

Royal Mencap Society

Mencap - East Cornwall 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?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

MENCAP - East Cornwall Support Service is a supported living service that provides personal care to people living in their own homes. Supported living services aim to enable people to live as independently as possible in the community. 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.

The service supports people living in 11 separate houses throughout the east of Cornwall. Some of these houses had previously been registered as care homes. At the time of our inspection the service supported 57 people with learning disabilities, 34 of whom received personal care.

We carried out this announced inspection on 12 and 17 October 2018. At the previous comprehensive inspection in August 2016, the service was rated Good. An additional focused inspection was completed in October 2017 in response to concerns about staffing levels at a particular house. The focused inspection also found that the service was good as the provider had taken appropriate measures to ensure people's needs were met. Prior to this inspection we again received information of concern in relation to staffing levels at the same house.

At this inspection we found that the service did not currently employ enough staff to provide all planned care and that agency staff were used regularly throughout the service. People told us low staffing levels had impacted on their ability to access the community and records showed people had been unable to participate in activities they enjoyed due to staffing issues. Staff told us, "Staffing levels have been testing. There were only five permanent staff when I started. A lot of agency", "Agency staff are normally on five out of seven days" and "We are understaffed quite often... It has been pretty short at times." Staffing records showed and managers accepted that there had been times during the summer when planned staffing levels had not been achieved.

Issues with the quality and accuracy of people's care plans and associated records were identified throughout the service. People's care plans did not always accurately reflect the support staff provided. Staff told us, "I know the care plans are not accurate. The information is out of date" and "The paperwork is a mess, it got to the point in July and August where I was having to copy paper work at home to use." Summary records of incidents had not been completed accurately or logically and did not include details of all incidents that had occurred.

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. The service did not have a registered manager at the time of our inspection and there had been a number of leadership changes within the service since our last inspection. However, an area manager had been recently appointed and an application for their registration was submitted following our

inspection.

Each house where the service provides support was led by a service manager who reported to the area manager. We found there had been a number of changes of service managers since our last inspection. In the house in which concerns had been raised about staffing levels there had been a lack of consistent leadership. Staff did not feel adequately supported and told us, "Continuity is key and this has not been there. I think there has been a horrible perfect storm to destabilise the [house] with the lack of continuity."

The providers quality assurance system had identified these issues prior to our inspection and significant additional leadership support had been provided to the staff team. Staff reported this support had been a positive impact and told us, "The new managers are brilliant. I can go to them with anything and they will help. They are there for the staff as well which is a big thing" and "Those three ladies are doing an amazing job." In addition, a new permanent service manager for this house had been appointed in the week prior to our inspection.

Both the new area manager and the new service manager for this house were being supported to complete significant additional training for their new roles. The provider's regional operations manager was visiting the service regularly to provide additional support and the intention was for the additional management support to remain in place until the new managers had completed this training.

In two of the three houses we visited the service was providing appropriate supported living care. However, in one house which was previously registered as a care home we have made a recommendation. This is because people in this house were not receiving individualised care in line with the visions and values associated with this model of care.

People told us they got on well with their support staff and during our inspection we saw that staff provided support with kindness and at a relaxed pace. Staff spoke warmly of the people they supported and told us, "The guys we support are amazing".

Staff were sufficiently skilled to meet people care needs and their training had been regularly updated. Records showed staff had received regular supervisions and annual performance appraisals.

Staff understood their role in protecting people from all forms of abuse and understood local safeguarding arrangements. The service's recruitment procedure were safe and all necessary pre employment checks had been completed.

Staff and managers had a good understanding of the Mental Capacity Act 2005 and staff supported people to make decision and choices throughout our inspection. There were restrictions on some people's liberty to ensure their safety and these restrictions had been appropriately authorised. However, we identified other individuals who lacked capacity in some areas and who were not free to leave their home without support from staff. We have recommended the service raise these issues with care commissioners, so if necessary authorisation from the court of protection can be sought for all possible deprivations of liberty within this 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?

The service was not safe. There were not always sufficient staff employed with the correct skills to provide planned levels of support. On some occasions people had not received their commissioned levels of care.

During the summer new staff had not received support and practical training in relation to how to support people with medicines. These issues had been identified prior to the inspection and additional training and support had been provided.

Recruitment procedures were safe and staff understood both the providers and local authority's procedures for the reporting of suspected abuse.

