Royal Mencap Society

Royal Mencap Society - Fryers Walk

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place over two separate dates. The first date on 18 January was unannounced but we arranged with the provider to come back on a second day to inspect the second part of their service. This took place on 30 January 2018. The provider is registered for both residential care and supported living, which comes under the umbrella of two regulated activities but under one location. The last inspection to this location was 19 December 2016 and 05 January 2017. At this inspection the service was rated as requires improvement in 3 out of the 5 key questions we inspect against. We identified one regulatory breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was for regulation 17- Good governance
Following the last inspection we asked the provider to complete an action plan to show what they would do and by when to improve the service in relation to the improvements and identified breach of regulation. This was provided when requested.

Fryers Walk provided two separate services. It was registered as a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. There were fifteen people living in three bungalows called Poppy, Daisy and Foxglove. All bungalows were staffed separately around people's individually assessed needs. In addition to the bungalows, there were offices on site for staff to use.

Fryers walk also provided care and support to fourteen people living in supported living settings, so that they can live in their own home as independently as possible. 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. At the time of the inspection, they were supporting eleven people with personal care. Some people lived by themselves and some lived with others who may or may not receive a regulated care service. The accommodation was owned and managed by a housing association.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. Registering the Right Support CQC policy.

The service had a registered manager at the time of our inspection. 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.

However, the registered manager was in the process of leaving to take over the responsibility of another Mencap service. The service had appointed new managers who were not yet registered with CQC. They were

sufficiently experienced and working alongside the existing registered manager. They were going to oversee the residential service with one manager overseeing two residential bungalows and the other manager the third bungalow. There was also a deputy manager for the residential service but they were off sick at the time of this inspection. In addition to the residential managers, another manager was employed and had applied for registration for the supported living service and had a date with the CQC for their interview. An experienced deputy manager supported them. The managers were well supported by the regional manager who was at the service each week.

The service was mostly well led and improvements had been made since the last inspection. The service was in the process of registering new managers with CQC. The managers had received a good induction into their role. We found that the services were managed separately and there was not clear communication across each site. We found some parts of the service ran more effectively than others and this made it difficult to assess if everyone using the service were getting good outcomes. For example, some people had regular opportunities to go out, others less so. Some people's records clearly demonstrated people's wishes and aspirations, other people's records did not. Some people living independently did not have sufficient opportunities to influence the service they received such as what staff would support them with and having access to their own medication and bank account.

However, we found overall the service was working hard to support its staff and were quick to identify any concerns about staff practice and ensure staff were supported to improve. Staff spoke with were motivated and passionate about what they did. The use of agency staff did not detract away from the level of service provided and agency staff sometimes took permanent contracts.

Risks were mitigated as far as possible and there were appropriate quality assurance systems, which took into account people's experiences and learnt lessons from incidents, accidents and any potential risk. Records were not always complete showing actions taken and this was an area for improvement

Staffing levels were adequate and vacant posts were being recruited into. The service had robust recruitment processes in place to ensure they recruited the right staff. There were good processes in place to support existing staff and help improve staff retention. The use of agency staff was kept to a minimum but still necessary to ensure the service was not understaffed.

Risks to people's safety were mitigated as far as possible and records recorded the actions staff should take to keep people safe. Regular health and safety checks helped to ensure the environments were free from risk as far as possible. We looked at people's environments in relation to the residential service but our regulations do not require us to do this in the supported living service. However, individual risk assessments were in place for both and covered peoples individual's behaviours and needs and their environments. Accommodation was suitable for people's individual needs and was on one level with appropriate equipment to support people's manual handling needs and sensory needs.

Staff knew how to and felt confident that they could recognise abuse and knew what actions to take to report it. The records in the service were inconsistent with regards to safeguarding concerns and incidents. For example, records we had asked for had been archived and there was not clear documentary evidence of actions taken. However, the provider was able to provide this information and has changed their practice to ensure information is more clearly documented in future.

Staff were trained to administer medication and there were clear protocols around this. Any errors had been identified and acted upon because there was robust auditing and staff were supported to improve their practice. However, in the supported living service audits did not help us to identify which medication

records had been looked at and we thought it would be clearer to carry out separate audits for each dwelling.

The service supported its staff to develop their professionalism and work in line with best practice. Staff new to the service completed a recognised foundation course and mandatory training suitable to their role. Staff were well supported and their performance monitored to help ensure high standards were maintained.

People were supported to eat and drink enough for their needs. There had been some improvements in this area after a number of concerns were identified. Staff had received training in nutrition and the service had established better links with the dietician and speech and language team.

Links with health care professionals were well established for the benefit of people and to ensure their needs were met as holistically as possible.

Staff understood and effectively applied the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards as applicable depending on the type of support they provided. People can be deprived of their liberty if lawful and only after approvals from the Local Authority. However, this only applies to residential care and not supported living services. People were involved in decisions about their care so their human and legal rights upheld. People had maximum choice and control of their lives and staff assisted them in the least restrictive way possible.

Staff were caring. They supported people according to their needs and wishes and where possible promoted people's independence.

People were supported to achieve their goals although it was not clear from each person's record if these had been identified.

