider reviews all policies and procedures to ensure they contain all required information to support staff with protecting people from harm and respecting their rights. We also recommend the provider ensures all staff are fully aware of the regulatory requirements of their role.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people and continuous learning and improving care.
•People received person-centred care that helped them receive positive outcomes.
•A person who used the service told us they liked the staff who supported them, and they made them feel good about themselves. They also said, "They remind me to have a shower and to do my teeth. I can forget sometimes. It's important to look nice."
•The manager held regular meetings with staff to ensure they were informed about any concerns or changes to their role which could affect people's quality of care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
•People, relatives and staff were engaged in a variety of different formats to gain their views of the care provided. This included regular phone calls during the COVID-19 pandemic to check they were safe and well. A relative told us they welcomed this phone call and felt the manager really cared for their and their family member's safety.
•We noted feedback from people and their relatives was recorded and used to drive improvement. Numerous positive comments had been received about the quality of care people had received. This included providing care in a way that protected people's equality characteristics. Staff had completed equality and diversity training to support them in their roles.

Working in partnership with others
•The provider worked with other organisations to improve care outcomes.
•Staff worked in partnership with other health and social care agencies to provide care and support for all.