Requires Improvement ●

Is the service effective?

The service was effective. Staff training was regularly updated and there were appropriate procedures in place for the induction of new members of staff.

People's choices were respected and staff were provided with appropriate guidance on how to meet people's needs if they became upset or anxious.

Although staff understood the requirements of the Mental Capacity Act 2005 we identified some people whose care plans were restrictive and had not been appropriately authorised.

Good ●

Is the service caring?

The service was caring. Staff provided support with kindness and compassion.

Staff supported people to make choices and respected their decisions.

Good ●

Is the service responsive?

The service was not entirely responsive. People's care plans were significant documents that were not fully understood by all staff.

Requires Improvement ●

These records had not been appropriately updated and did not reflect the current support staff provided.

Information about people's likes and interest had not been consistently recorded.

Staff had been provided with detailed guidance on how to communicate effectively with people and we observed these techniques being used successfully.

Complaints received had been investigated and where appropriate action taken to prevent similar issues reoccurring.

Is the service well-led?

The service was not well led. Records and people's care plans had not been accurately maintained to constantly reflect the support staff provided.

Managerial changes had impacted on the service performance. Quality assurance systems had identified these issues prior to our inspection and arrangements had been made to provide significant additional management support.

In one of the settings we visited people were where not receiving individualised supported living care.

Requires Improvement 

Mencap - East Cornwall 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 inspection took place on 12 and 17 September 2018 and was announced in accordance with our current methodologies for inspection of services which support people in their own homes. Announcing the inspection enabled us to make arrangements to visit three of the houses where this service provides support. The inspection team consisted of two adult social care inspectors.

The service was previously comprehensively inspected in August 2016 when it was found to be fully compliant with the regulations and good in all areas. As a result of concerns reported to the Commission in relation to staffing levels we completed a focused inspection in October 2017. That inspection found, although there had been issues in relation to staffing levels these had been appropriately managed and peoples' needs had been met.

Prior to the inspection we reviewed all the information we held on the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law. Prior to this inspection we had again received information which raised concerns about staffing levels within the service.

During the inspection we met and spoke with seven people who used the service, 13 staff, the new area manager, the registered manager from another Mencap service who was providing leadership to one house and the providers' regional operations manager. In addition, we observed staff supporting people in the three houses we visited. We also inspected a range of records. These included five care plans, four staff files, training records, staff duty rotas, meeting minutes and the services policies and procedures.

Is the service safe?

Our findings

Our previous responsive inspection of this service was completed as a result of concerns about staffing levels in a specific supported living setting. At that inspection we found, although there had been significant staffing challenges, they had been appropriately managed. Planned staffing levels had been achieved using agency staff and a targeted recruitment drive was underway to improve staffing levels at this house.

Prior to this inspection we again received information of concern in relation to staffing levels at the same house. As a result, during this inspection we visited the house and spoke with people living there and their support staff. People told us that staffing levels had impacted on their ability to access the community, especially when the service was understaffed at the weekend.

Staff said, "Staffing, obviously not great. We are using a lot of agency but they have some new staff on the way", "Staffing levels have been testing. There were only five permanent staff when I started. A lot of agency", "Agency staff are normally on five out of seven days" and "There have been times when there are two agency staff on but there is always one contracted staff." Records showed that, in this house during June, July and August 2018, 21% of planned care shifts had been provided by agency staff.

Staff also told us there had been occasions where planned staffing levels had not been achieved and managers acknowledged this was correct. Staff comments included, "There was two staff on at one point [during the weekend prior to the inspection]", "We are understaffed quite often...It has been pretty short at times" and "At the weekend if there are only two staff on we can't support people to go out. Yesterday we had enough staff and two people went out to Mevagissey."

We also looked at agency usage and staffing levels in the other houses where the service provided support. We identified that there were a number of vacancies across the service and found that agency staff had been used to provide 11% of all planned care shifts during the June 2018 to August 2018 period. Staff from other houses told us, "At [house name] agency usage is 30 to 80 hours per week", "It's not major but we are a little understaffed...we used 12 hours of agency staff last week." Service managers told us, "I always get agency staff to cover, I try to get the same staff so they are familiar with the people we support." Records showed this had generally been achieved. Agency staff on duty on the day of our inspection told us, "There is an agency introduction file and I had a briefing on fire safety." We reviewed this file and found it contained information about emergency procedures and the one-page care plan profiles for each person living in the house.