People were consulted about their care needs and communication plans told us how staff communicated with people and took into account any sensory needs they might have.

The service was responsive and people's support plans were detailed. However, more work was needed to be done to ensure people's records showed what progress people were making towards an agreed goal or wishes.

There was an established complaints procedure and the service took account of any feedback it received about the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were enough staff to provide safe, effective care. Individual reviews were taking place to establish if people's needs had changed and how unmet need was going to be met.

Medication practices were robust. Staff were trained to give medication and there were adequate systems in place to monitor staff practice and audit medication to ensure it was given safely.

The service was free from obvious hazards and where possible risks were mitigated.

Staff were trained to recognise and respond to any concerns or potential abuse and knew who to contact.

Staff were encouraged to reflect on practice and mistakes were managed in a proactive way so lessons were learnt.

Is the service effective?

Good

The service was effective.

Staff were supported to extend their knowledge and ensure they were kept up to date with best practice.

Staff received a good induction and ongoing support to ensure they were well supported and continued to demonstrate they had the knowledge and skills they required to meet people's needs safely.

Staff supported people to eat and drink enough sufficient to their needs where this support was required. There was adequate monitoring of this but the management oversight of this varied so not all records were as robust as they should be.

Staff supported people to make their own decisions and choices. When they were unable to do this staff involved others to help ensure decisions were made in people's best interest.

Liaison with health care professionals was appropriate to people's needs but had been slow in the past but lessons had been learnt from this.

Is the service caring?

Good

The service was caring.

Staff supported people in line with their wishes but goals had not always been set for people.

Staff demonstrated the right values and the service effectively managed staff to ensure any poor practice was addressed.

People were consulted about their needs and their wishes in line with their care and the wider service.

Is the service responsive?

Good

The service was responsive.

Some people had individually funded hours and could be supported in line with their needs and wishes. However, this was not the case for everyone. Reviews were taking place to help ensure the service could continue to meet people's needs and had adequate funding to do so.

Support and care plans were well written but we did identify gaps in records and some inconsistencies across the service.

There was an established complaints procedure and the service took into account people's experiences of the service.

Is the service well-led?

Requires Improvement

The service was mostly well led.

The registered manager was leaving and new managers recruited to post. They were waiting for their fit person's interview with CQC. The support they had been given was appropriate and the Regional manager was actively involved in the service.

Improvements in record keeping would enable us to see a clear outcome for incidents and safeguarding concerns. The service did manage these effectively but needed to improve its record of action.

There was adequate oversight of the individual services but there were some differences in terms of auditing and record keeping which could be tightened up.

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Detailed findings

Background to this inspection

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

An inspector and their inspection manager carried out the inspection. It took place on two dates 18 and 30 January 2018. The first inspection was unannounced, the second announced. The inspection was undertaken in two parts to inspect the different parts of the service.

The first day we inspected the residential service. We visited the three bungalows. We spoke with five care staff, the two managers who were waiting for their CQC registration as well as the registered manager and the regional manager. We met people using the service but our communication with them was limited due to the nature of their disability. We carried out observations at lunch- time and observed different activities throughout the morning. Some people were out throughout the day attending planned activities. We looked at three staff records, accessed training, and supervision schedules. We looked at medication arrangements in one of the bungalows and looked at audits, the medication policy and medication training. We took a copy of notifications and followed up safeguarding concerns and incidents. We took a copy of the statement of purpose, which was not person specific but generic. We reviewed minutes of meetings and feedback from people. We looked at four support/care plans as well as other records associated with people's care.

On our second day, we inspected the supported living service we have tried to report on separately within the report. We spoke with the deputy manager, the acting manager and four care staff. We spoke with four people when we visited them in their flats. For each person we visited we looked at care records and arrangements for people's medication and finance. We also looked at records for accidents, incidents, safeguarding concerns, and audits.

Before the inspection, we reviewed information we already held about the service including notifications, which are important events the service is required to tell us about. We also used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least annually to give some key information about the service, what the service does well and improvements they plan to make.
We spoke with the local authority safeguarding team, the local authority quality monitoring team and a number of health care professionals. We received communication from relatives about the service. We also viewed a number of 'Share your Experiences' forms, where people have used our website to provide feedback.

Good

Is the service safe?

Our findings

At our last inspection to this service, 19 December 2016 and 05 January 2017 we rated this key question as requires improvement. At the last inspection, there were concerns about medicines management and the management of risk. At this inspection, we rated this key question as good.

The staff we spoke with were aware of how to raise safeguarding concerns and felt able to within the organisation. They were also aware of whistleblowing procedures and external agencies they could report to if they felt their concerns were not being addressed. Staff said they worked as a team and felt able to raise concerns and challenge practice. Staff said they had access to phone numbers needed to report concerns and were always able to access management support. They said they also had handbooks and access to policies. Staff said they had a day's safeguarding training and this was refreshed. Staffs knowledge of safeguarding was tested by the provider as part of the initial interview and revisited as a standard agenda item in staff meetings/supervisions.

