Royal Mencap Society

Plymouth Support Service

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

Plymouth Support Service is a domiciliary care service registered to provide personal care. The service provides personal care and support to adults of all ages living in their own homes within the Plymouth area. It provides a service to people with a learning disability who may also have a physical disability and people living with sensory impairment.

Plymouth Support Services also provides care and support to people living in a 'supported living' setting. Where people live in their own home and receive care and/or support in order to promote their independence. If there is genuine separation between the care and the accommodation, the care they receive is regulated by CQC, but the accommodation is not. The support that people receive is often continuous and tailored to their individual needs. It aims to enable the person to be as autonomous and independent as possible, and usually involves social support rather than medical care.

The service supports some people on a 24 hour basis and others who may require support with personal care needs at specific times of the day and/or night. At the time of this inspection, seventeen people received support with their personal care needs from the agency including people in the shared houses.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection in April 2016 the service was rated Good. At this inspection we found the service Required Improvement.

Why the service is rated Requires Improvement.

We visited and spoke to 15 people in their own homes and observed the interaction between them and the staff supporting them. People were not all able to fully verbalise their views, so staff used other methods of communication, for example visual choices and sign language.

The service was not consistently safe. When asked, people from one shared house said they did not feel safe. They raised concerns about a person who lived nearby. This person and the people living in the shared house had to gain access to their front door via the shared car park/garden area. People did not feel safe leaving their own home, some people missed appointments if the person concerned was outside of their home as they felt too frightened to leave. Staff also felt intimidated either going off duty or if they were leaving with people they were supporting to access the community if this person was outside in the shared car park/garden area. The service manager was currently in talks with the local safeguarding team over this issue.

People and relatives also raised concerns over a second provider currently providing overnight care for people in one of the shared houses. They were not happy with the level of care and one person commented; "Not sure if they are going to turn up." The provider was due to stop providing care shortly.

Staff highlighted an issue with one person and their current funding level to help keep them safe and well cared for. This person's care records all clearly showed they required two to one staffing to assist them to the toilet. At times this person was in the shared house with only one member of staff. Staff told us of an occasion that this person had to wait 45 minutes to be taken to the toilet. This could have caused this person a lot of discomfort and the Commission reported this to the local safeguarding team. The service manager overseeing this service said they were in the process of trying to obtain additional money to fund extra hours to support this person whose health had deteriorated over time due to increasing age. However records showed this person had been receiving over 700 minutes of additional care hours currently provided. These additional hours could indicate that this person may need a more suitable placement. Also if they were deemed to lack capacity to make that decision then a best interest meeting may need to be considered. After one of our site visit days a re-assessment of this persons hours had been carried out by the local authority and an additional two hours a day had been allocated. The service manager said they would discuss this with the registered manager as this still fell short of additional hours currently being provided.

Staff raised concerns over the number of staff employed to cover the current work load. For example some staff worked over 60 hours a week and another had completed six waking night duties to help support people have consistent staff working with them. Though some staff felt this was staffs own choice, other staff felt pressured into working extra hours.

People's risks were assessed, monitored and managed by staff to help ensure they remained safe. Risk assessments had been completed to help support positive risk taking, and help reduce risks from occurring. Risks associated with people's care and living environment were effectively managed to ensure their freedom was promoted. People were supported by consistent staff to help meet their needs. People's independence was encouraged and staff helped people feel valued by supporting people to engage in everyday tasks, for example helping prepare meals. However some people's independence was at times restricted due to not feeling comfortable leaving their home due to issues with a person living near a shared house.

People however felt safe with the staff that supported them. Family members provided positive feedback about the management and staff, the safety of people and how staff related to their loved ones. Comments from relatives included; "Safety comes high on their list of priorities."

People's medicines were managed safely. People were protected from abuse because staff knew what action to take if they suspected someone was being abused, mistreated or neglected. People had their needs met by suitable numbers of employed staff. Staff were recruited safely and checks carried out with the disclosure and barring service (DBS) ensured they were suitable to work with vulnerable adults.

The service was not consistently well led.

We were assisted during our inspection by two service managers. These two service manager were in day to day control of the service. This included each one overseeing a shared house individually, and jointly overseeing people who received care in their own home. We also had contact with the registered manager of the Plymouth service during the inspection. We then met with another registered manager for the company to provide additional feedback after the inspection in the temporary absence of the registered manager of the service.