We received a notification regarding a recent safeguarding relating to a person who had moved to the service. This had not gone well and they had some unmet health care needs. The person ended up in hospital and it was felt they did not receive timely care interventions. The manager said they had learnt from this incident and had reviewed their paperwork. They said the assessment/transition period was much longer with opportunities for people to visit the service and become familiar with the staff. They said this enabled staff to assess people in the environment they were coming from and in the environment, they were moving to. They said they could also consider compatibility with other people living at the service. This demonstrated that the service learnt from incidents to help improve the service.

Whilst at the service we identified a number of possible safeguarding concerns, which had not been reported to the local safeguarding team. We asked the service for more details which they provided promptly. One regarded missing monies but after investigation the money that had been misplaced was located and therefore a referral was not necessary. There were concerns about medication but the provider assured us that there was one person who missed medication and this was reported to the safeguarding team and CQC and evidence was provided of this. There were no ill effects. For another person medication was not missed but a script was not put through for a repeat prescription, this was quickly rectified. Other errors had been rectified and had not resulted in harm to people.

We looked at arrangements for people's finances in the supported living service. Not everyone had their own bank accounts and this was being addressed. Staff accounted for any personal spending by using cash balance sheets and keeping receipts for expenditure. Monies were taken for rent and shopping with some people sharing the cost of shopping and bills where they shared accommodation. This was accounted for. There was a financial policy, which had not been updated for a number of years. It stated staff could not have access to peoples cash/debit cards or know their pin numbers and there were clear procedural arrangements in place. Staff told us anything over fifty pounds needed management authorisation.

Concerns had been raised about the behaviour of a person using the service, which put others at risk

including staff. In this instance, the provider told us that incidents were recorded and staff were offered support including training in dementia care. Charts were kept of people's negative behaviours to try and identify a cause or what helped to manage the person in a more positive way. Staff said referrals were made to other health care professionals where possible. Staff had training on supporting people living with dementia but there was no training around positive behaviour support or de-escalation techniques. However, some staff working in the supported living service said they had received this. It did not appear on the training matrix so we could not be assured all staff received this necessary training.

There were further incidents involving the supported living service, one resulted in a person moving out due to their behaviours and compatibility with other people. When we asked for details of this, the service told us records had been archived. The local authority safeguarding team were not able to provide us with the information we needed to make a judgement. The provider has since sent the information to us and this demonstrated that the service took the necessary actions and worked cooperatively with the Local Authority. . Another incident did not have enough information to help us decide if actions taken were appropriate to risk. This has since been provided. Since our inspection, the provider has told us that they have implemented a new form, which will provide a clear audit of all safeguarding concerns. This is particularly relevant as they told us the procedures for reporting safeguarding concerns in Norfolk is via telephone so there had not always been a clear record either from the service or safeguarding team.

Known risks to people were addressed through staff practices. Staff working in the residential setting told us they had regular fire drills and practiced evacuations. They said there were regular checks to ensure the premises were safe and fit for purpose. Individual risk assessments were in place for people and documented how staff should mitigate risk. These were accessible to staff.

We saw in the residential service a health and safety folder, which showed regular checks for the environment and individual equipment used. Checks ensured equipment was safe to use and remained in good working order. People living in their own homes had individual risk assessments and the responsibility for maintaining the accommodation belonged to the housing association.

People had a one-page profile in place. They also had a personal evacuation plan in the event of a fire or other emergency and this detailed what support the person might require. People's records also included emergency contacts and any other relevant information such as epilepsy management and manual handling plans. This helped ensure staff could safely support people.

Staff working in the residential service were confident that there were enough staff to meet people's needs and assist people out into the community on a regular basis. One member of staff told us, "There is regular agency staff, they are part of the team, some are outstanding, things are getting better". Staff us told that the same agency staff were booked as far as possible to help achieve consistency for the people using the service.

We observed staffing levels to be appropriate during both days of our inspection. We inspected the three residential properties on the first day and the supported living service on the second day. People living within the residential service had support throughout the day and night to ensure their needs were met. People had complex needs but they had individually agreed levels of support in place with some people accessing regular activities throughout the week. Staff said some people had individually funded hours within the residential service.

Everyone in the supported living service had their own agreed staffing hours. This meant the service could effectively be planned around people's individual needs. We observed the level of support people received

throughout the day but people were not able to tell us about how they experienced the service due to complex needs and limited verbal communication. We asked staff about people's needs and staff said the staffing levels were good. During our visit to the first bungalow, Poppy, there were two people who used the service there. Two people had already gone out for the day. Staffing had not been reduced because of this, which meant people remaining at the service had one to one support. The home had one void. Staff said the only difficulty they had was when going into the community people needed 1-1 support due to frailty, behaviour or mobility issues. This had to be planned to ensure there were sufficient staff. The service had a minibus they could use but only when they had sufficient staff and staff who could drive.

We noted in the supported living service one person had additional staff to support with their transition from another registered service. Staffing support had been reduced when safe to do so. Staff supporting from the other service, reported some staffing issues but said these had been resolved recently.

We spoke with management about staffing and they told us they were in the process of getting people reviewed with the local authority to ensure they had the right number of hours and funding for each individual to ensure they had personalised support. They said statutory reviews had not always happened annually and changes in people's needs and reduction in day services had impacted on staffing budgets. They said they were covering the shifts of those permanent staff that were absent from work with agency staff. Staff sickness was monitored and recruitment was ongoing. One hundred and sixty hours of agency were being used a week which was significant but reducing. Planning helped ensure consistency of staffing. Three staff had just been recruited. There was no evidence of missed calls or planned care being compromised.

The service had both waking nights, on call and sleep in staff to ensure people's needs could be met over a twenty-four hour period. Some staff such as the managers were not rostered on to provide care so were able to step in and support staff if necessary.

There was good on call arrangements for out of hour's support which staff expressed confidence in.

We reviewed people's medication records. There was a list of medication people were taking. This was recorded in their support/care plans. Staff spoken with were knowledgeable about medication administration. There were clear policies and procedures and guidance about different medication groups and their usage. Medicines were stored safely with keys held securely by staff. Medicines were kept according to prescriber's instruction with daily checks on the temperature of the storage facility.

We looked at medication records and saw clear instruction for administering medication such as name, dose, and time including time critical medications. There was guidance for staff to follow about when to administer medicines including those prescribed on a 'when necessary' basis. There was a staff signature sheet so the signatures on the medication record could be identified. Staff said only staff who had received medication training and had their competencies assessed could administer medications. Staff were clear about what happened if errors occurred, who to report it to and said they would be taken off medication administration until they could be retrained.

Senior staff completed audits on medicines management at least monthly. The service had a medication champion who oversaw medication practices and was a contact point for other staff.

We saw evidence that people's medicines were kept under review by the GP or other health care professional.

We reviewed people's medication that lived in supported housing. There was a clear record of what people were taking but saw in one person's record prescribed creams had not been available twice when required. This had not been picked up by audits. We saw that some missed signatures had been identified and addressed with individual staff in supervision. We noted in the supported living service medication audits were done across the individual dwellings without specifying how many records were looked at. We thought it might be helpful that rather than doing whole service audits, each person's individual medication should be audited.

Most people had support with medication but one person had asked if they could take their own medication. The service had reviewed this through the multidisciplinary team to help ensure the person had capacity and could be supported to safely take their medicines. This was established as a long -term goal. There were clear parameters to help the person move towards their goal.

Staff recruitment files provided evidence of robust recruitment procedures to help ensure only suitable staff were employed. Records included a disclosure and barring check, written references, job application with full work and employment history, proof of current address and photographic identification. Records also included interview notes and a written exercise to ensure staff were able to complete records as part of their duties. We noted where a criminal offence had been committed by staff this had been discussed and noted as part of the interview to consider its relevance and whether the person should be employed. However, we did not see any subsequent risk assessments or additional monitoring of staffs performance, which we might expect to see in order to manage any potential risk.

Staff told us that the people who used the service had a chance to be involved in interviews and meet staff before they started work. We could not be assured how often this happened but recognised this was good practice. People raised concerns about an agency worker who had seemed unaware of their needs and did not support the person in accordance with their needs. This suggested to us that agency staff did not always receive an adequate induction.

Staff said there were lessons learnt. For example if there was a safeguarding concern or medication error staff were supported and extra training provided to staff. Outcomes were shared with staff and the service had clear disciplinary processes. We saw examples of where poor practice had been addressed with staff with clear agreed actions for improvement in practice. Where actions of staff had potentially more serious consequences or staff had failed to improve previous poor practice staff would be disciplined or their contracts terminated.

Good

Is the service effective?

Our findings

At our last inspection to this service, 19 December 2016 and 05 January 2017 we rated this key question as requires improvement. At the last inspection, there were concerns about people's rights not being upheld. At this inspection, we rated this key question as good.

We asked staff about innovate practice and how they were working in line with legislation. Staff told us they got lots of training and this was kept up to date. They also said as part of their support, they completed 'shape your future,' a three monthly review where staff set out their goals and aspirations. They said the service recognised 'top talent' in which staff were noted for skills, attributes and previous experience they might have. The service had champions. These were staff who had an area of interest in which they took a lead in and supported staff. They would act in an advisory capacity. For example, the service had medication champions. Staff were given additional support and training for these roles.

In terms of innovative practice, staff told us they were involved at looking at hospital admissions and how people with learning disabilities are treated. This was in recognition that staff had not felt that other professionals always had a clear understanding of the needs of people with disabilities. The staff said they were trying to shape practice and were working closely with the learning disability nurse working at the hospital. This would help ensure people received a seamless service that was person centred and appropriate to their needs.

Staff all told us that they had been well supported. Staff said during their induction they had received all relevant training and had been doing the care certificate. This is a nationally recognised induction framework for staff working in adult social care. Staff explained that training included service specific training such as an introduction in to learning disability, epilepsy and autism. Staff said they were trained to administer medication.

Staff working in the supported living service told us they had regular face-to-face support, mandatory training and training based on people's specific needs. For example, staff said they had done some training around mental health and diabetes.

Some staff said they did not receive clear training to help them support people who might demonstrate behaviour that may challenge staff or other people using the service. The staff-training matrix showed staff did autism workshops and personal safety but not how to deescalate situations, which put them or others at risk. Staff mentioned a few people where these techniques could be helpful.