The feedback we received from support staff was variable. Some staff told us one of the service managers was very approachable with some saying; "X [the service manager] is working hard to resolve some issues we have with "X [a person who lived close by]" and "Very approachable" and "Very good manager and involved in the home."

The feedback on the other service manager was less positive; "Unapproachable", "X [service managers name] doesn't speak to us (staff) when they are in the home", "The worst manager I've worked with." We passed this information onto another registered manager for the company in the absence of the registered manager for this Plymouth service.

The provider had systems in place to monitor, assess and improve the service. However, the current checks and audits carried out were not effective in giving the provider and registered manager a clear oversight of the service or alert them to issues raised during our inspection. For example, that some staff were very unhappy with the running of one of the shared houses, that there was a short fall on providing safe care for one person, namely they only had one staff available to them when they may at times require two staff to assist with personal care. Also the number of additional hours which were being provided to one person over and above their allocated funded hours, possibly indicating an increase in their care needs or a more suitable care package.

People and relatives said they found access to the management team easy and approachable. Though some staff were positive and happy in their jobs, other staff said they were looking for work elsewhere and unhappy in their jobs due to lack of support. There was a clear organisational structure in place.

The service was responsive to people's needs and people were given a wide range of choices about their day to day lives.

The service manager had been responsive in contacting the local authorities before our inspection over issues including the problem with a neighbour who the service was finding challenging and the concerns raised by the people, relatives and staff over the second care provider involved in one shared house. During the inspection one person needing additional staffing, for extra support for all transfers and to meet toileting needs, had been referred to healthcare professionals for a re-assessment of extra funding.

However these were still ongoing issues that had not yet been resolved for the people concerned.

People had access to a very wide range of organised and informal activities which provided them with mental and social stimulation. People were supported to access the local community.

People were enabled and supported to lead fulfilling and active lives. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People could make a complaint and relatives were very confident action would be taken to address their concerns. One relative said how the service manager had responded to the issues with the neighbour when they raised concerns. The registered manager and provider treated complaints as an opportunity to learn and improve.

People's communication needs were known by staff. Staff adapted their communication methods dependent upon people's needs, for example using simple questions and easy to understand information for people with cognitive difficulties. Information about the service was available in different formats to

meet people's individual needs. The service was responsive to people's individual needs and provided personalised care and support. The provider had taken account of the Accessible Information Standard (AIS). The AIS is a requirement to help ensure people with a disability or sensory loss are given information they can understand, and the communication support they need. People received information in a format suitable for their individual needs. Throughout the inspection we saw evidence of how the provider and staff understood and promoted people's rights as equals regardless of their disabilities, backgrounds or beliefs.

People received effective care from staff who had the skills and knowledge to meet their needs. Staff meetings, one to one supervision of staff practice, and appraisals of performance were now undertaken and meetings documented. Staff without formal care qualifications completed the Care Certificate (a nationally recognised training course for staff new to care). Staff said the Care Certificate training looked at and discussed the Equality and Diversity policy of the company.

People's equality and diversity was respected and people were supported in the way they wanted to be. People's human rights were protected because the registered manager and staff had an understanding of the Mental Capacity Act 2005 (MCA).

People were given the choice of meals, snacks and drinks they enjoyed while maintaining a healthy diet. Staff monitored people's health and well-being and made sure they had access to other healthcare professionals according to their individual needs.

People continued to receive a service that was caring. Staff demonstrated they knew people well through their conversations and interactions. If people found it difficult to communicate or express themselves, staff showed patience and understanding.

People were observed to be treated with kindness and compassion by the staff who valued them. The staff, most who had worked at the service for a number of years, had built strong relationships with people. Staff respected people's privacy. People or their representatives, were involved in decisions about the care and support people received.

We found one breaches of regulations. The action we have taken can be found at the back of the full version of the report.

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 always safe.

There was not always sufficient staff on duty to meet people's needs safely.

Though staff did their best to keep people safe, people in one shared house felt unsafe leaving their own home due to concerns over a neighbour's behaviour.

People had risk assessments in place to mitigate risks associated with their individual needs.

Staff were recruited safely.

People received their medicines in a safe way.

Staff followed safe infection control procedures.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Requires Improvement

The service was not always well led.

Checks and audits had not highlighted all areas for improvement identified during this inspection.

The management team did not all provide supportive approachable leadership.

People's feedback about the service was sought and their views were valued and acted upon.

Staff were motivated and inspired to develop and provide quality care.	