Staff confirmed that as part of their induction they had shadowed more experienced staff and had the support they needed. Where agency staff were used, they completed an induction and the service got confirmation from the agency about the staff member's recruitment details and training undertaken. One staff member told us, "I shadowed other staff for six weeks and until I had completed all my initial relevant training."

Some staff had completed additional training and European funding had been applied for so more staff could take advantage of enhanced learning opportunities. All managers and deputy managers were supported to do additional qualifications in care.

Staff told us there were individual service meetings and occasionally whole staff meetings and that information sharing was good. Most staff worked almost exclusively in set bungalows or in the supported living part of the service. Although we could understand the rationale for this in terms of consistency, it was not clear how the managers ensured the same high, consistent standards across the whole service. We found varying standards in terms of record keeping and activities for people. It was important there was clear oversight of this across the service.

We observed lunch in one of the residential services. Staff supported people appropriately and tried to facilitate their independence such as by using adapted cutlery. We noted that staff in one bungalow offered people a choice of meals but gave this information verbally. We were not assured that people were able to make informed choice based on verbal information and did not respond to staff offering them a choice. Staff therefore made the decision. People's experiences could be enhanced by being shown different options. Guidance from other health care professionals had been sought and food was cut up when necessary to reduce the risk of choking. Staff told us people needed supervision and advice to eat slowly and not to cram food into their mouths.

In another bungalow we saw positive interactions between the staff and people living in the service, the staff supported people to make healthy choices. For example, one person in the service liked coffee and was supported to make numerous cups per day. The staff supported them to have ordinary and decaffeinated coffee. They also liked fizzy drinks but staff reported that they would drink excessive amounts and therefore they have included into the daily routine a trip to the shop to purchase a smaller bottle rather than having large supplies in the unit.

Food and fluid charts were not routinely used but would be if there were concerns about unplanned weight loss or dehydration, particularly where people could not anticipate their needs. We reviewed records and they were not sufficiently robust. Records did not include a totalling up of fluids or an individual fluid target. Food consumed was recorded but not the portion size. The records by themselves had very little value in determining if the person was eating or drinking enough. Weight records were kept but we found these also to be of little value because of gaps in monthly recording and no evaluation of people's weights in terms of their nutritional needs. We did not see anyone with concerning weight loss but the frequency of weights made this difficult to evaluate. We did see evidence of involvement by dieticians and other professionals and staff offered healthy meals. Guidance was in people's records about increasing people's weight and promoting healthy eating.

A recent safeguarding concern had highlighted issues around meeting people's health care needs. Since then the manager told us they had liaised with the speech and language nurse and dietician and they were providing training for staff. There was also a weekly review of care-plans in place for people at risk of choking or requiring a specialist diet.

People able to comment told us staff made and supported people to attend health care appointments and supported people to stay healthy and active. One told us about treatment they had needed and how staff had explained everything to them. They told us about their experience of being in hospital and how staff had supported them. They told us how they attended the healthy living centre. They had support to manage their own health care needs.

People's support and care plans gave us sufficient information about people's needs and how staff should support people to stay healthy. Staff had sufficient knowledge about people's health care needs including epilepsy and diabetes. Staff told us and this was supported by the records we saw that people had access to other health care services as needed such as the GP, speech and language and nutritionist. When we spoke with core staff, they had a good understanding of people's needs. Staff told us people were registered with the one GP practice that knew people well and provided a good service.

People had a hospital passport, which collated all the information about people's health care needs in one document. This made it easier for staff to see at a glance what people's needs were. It was also a document which could go to hospital with people so health care professionals, unfamiliar with their needs, had information available in order to help them provide a consistent and individual service as well as ensure they got the right care.

Staff told us they were well supported by other health care professionals particularly within the community setting but less so if people needed to go into hospital but staff were working to address this. Staff said they were sometimes frustrated that other professionals did not listen to them when they asked for assistance. Clearer record keeping and monitoring of people's changing needs might help staff clearly evidence gaps or changes in peoples' needs.

We identified a concern with inconsistent practice in regards to monitoring of people's bowels. Staff said if people were independent they did not monitor this but where people were prone to constipation and were perhaps not as mobile there was a record for staff to complete. However, we did not see that these records were checked to help ensure the person was not becoming constipated or when they might need medication. Gaps in records did not give us a complete picture.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Records indicated if people had capacity or not. One person was deemed as not having capacity to understand why they needed to take regular medication and needed staff to administer this to help manage their epilepsy. There was a mental capacity assessment and a best interest decision to state staff were to administer the person's medication. However, the form was not dated or signed which is important in terms of showing who had been consulted and who had agreed to the best interest decisions. The service demonstrated that where it was necessary to restrict people under Deprivation of Liberties safeguards, this had been done lawfully and applications had been made to the local authority. Deprivation of liberties safeguards is only applicable when we support residential services and not supported living services.

In the supported living service, we saw details of people who were linked to the person such as family, next of kin and any other health care professionals who might need to be contacted. Where decisions were agreed the rationale for these were recorded and it was clear what people could do for themselves and what they might need help with including understanding the decisions they might be asked to make. Best interest decisions were supported by mental capacity assessments, which were decision specific as required by legislation.

The environment was considered in relation to the residential service but it is not an aspect for us to look at with the supported living service. People lived in shared bungalows, which were hygienically clean, free from

obvious hazards and in a good state of repair. Individual bedrooms were personalised to the individual. We observed covered radiators to reduce the risk of scalding. We saw that where required furniture was secured for the safety of all. Medication was locked away and secured. Floors were hygienically clean. There were clear processes in the event of fire or emergency evacuation.

Good

Is the service caring?

Our findings

At our last inspection to this service, 19 December 2016 and 05 January 2017 we rated this key question as good. At our latest inspection, we found it was still good.

We asked people who were able to communicate their needs about the staff that supported them. People were complimentary about the regular staff. However, two people made us aware they had not been happy with a recent agency staff member. The provider was aware of their concerns and assured us that the agency staff would not be supporting people again which took into account people's wishes. They also raised concerns about some staff and their poor understanding of English and said they could not understand them. This again referred to agency staff. This was not something we identified as an issue as part of our inspection. Staff were observed as having good spoken English but we observe a staff member who spoke loudly to people when this was not necessary. People had individual communication plans so staff should be aware of how best to communicate with people and the provider should ensure staff have good communication skills and a basic job requisite.

People told us they were happy and not wanting to leave the service. Staff were positive. One said, "I love it here, it is different every day". We noted in one bungalow in particular staff clearly enjoyed working there and there was 'high energy.' Newer staff said they had fitted in quickly and were well supported by existing staff. Staff in this bungalow told us that people were supported by families and there was regular contact, activities and fund raising so people could undertake more activities. One staff member said, "The best things about working there is 'seeing them happy' [people living in the service]."

Staff spoke with people directly and asked them permission to support them with a task or to enter their room to clean. Staff were respectful when they spoke with people but one staff on occasion referred to people as 'boys,' and 'girls.' which was not appropriate and should be addressed throughout the service. People's support and care plans included people's preferences and choices.

Staff spoke of a person who had many restrictions in place in the past due to their behaviour. Staff described what matters most to the person and how they were able to support the person without these necessary restrictions in place. We saw photographs of different events, holidays and activities people had participated in. People had photo books, which included photos from their childhood etc., but also a range of more recent photos showing the activities and holidays they had done. The bungalows were also decorated with a large number of photos of each person and them as a group.

People's care and support plans included recorded consent from the person or their representative about keeping sensitive data and who might be able to see this information including CQC inspectors.

People's cultural needs were not well documented in peoples support/care plans but staff were aware of them. Staff told us how they supported people to access different things, including churches, which might meet their needs. They told us about people's specific dietary needs and any religious needs.

Communication within the service was good between shifts with staff recording in diaries, and handover books. It was less clear how the service communicated with families particularly those who did not visit regularly. There were no family meetings as such but families were invited to care reviews for the individuals. The regional manager told us they were working on a newsletter, which would help families stay in touch with what was going on. Staff told us there was a closed twitter account, which was used to share information about the service, different events that had taken place and photographs.

There were resident meetings and minutes of topics discussed. We saw that some people had good networks of support and were not reliant on staff to meet all their needs. Accommodation arrangements meant general housing was mixed in with more specialist housing provision and staff said this worked really well. Accommodation was accessible to town and people accessed further afield to attend both specialist day activities and more general activities such as shops, pubs and restaurants.

We saw for some individuals there was input around managing relationships. Staff involved the mental health team, and the learning disability team. We saw less information about how people were supported to develop life skills as no one was involved in supported employment or college.

Staff said people were supported to make choices and gave holidays as an example. They showed us a folder with three different holidays in which people had chosen to go together. They also did so individually with families. One person in the unit was due to go away for the weekend to visit family.

We spoke with staff about how they saw their role. Staff told us they supported people to be as independent as they could be. One staff said, "We enable people.' Another told us how much people could decide for themselves how they wished to spend their time and support/care plans made it clear what staff should help people with to become more independent. We spoke to several people living in their own accommodation. They had been upset by an agency staff doing things for them they could do themselves and going through their house without permission. They had both spoken up and this agency staff was not permitted to come back and work with them again. This demonstrated that people were listened to and were able to influence the care and support they received.

Good

Is the service responsive?

Our findings

At our last inspection to this service, 19 December 2016 and 05 January 2017 we rated this key question as good. At our latest inspection, we found it was still good.

People who were able to tell us about their experiences were mostly positive and said they liked the staff and the things they did. Some people had anxieties when being supported by staff who did not know them as well and it took time to gain their trust. When we spoke with people, some people had asked to be supported by their regular staff, as they were feeling anxious when speaking with us. Other people were not able to tell us about their experiences but we observed people to be relaxed in staffs company and engaged in different activities. The atmosphere in the residential service was different in each bungalow, one was very calm another was less so but staff personalities matched the needs of people using the service.

One person told us what they liked doing and regularly went into town, to the shops, getting on the bus and liked poetry and books.

We first inspected the residential care unit. People had a range of different activities around their individual needs. Staff said people used local facilities as well as getting taxis to venues further away. Some people attended day centres and other clubs such as music club and social clubs. We saw evidence of trips to London to visit winter wonderland, ice-skating and annually planned holidays. One person had taken up Zumba. Another loved anything involving music including watching shows and learning to play instruments. Some people had more limited opportunities but this could be understood in relation to people's age, motivation and cognitive abilities. One person did not attend any formal activities in the community. They used to attend a day service but due to the advancing cognitive impairment and sensory issues, they no longer attended. We did see staff frequently engaging with them and giving them objects/toys they could explore.