Plymouth Support Service

Detailed findings

Background to this inspection

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

This was a comprehensive inspection. The inspection site visit activity started on 23 April 2018 and ended on 31 May 2018. It included office visits and visiting people in their own home. We visited the office location on 23 and 25 April to see the management team and office staff; and to review care records and policies and procedures. We followed this up by meeting a registered manager for the company on the 1 June 2018 to provide feedback. This registered manager was standing in for the registered manager of the Plymouth service who was away at that time.

We gave the service 48 hours' notice of the inspection visit because the location provides a domiciliary care service and we needed to be sure that office would be staffed and enable time for home visits to be arranged. The inspection was completed by one inspector.

Before our inspection we reviewed the information we held about the service. We reviewed notifications of incidents that the provider had sent us since their registration. A notification is information about important events, which the service is required to send us by law.

We reviewed the information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we met with 15 people who received support with personal care. We spoke with six relatives for their views on the service. We spoke with ten staff members and received feedback from four professionals involved with people who use the service. We were supported by the two service managers who oversaw the day to day running of the services and spoke with the registered manager of this service and provided feedback to another registered manager who was overseeing the Plymouth service because the Plymouth service registered manager was unavailable.

We looked at six records which related to people's individual care needs. We viewed three staff recruitment files, training evidence and records associated with the management of the service. This included policies and procedures, people and staff feedback, and the complaints process.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in April 2016 the service was safe. At this inspection we found improvement were needed to keep people safe.

The provider and registered manager had not fully protected three people who received care from them, from abuse, or from being frightened to leave their own home. The three people in one supported living house raised some serious concerns to the inspector. They said they had missed many appointments and were frightened to leave their own home because of the behaviours of a neighbour. Staff also shared that they too felt intimidated either going off duty or if they were leaving with people they were supporting to access the community. We also observed one staff who was due to support one person with an appointment, stay in the shared house until the neighbour had gone into their own home because the neighbour was showing behaviours that staff found challenging. This meant the person in the shared house missed their planned appointment. A relative also told us of similar issues. The house manager had contacted the local authority and had also involved commissioners, social workers and the agency supporting this person to try to get help to resolve the situation.

However this situation has been going on for some time we therefore spoke to the local authority commissioning team and the registered manager of the agency involved. They all confirmed that there is a commitment to resolve this issue for all concerned.

We discussed this with the registered manager, the service manager for this house and the local authority. The service manager confirmed plans had been made to discuss this in more detail in a planned meeting involving Plymouth Support Services and the local authority. One staff member said; "[X-the service manager] who oversees the running of this one shared house is 100% committed and really trying to sort out the problem for people." Whilst this was a positive step, a more urgent approach was needed to protect all those involved.

One of the shared houses had two agencies involved in providing 24 hour care. One person said they didn't feel safe with the agency that provided overnight care because they; "Didn't know if they would turn up." A relative said of this second agency; "Not good" and went on to say their relative did not like them. Some staff working in this shared house, felt people were not always safe at night due to the inconsistency of night staff provided by this second agency. However, the service manager confirmed this arrangement was due to end soon with Plymouth Support Service due to provide 24 hour care for this shared house. People staff and relatives said they were very happy with this new arrangement coming into force in July 2018. Information provided to the commission confirms that Plymouth Support Services are now the sole provider for care at this shared house.

Staff told us of a recent incident where there were three people in one of the shared houses with only one member of staff. One of these people required two to one support to be assisted with their toileting needs and they were told they'd have to wait for more staff to return to the shared house before being able to be assisted. This person had to wait 45minutes to be taken to the toilet. Staff said this would have been very

uncomfortable for this person due to their health issues. This person's general health had deteriorated over time due to their age. Staff discussed this with the service manager of this shared house. Staff said they were not happy with the response and felt two staff should be always available when this person was at home. The service manager said; "They (the person needing the toilet) will have to wait as we are not funded for two-to-one for this person at all times. This will also happen more and more, (one staff member being left with three people). Another staff said; "We can't support X if only one staff left in house. This goes against her risk assessment." This person's care records and risk assessments clearly indicated this person needed two to one staffing when being assisted with their toileting needs.

We raised a safeguarding alert over this matter. The service manager told us they had applied for a re-assessment of this person's needs, confirming the need for 2 staff, and also applied for additional funding for this person but were still in negotiations with the funding authority. However, by day 4 of our inspection, the service manager had achieved two hours extra funding a day. The service manager told us, in their view, that the extra hours being provided for this person still fell well short of the hours needed to keep them safe and comfortable.