People using the supported living service had varying levels of support and some had one to one for most of the day. This enabled them to go out as they wished and be supported to maintain their living accommodation and help around finances, medication and personal care.

Before the inspection, we had received concerns about a person who had moved to the service and had not settled. The person's health was declining and staff took some action to support and monitor this but it had not been adequate. The manager said lessons had been learnt and they considered any new admission very carefully and any introduction to the service was slow. The exception to this might be if there was an emergency. We saw the admission assessment for someone, which was detailed and listed all the information staff might need to know. However, we could not see from the assessment who had been involved in pulling the information together. The persons own wishes and views were not recorded. A care plan had been put in situ soon after admission and a review to discuss how they were settling in and if their needs were being met, was held soon after admission.

Another person had recently moved to the service and had many hours of support. They had been

supported by staff at their previous placement to help support a smooth transition and enable the person to get to know new staff. Routines and familiarity were very important and had been managed well. The person was reported to be very settled and accessing the community much more than they had previously been able to do. Staffing levels were planned around their needs and the service provided the person with continuity with staff working twelve-hour shifts to help facilitate this.

Support and care plan were written in a very person centred way and focused on what the person enjoyed and was able to do for themselves. It included statements like, 'I'm great at…' or 'I need help with.' Staff told us that care plans were updated by all staff, which gave them the opportunity to have their input and be contributed to by staff who knew people well. Staff told us they were moving to an electronic system.

Daily notes in both the residential and supported living service were good and showed what people had been supported with and what they had been doing including different day activities, attending church and any health issues they might have.

Staff spoken with were knowledgeable about people and told us things that were helpful to know but were not included in the support plan/care plan. This meant should regular staff leave their knowledge might not be known or shared with new staff. For example, we met a person who staff said used to have very difficult behaviours and lived in a restrictive environment. However, staff told us that the person now had a much fuller life and was able to manage their anxieties. Staff said they understood their triggers and could give the person strategies to calm down before their behaviour escalated. By knowing this person's routines and preferences staff were able to anticipate their needs and prepare them for any likely change to their routine such as a change in activity or staffing. This reduced their anxiety and the likelihood of a negative incident. The concern was that this person was likely to be supported by agency staff who would not have the same insight in to their needs and their needs were not fully documented.

Information was presented under the different areas of need with a one -page profile that could be used by agency staff to gain a brief overview of the person's needs.

Care and support plans were reviewed when necessary and at least every six months by the service. Annual statutory reviews by the local authority were not up to date but were being chased by the service.

There was some guidance about people's specific behaviours and what might trigger behaviour such as shouting due to frustration. Staff used charts to indicate what was happening before the behaviour, what behaviour was exhibited and how the behaviours were managed. However, there was little guidance in the way of understanding why people might behave in a certain way or how staff could deal with the behaviour in a consistent way. Staff were not able to tell us if there had been recent input from health care professionals about how best to deal with people's anxieties and behaviours which put the persons or others at risk. However, people's records gave us information about when people had been seen by other health care professionals.

The service had a series of risk assessments for individuals including for their health, medication, day to day activities such as bathing, the environment and access to the community including using the service minibus. These were subject to review.

Having read the support/care plans, we had a good overall picture of the person's needs. However, what was missing was peoples preferred routines based on their individual likes and routines. We could not always see what people's aspirations and goals were. Information varied from bungalow to bungalow. We saw in one bungalow people's records included speech bubbles, which recorded what people wanted to do,

their goals, agreed outcomes and actions to be taken to help people achieve these. In some records we saw detailed health action plans but these were not in every support/care plan we looked at which meant there were some inconsistencies in the records we saw.

There was also limited information about people's night routine, which was a concern when agency staff were sometimes covering night duties. We saw for at least one person they had difficulty distinguishing between night and day routines and needed as much support throughout the night. Daily notes indicated, 'The person up all night.' There was nothing in their support plan about establishing a clear night routine.

The service supported people for as long as was appropriate to do so according to people's needs. In the support/care plans we looked at there was no information about people preferred wishes or end of life plans. Staff said they did discuss this with people and relatives when appropriate. Staff told us they had not had training around end of life care but would work with other agencies to provide this. Training should be provided to support staff to provide good care to people at the end of their life and where possible avoid hospital admission where this is what people would want.

We discussed the needs of one person who had a life limiting illness and the service explained how they engaged with other health care agencies to ensure their needs were met as comprehensively as possible. They said staff were developing the skills to support them and work closely with the family.

One person spoke about the loss of a family member and was distressed when telling us. They also had minimal family support. Staff spoke with them in a supportive, kind way and helped them to explore their feelings. This was well managed by staff. Another person got fixated on issues of illness and bereavement. Staff supported them to manage their anxieties and focus on more positive aspects of their life.