One staff member raised with the management of the service that a new person they supported had taken to shouting at one of the other people in one of the shared houses. When this was raised with the service manager of this shared house, staff said they were told; "Oh well, she'll have to get used to it." We discussed both of these issues with the registered manager of the service during feedback. They confirmed they would deal with these issues and discuss them with the management team.

Apart from the issue of the night cover mentioned above, people had sufficient numbers of staff working to help keep them safe and make sure their needs were met. We observed staff meeting people's needs, supporting them and spending time socialising with them. Staff agreed there was sufficient staff to meet people's needs. However, some staff said this was only possible because regular staff were working additional hours. Some staff felt that the service had taken on additional people to provide extra support to in their own home at very short notice. They told us this meant some staff were working extra hours and long hours to help with the consistency of staff to support people. Other staff said it was the choice of these staff to work extra hours whilst others felt staff couldn't say no. Staff said they had worked over and above their normal hours and they did this to provide continuity of staff to people they cared for. One service manager said they had been trying to recruit more staff but were still trying to fill one vacancy.

People were supported by staff that were safely recruited. Records showed that the necessary checks were undertaken prior to an applicant commencing their employment, to help ensure the right staff were employed to keep vulnerable people safe. The Provider Information Record (PIR) records; "When we recruit staff we ensure that they go through an inclusive recruitment process meaning the people we support get involved in the interview process."

One relative told how their relative had been admitted to hospital for an operation. They went on to say how the service manager of the service their relative lived in, had ensured their relative would be safe on their return home. This included ensuring they had the appropriate equipment and the premises where safe for their relative to move around in.

Staff, who worked alone, were protected and a lone worker policy was in place as well as a whistle blowing policy being available to all staff. An out of hours on call service was available to support staff safety and ensure people expecting visits received them. Staff vehicles, MOTs and car insurance were checked to ensure people were safe if they were travelling with staff.

People were kept safe by staff who understood how to identify the signs of abuse and what action they would need to take if they witnessed or suspected that someone was being mistreated. This included an understanding of which external agencies they would need to alert. There was an up to date safeguarding policy in place that staff were aware of and able to access. These policies and regular feedback from people using the service, helped protect people from discrimination. Staff confirmed they had completed safeguarding training.

People were supported and encouraged to take an active role in keeping their service and personal space clean where they were able. Staff completed infection control training and how to protect people from associated risks.

The management of people's risks did not always ensure they were fully protected. Some staff commented that they had been asked to work with one person who was displaying high anxiety behaviour and they had not met this person or worked with them before they had been asked to cover working a shift with them. This could have placed the person at risk of inappropriate care.

We recommend the provider explores processes of providing staff with appropriate information and training to care for people in advance of them providing that care.

People had documentation in place relating to the management of risks associated with their care. Risk assessments were detailed and provided staff with specific information on all areas where risks had been identified. This included environmental risks within the person's own home, as well as risks in relation to their care and support needs and any behavioural needs to help keep people safe. Incidents and accidents were monitored and actions taken to prevent the problems occurring again. Updated risk assessments were read and followed by staff. Regular service reviews and quality monitoring checks ensured procedures were followed. Staff had received fire training and were aware of the emergency procedures to follow in the event of a fire.

People's medicines were managed safely. People's medicines were administered as prescribed. Medicines were stored in people's own home in locked cabinets. Staff were keeping accurate records of when people's medicines had been given.

Good

Is the service effective?

Our findings

The service continued to provide people with effective care and support. Staff, who worked regularly with the same people to provide continuity, had a good knowledge of people they supported and were competent in their roles which meant they could effectively meet people's needs.

People were supported by staff who were well trained and received regular support. Staff were supported by ongoing informal and formal face-to-face supervision, spot checks, competency checks and an annual appraisal. Though one staff member said they had not had supervision since they started work for the company. Staff received monitoring of their practice, and team meetings were held. Some staff confirmed the management had an open door policy. Including one staff saying; "Can always contact them." However other staff felt they were not able to talk to one of the service managers and felt; "Team meetings are always negative, negative, negative." We fed this information back to a registered manager for the company, standing in for the registered manager for the Plymouth service. We received email confirmation from the operations manager confirming they would be dealing with these issues.

Staff confirmed regular training was provided in subjects which were relevant to the people they supported. The registered manager had ensured staff undertook training the provider had deemed as 'mandatory'. Staff completing the Care Certificate (a nationally recognised qualification for staff new to care) covered equality and diversity and human rights training as part of this ongoing training. Staff completed an induction which also introduced them to the provider's ethos and policy and procedures.

The registered manager and staff understood their responsibilities in relation to the legislative framework of the Mental Capacity Act 2005 (MCA). 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 people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and the least restrictive option available. For example two people had best interest meetings held involving family members and one involved a financial trustee to discuss funding a cruise trip abroad.

However we would recommend that the management team look at arranging a best interest meeting for one person who may lack capacity to discuss their current care package and number of hours being provided. This is to consider, following assessment of their current needs, if the current placement remains suitable.

People's right to make decisions about their lives was respected and supported by the staff. Staff used appropriate communication methods for people to help ensure people had their right to have control over their care and treatment respected. The person's chosen communication method and their physical response was written in their care records. Where people lacked the capacity to understand the implications of decisions about their care, best interests decisions were taken with relatives, healthcare professionals, advocates and care staff who knew them well.

People's care file held communication guidelines. Staff demonstrated they knew how people communicated and encouraged choice whenever possible in their everyday lives. Pictorial images were displayed to help support people in their day to day lives and in a suitable format for everyone. This demonstrated the provider had taken account of the Accessible Information Standard (AIS). The AIS is a requirement to help make sure people with a disability or sensory loss are given information they can understand, and the communication support they need.

The service had policies and systems to support people in developing their relationships with each other and those outside the service. This included identifying the right training for staff. The service managers were aware of how to support people to maintain their personal relationships. This was based on staff understanding who was important to the person, their life history, their cultural background and their sexual orientation.

People's nutritional needs were met. Staff knew what foods people liked and disliked and foods they were unable to eat. People were supported to plan and cook healthy meals of the person's choice. Some meals where planned as a group meal, for example the Sunday roast which was made in agreement with all the current occupants of one shared house. Staff understood each person's ability and rights to make choices and decisions regarding their meals.

Good

Is the service caring?

Our findings

People continued to receive a service that was caring. Relatives commented; "The staff are very, very good." Another said; "Marvellous care! Brilliant! X has been happy with everything. We can see they are content." Another relative whose relative lived in one of the shared houses before they passed away said; "Excellent quality of care delivery."

People who received a service had done so for a number of years and had built strong caring relationships with the staff who worked with them. People we met all appeared happy and comfortable with the staff working with them. Staff were cheerful, friendly and positive. Staff knew each person well. Staff understood the importance of treating each person equally, and as an adult and a valued individual. One person said the staff were; "Very caring, always."

People had their own home or a shared house arrangement. The staff were observed respecting when people wanted time alone. Staff struck a balance of people having privacy and checking people at regular intervals to see if they were safe and fine. Some people had 24 hour care whilst others had set times for staff to support them with their personal care and other activities.

People were supported by staff who were both kind and caring, and we observed staff treated people with patience and compassion. People were chatting with staff about plans for the day and the conversations were positive. People with specific communication needs were given time to make choices about what they wanted to do to. Staff, were attentive to people's needs and understood when people needed reassurance, praise or guidance. This included one person who was anxious about leaving their home due to the ongoing difficulty with a neighbour who received care from another provider and showed behaviour that could be perceived as challenging. Staff were attentive and provided reassurance this person and other people in the shared house.

People's care plans detailed family and friends who were important to them. This helped staff to be knowledgeable about people's family and enabled them to be involved as they wished. People and their relatives were encouraged to be involved in all aspects of care. Regular reviews with people and those that mattered to them were in place.

People's independence was respected. For example, staff encouraged people to participate in household tasks including preparing their own meals or meals for the people they shared a house with. Staff were observed supporting people with their independence. Staff understood people's individual needs and how to meet those needs. They knew about people's lifestyle choices and how to help promote their independence. However some people in one shared house had their independence restricted due to not being able to leave on their own or enter their own home at all times. Particularly if a neighbour they felt uncomfortable with was in the shared car park/access area outside.

The values of the organisation ensured the staff team demonstrated genuine care and affection for people. This was evidenced through our conversations with the staff. People received care from a regular staff team.

One relative said of the staff member supporting their relative; "They are so supportive and we can't fault them in anything they do." This consistency helped meet people's behavioural needs and gave staff a better understanding of people's communication needs. It supported relationships to be developed with people so they felt they mattered.