There was an established complaints procedure which gave people the opportunity to raise formal complaints should they feel this necessary. These were logged and showed how they had been responded to and in what time scale. We reviewed feedback received from people and their families. There were some inconsistencies in how the complaints had been dealt with, some complaints not showing clearly how they had been followed up or the outcome where as others had drawn conclusions. Information was provided at our request but was not all together with the original complaint. This was discussed with the regional manager so practices could be improved upon.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection to this service, we rated this key question as requires improvement. At the last inspection, there were concerns about the management and oversight of this service. We made a breach of Regulation 17, Good Governance. At this inspection, we rated this key question as Requires improvement. Since the last inspection there has been good progress made. This was demonstrated by the service's action plan and progress made towards becoming fully compliant with relevant legislation and standards. We have rated the service requires improvement as we noted that each part of the service was managed quite differently with very little overlap. This resulted in inconsistencies across the service mostly in relation to record keeping which could mean people experience different care outcomes, which might not meet their needs.

The service appeared well managed and managers recently appointed were well supported by the registered manager who was about to leave and the regional manager. A sufficient handover period would hopefully ensure the continuity of the service. Our only concern was both the residential and supported living were registered under one location and were managed separately with different managers and statement of purposes. It was not clear about how lessons learnt were shared across the two different services or how joined up they were in terms of having consistently high standards across both service types and even between the two managers working across the three residential homes. Things working well in one part of the service were not necessarily repeated in another part of the service.

We reviewed safeguarding concerns, incidents records and feedback about the service. We found incomplete records or information completed and filed in different places with no cross- referring. We found it very difficult to track through. Once we asked for the information this was provided but we found the way things are recorded needed to be improved to demonstrate outcomes and lessons learnt and to be generally more robust. By way of an example, one person was given the wrong medication and staff had sought advice from 111, they had asked for more specific information, which staff could only get from the GP. No harm came to this person but we could not see from the record if staff had followed this up and got information from the GP or the outcome based on advice received. Some information was recorded on an incident sheet, other bits in daily records, professional's visits and so forth. We found some inconsistencies in how people's needs were recorded with little or no reference to end of life care. Some records had clearly stated goals staff were supporting people to achieve where some care plans did not include these. There was poor planning for how a person's needs should be met at night. This meant we were not assured people would always get their needs met accordingly.

People told us they knew the manager, felt able to approach them, and said they saw them regularly.

Staff spoken with felt well supported by the management team and we saw managers were visible and supportive of each other. Staff described management as responsive and available. One staff member said about their manager, "They are amazing; they listen to and act on your suggestions." It was clear from the records we saw that poor practice when identified was dealt with according to the organisation policies.

One staff told us, "There are staff meetings every couple of months. Managers are always available and supportive …nice to know you have support at work." Staff told us there had been many changes to the service. We asked for some examples. Staff said people using the service were happier, did a lot more and had goals achieved. Staff said the paperwork was much more streamlined. They said a new booklet had been introduced which included people's daily notes, menus and everything else about the persons daily needs.

We spoke to one member of staff who told us how the service had moved forward in terms of staff recruitment and a shift in focus to a more personalised service for people where they had more autonomy. This was particularly true for the supported living service where staff tried to understand the purpose behaviour served and how staff could influence and shape people's behaviour in a more positive way. They said staff were doing a three day accredited training course from the British Institute for Learning Disabilities. (BILD).

Staff reported good working relationships with other health care professionals, family and the wider community. The service had quality assurance systems in place in which it routinely asked people, families and stakeholders for their feedback about the service. There was no one with advocates so it was difficult to see how everyone could feed in to this process and have their say. The most recent quality audits was completed in November 2017 and from 14 surveys sent out 13 were returned and from the family surveys 14 were sent out and 8 were returned. These were mostly positive with a few negative comments.

The service had actions plans stemming from any feedback showing how they had addressed it. They also had information from safeguarding incidents, which were reported to the registered manager and regional manager so they could review actions and if they were proportionate to risk.

Most of the feedback we saw was positive such as, one relative was recorded to say 'More than pleased with the care. We are lucky to have x in such a family unit.' One staff told us, "All jobs have ups and downs but this one has more ups. I am happy to come to work. Things are different every day."

Quality monitoring audits viewed included health and safety audits, infection control and medication audits. There were also actions plans devised in house or because of concerns raised by other agencies such as the local authority. The service was able to demonstrate what had been identified and how they had actioned it. Information was collated from different audits and fed into actions plans to show how issues had been addressed. Examples included audits of staff and peoples records. An audit had picked up that a person had not been to the optician for several years. This was immediately rectified. The regional manager said through analysis of accidents, incidents and safeguarding concerns they could pick up themes and trends, which could inform what action they should take or if actions taken were appropriate. When things became overdue, this was highlighted as a risk.

A quality-monitoring tool was being updated to more accurately mirror the key questions we inspect against. This should help the service to more effectively monitor its service against key performance indicators.

Managers felt well supported and there were opportunities to attend regular area managers meetings and the regional managers also met regularly The Mencap Society had internal awards entitled, 'You rock' which awarded staff practice with a gift such as chocolates or vouchers in recognition of the work staff did. Staff who were working well could also be recognised as emerging talent which might qualify them for personalised funding to support training and opportunity for internal promotion.