Good

Is the service responsive?

Our findings

The service was responsive.

People able to, staff and relatives told us that people had access to a wide range of personalised activities. One person told us, "I enjoy painting. The staff help me with this." Their relative said how the staff supported them with painting due to their deteriorating eyesight. They went onto say how this person then sells their paintings and raises money for charities. Staff said people are doing activities whenever they wish to. People in one shared house produced a newsletter and this told of activities and holidays undertaken including cruise holidays, trips to Disneyland and another person going to Mallorca to celebrate a big birthday. People had a timetable plan and picture board of daily activities they may wish to carry out. People told us of the holidays they were supported by staff to enjoy. Social clubs were attended by people so they could meet friends.

A relative said how the agency were currently arranging a holiday to Ireland for one person who had always wished to go their due to their grandparents coming from there. Relatives went on to say how their relatives had had some excellent holidays over the years including several cruises and trips aboard.

Staff had a good understanding of people's needs and continued to find creative ways of supporting them to have an exceptional quality of life. For example, one relative said how the needs of their relative had changed and the management of the agency had responded by arranging for their relative to have a staff member with them so they were able to still access the community and attended activities of their choice without effecting their quality of life.

People received personalised care that was responsive to their needs. People's care plans were very person-centred, and detailed how they wanted their needs to be met in line with their wishes and preferences. People's care plans also detailed their social and medical history, as well as any cultural, religious and spiritual needs. One person told us how they attend the local church. Staff monitored and responded to changes in people's health or behavioural needs. All the care plans included detailed "hospital passports." This document helped inform hospital staff about people's preferences and how they communicated if they needed to go into hospital. However, one person's care plan clearly indicated they now needed the assistance of two staff to assist them to meet their toileting needs and this was not always provided for this person.

A relative told us how their relative had needed to go into hospital for a major operation and was very poorly. They said their relative was extremely concerned about hospital visits and admission as they associated this with the death of their parents and said their relative found the process "Very daunting." However the service responded to this by providing additional staff support while their relative was in hospital and all hospital appointments before admission for the operation. The relative said the response by the management team did not stop there. They went onto say the management team then ensured the person was 100% fit and well and able to move back into their own home and that they had all suitable equipment, staffing and extra supported needed in place before the person was discharged. Another person

who had an operation and had communication difficulties was going to move to a nursing home on a temporary basis for rehabilitation. However the staff recognised this person's needs and the impact of a different placement on their recovery. The staff and agency wanted the best outcome for this person and their well-being. Therefore the service responded by arranging a meeting with all the tenants in one of the shared houses and agreed to temporarily change the lounge area to a bedroom. This enabled their friend and housemate to move back into their own home with outside professional support visiting to support the staff and person concerned. The service manager for this shared house said; "He has since made a remarkable recovery and with limited distress to him."

People's likes, dislikes and their aspirations had been identified. For people with limited verbal communication skills care plans identified ways of facilitating communication with the use of pictures, photos and symbols. Care plans held information on personal choice and the importance of supporting maximum independence. For example, people were given as much choice as possible about how they liked to spend their day and where they wanted to go. If people had protected characteristics under the Equality Act these were respected and documented. The provider's policies and procedures reflected that people would be treated equally and fairly.

The company had a complaints procedure displayed in the service for people and visitors to access. People, when asked, said they could talk to the staff if they were not happy with things. The registered manager and service managers clearly understood the actions they would need to take to resolve any issues raised. They explained they would act in an open and transparent manner, apologise and use the complaint as an opportunity to learn. Staff told us that due to some people's nonverbal communication, they knew people well and worked closely with them and would monitor any changes in behaviour. The registered manager and service managers told us, they would take action to review the policy to ensure it was in line with the Accessible Information Standard (AIS). The AIS is a new requirement to help make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. People had either family member or advocates appointed to ensure people who were unable to effectively communicate, had their voices heard. However some people living in one shared house had raised concerns about a neighbour and this was being handled by a service manager. The people, relatives and staff who raised the issues with us however still had major concerns about this neighbour and the effect it was having on people's lives.

One person with communication difficulties had assisted the local authority on an interview panel to employ a new speech and language specialist within the local learning disability team. The agency responded to this request by supporting this person before the interview. The interview panel sent feedback to the agency and said; "Having X there had really helped them to assess each person's (candidate) ability to interact with someone who was at times a little bit difficult to understand." This person has since assisted with the recruitment of another speech and language specialist.

The agency had responded to a new person requiring support. This person was living with some mental health issues and extreme anxiety. The agency had been excellent in their response by providing staffing support at short notice. They also realised that this person required additional one-to-one support overnight due to their anxiety. While they applied to the local authority for funding for this additional support the agency supplied extra staffing at their own cost as they recognised the need to support this person for more hours than was currently funded. However some staff raised concerns that the agency had taken on this person and another person's support without looking at the implications of having sufficient staff support to provide this new care package. These care hours/support were only being met on some days by the goodwill of current staff employed working long days and extra hours. The registered manager and provider said they would look into these issues and other issues including staffing levels and number of

hours staff work.

Plymouth Support Services prided themselves on the end of life care they had provided for people. They worked hard to ensure people who wished to remain at the home during their final days were able to, comfortable and pain free. They also documented people's end of life requests to help ensure people received their end of life wishes after they passed. For example where people wanted to be buried.

At the time of this inspection there were no people close to the end of their lives. However, the staff spoken with understood ways of ensuring people would receive appropriate care at the end of their lives, with dignity and as much independence as possible. This meant that any people who needed end of life care in the future could be confident their needs would be met. The PIR recorded; "Where parents of people are ageing, support is given to plan ahead in readiness for the bereavement process."

Staff worked had worked with St Luke's Hospice and the District Nurse team to provide end of life care for a person who passed away. A service manager said staff had a good working relationship with doctors and nurses to ensure this person who had required pain relief had this promptly. The person's care ensured privacy, comfort and dignity, and any equipment they required had been provided. This showed us staff were skilled at delivering compassionate care in people's last days. A relative of this person send us information about the care their relative received and said; "X (a service manager) and the team were passionate and shared my view that [X] should see out her remaining days at her home of 17 years. The up-skilling and adaptation/change skills amongst the team (driven by [X-the service manager]), coupled with outstanding communications with me to ensure resource, equipment or such other requirements/escalations were quickly put in place or input to specific specialist carers/medics as required, was in my experience quite unique, and again outstanding. The support for her end of life needs, whilst I know were tough for all involved, were again outstanding, and again excellent communications with me when I could not be present in Plymouth. But more specifically excellent communications in place across the entire team meant that [X's] final months were as positive as we could humanly have achieved, and she passed away peacefully in her home."

One shared house had a sudden death of a person many of the staff had cared for over a number of years. Staff said how much it was a shock to them all. However some staff felt un-supported over this incident. With one staff saying; "No support- X [the service manager] didn't seem to care." The management team confirmed the company had a telephone counselling service available for staff at any time and phone numbers were given to all staff when they started employment. However, they would ensure the number was highlighted to staff again.

Requires Improvement

Is the service well-led?

Our findings

The service was not consistently well-led. At the last inspection in April 2016 the service was well led. At this inspection we found improvement was needed to ensure quality of care in all areas was sustained. We spent time discussing our inspection findings with another registered manager of the company who was covering in the registered manager's absence.

The PIR records; "As Registered manager I have overall responsibility for the Safety of the service and make regular visits to the services. Underneath me I have 2 service Managers and an assistant service manager. There are 2 x supported Living services under this registration as well as some people in the Community that we support. These service managers are responsible for the day to day running of the service and have an almost daily presence within these services."

We discussed how the current management structure, [the provider and registered manager] needed consideration to maintain standards of care across all areas. Two service managers oversee a shared house each. However we were informed by staff that the registered manager does not attend staff meeting within each shared house and some commented that they either had not met the registered manager or see them very little. Closer oversight of the service by registered manager and provider could have enabled them to have an insight to the difficulties people and staff were experiencing. For example staff at one house being very unhappy with the service manager's approach.

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. We were assisted during our inspection by two service managers. These two service manager were in day to day control of the service. This included one service manager overseeing a shared house each and jointly overseeing people who received care in their own home within the community. We provided feedback to a registered manager of another service due to the temporary absence of the registered manager for the Plymouth services.

People were not all able to fully verbalise their views. Relatives and people who were able to spoke well of the care they received. Comments included; "Always kept informed" and "X (a service manager) treats people as individuals."

The registered manager and provider did not always have effective oversight to ensure people's needs were met appropriately. During the inspection we found one person with a package of care was not always having their needs met. We intervened and during the inspection period a re-assessment of their funded hours took place. However, this still fell short of the number of hours they required to safely meet their personal care needs.

The systems in place to assess and identify staffing levels in response to current and new packages of care required improvement. This was to ensure staff were not working excessive hours and people had their

needs met at all times. On our visit on the 31 May we were informed a person had been allocated two additional hours a day for extra support. The service manager had negotiated funding for these additional two hours to assist with their toileting needs. The service manager had also changed the staff rota to help ensure this person had two staff available to them at certain times of the day, however this person still had times where they only had one staff member with them. For example if they went into the community for any activities only one staff member accompanied them. Therefore they would need to return home if this person needed to use the toilet. The service manager stated the staffing rota had been changed but only after we had raised a safeguarding alert over the time this person was left for 45 minutes. Therefore the management had failed to have effective oversight and monitoring of staffing arrangements as they had not recognised the need for changing the staff rota.

It was unclear how the day to day staff culture was kept under review. We found staff morale was mixed. The feedback we received from support staff was variable. Staff told us one of the service managers was very approachable while the other was not. The positive comments for one service manager included; "Very approachable", "Working really hard with other company (this was in reference to neighbour causing problems)", "Is always really good" and "X is great."

Not all staff felt feedback given by management was constructive and motivating. While staff commented on the other service manager; "Not listened to", "Don't feel listened to at team meetings", "Not treated well", "Cares for people living here but "speaks to them like children", "Not well run", "I do speak up in team meetings but feel a lot of what you say isn't heard/listened to", "Mencap themselves are brilliant. But this one! (service manager) Well this one is something else!", "She has brought the moral very low", "I have gone home in tears because of her" and "I think she will get rid of us if we say anymore." We passed this information onto the registered manager who was currently overseeing the Plymouth service.

Not all staff had confidence in all levels of management at the service. Some staff said they had not met the registered manager while another said they had spoken to the registered manager about their concerns over a service manager attitude. Staff confirmed that the registered manager did not attend their staff meetings to enable them to hear what staff had to say or raise concerns. One staff member said of the team meetings held; "I do speak up in team meetings but feel a lot of what you say isn't heard/listened to."

The registered manager and provider's systems for monitoring and oversight of current issues were not effective. The service managers had both previously spoken to local authorities over the issues raised during this inspection. Namely concerns about people's safety with the neighbour, issues over the second care provider and the requirement of additional staffing for someone who now needed two staff to assist with their toileting needs. However each issue was currently still an ongoing concern for people, relatives and staff. The neighbour was still displaying behaviours that could challenge and was preventing people feeling safe leaving and returning to their home. Care from the second care provider was due to cease in July 2018.

The registered manager and provider failed to have fully effective quality assurance and governance arrangements. Current checks and audits carried out were not effective in giving the provider and registered manager a clear oversight of the service or alert them to issues raised during our inspection. For example how staff were very unhappy with the running of one of the shared houses, how there was a short fall on providing safe care for one person and how many additional hours were being provided to one person possibly indicating their need for a different placement.

The provider's governance framework and quality assurance systems, had failed to effectively and consistently identify where improvements were required.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

However, there was open communication with families. Relatives had developed a good relationship with the service managers and some had regular contact with their family member and the service staff. Other relatives had less involvement but were interested in what was happening and said they were kept up to date.

People had a service which was continuously adapting to changes in practice and legislation. For example, the company were aware of, and had started to implement the Care Quality Commission's (CQC's) changes to the Key Lines of Enquiry (KLOEs), and they were looking at how the Accessible Information Standard would benefit the service and the people who lived in it. This was to ensure the service fully meet people's information and communication needs, in line with the Health and Social Care Act 2012.

Aspects of the provider's governance framework, helped monitor the ongoing quality and safety of the care people received. For example, there were processes and systems in place to check accidents and incidents. These helped to promptly highlight when improvements were required.

The provider learnt from mistakes and ensured people were safe. The registered manager and provider had an ethos of honesty and transparency. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

The providers PIR records; "At Mencap we have a core set of values that we want all of our staff to demonstrate. These are Positive, Caring, Challenging, Trustworthy and Inclusive." It goes onto say; "We regularly review with staff the core values and with observations and comments we make sure that they are always caring to each other and those that we support."

The provider website records; "Our vision is a world where people with a learning disability are valued equally, listened to and included."

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 17 HSCA RA Regulations 2014 Good governance The provider's governance framework and quality assurance systems, had failed to effectively and consistently identify where improvements were required.