Team meeting minutes from other houses showed there had been occasions where planned staffing levels had not been achieved and that staffing issues meant some people had been unable to participate in activities they were known to enjoy. For example, one house's team meeting minutes recorded, "Swimming has ceased as not able to do with the mix of staff recently. Look at reinstating the activity when possible." Managers also recognised there were issues in relation to the availability of staff who could drive and commented, "Transport is a big issue, people are having to spend a fortune on taxi's."

There were issues in relation to staffing levels and staff skill mix across the service that had negatively impacted on people and had on a small number occasions, reduced their quality of life. The service was in breach of the requirements of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to our inspection the provider had recognised that the service was short staffed and managers told us, "Recruitment across the whole area has been a challenge." As a result the regional operations manager had arranged for additional resources to be put in place to support a targeted recruitment campaign for the house about which staffing concerns had been reported to CQC. This had led to an increase in applicants for available roles and staff said, "Two new staff have been appointed and five additional staff have been employed but not yet started here." The recently appointed area manager told us addressing the staffing challenges was, "Operationally, our number one focus". Listening exercises were planned with staff to identify the issues that had led to the service's staff retention challenges.

The area manager told us their aim was to overrecruit to prevent similar staffing challenges from reoccurring and to eliminate the use of agency staff. However, we noted that similar plans had been in place at the time of our previous inspection but these measures had not prevented the staffing issues identified in this report.

The service had safe and appropriate staff recruitment procedures. Staff files contained all necessary references and showed disclosure and barring service checks had been completed to ensure staff were suitable for employment in the care sector. Where staff performance issues had been identified managers had used the provider's disciplinary procedures appropriately to ensure people's safety and drive improvement in the service's performance.

The providers policy was for new staff to receive 'onboarding' training and coaching in the specific systems used for supporting people with their medicines. This was to be delivered by each house's service manager. In the house where there had been significant management changes and a high turnover of staff this training and support had not been provided during the summer. Staff in this house told us, "From May we stopped doing meds control (audits) as only two staff knew how to do it", "Staff did not shadow enough to be confident to do it, staff did not get the supervision with meds. You had a situation where new staff were shadowing inexperienced staff to learn what to do" and "There has been a lack of medicine observation for new staff." Staff in this house had lacked confidence in relation to medicines management and on an occasion prior to our inspection a person not received appropriate support with their emergency medicine. In addition, a number of medicines errors had occurred in this house during the summer months.

Internal audits had identified these issues and as a result staff in this house had received additional medicines training and targeted supervision from the new management team. Staff told us they now felt more confident supporting people with their medicines. The medicine administration records we reviewed at the time of this inspection demonstrated people were now being safely supported.

Each person's care plans included specific guidance for staff on the support they required with their medicines. This included details of how people liked their medicines to be presented, what support they required and details of any side effects associated with their medicines. During our inspection people were able to request 'as required' pain relief and we saw this was provided promptly.

Risks in relation to people's care and support needs had been identified and assessed. Each person's care plan provided staff with guidance on the action they must take to protect both the person and themselves from each area of risk. For example, one person who used a frame to mobilise was at significant risk of falling. Their care plan included guidance on how prompt the person to use their equipment safely and how

to provide encouragement to ensure the person's safety if they became tired. We observed staff using these techniques successfully to support the person's independence during the inspection.

There were appropriate emergency procedures in place in each of the houses where the service provided support. A Personal Emergency Evacuation Plan had been developed for each person which included details of the support they would require in the event of a fire or other emergency evacuation.

People told us they felt safe with their support staff and staff said, "People are very safe", "I would say people are safe yes and they are safe out in the community as well" and "I would say people are safe." All staff had received training in how to protect people from abuse and all forms of discrimination. Information about local safeguarding systems was readily available and staff understood how to raise concerns in relation to peoples' safety.

People were supported to maintain a clean and healthy environment in each setting and cleaning contractors had been sourced to provide additional help with cleaning in communal areas of each setting. Staff had received appropriate infection control training and personal protective equipment was available when required.

Some people needed help to manage their finances and there were appropriate systems and procedures in place to provide this support. Where staff made purchases on a person's behalf detailed records were kept. Financial records were regularly audited and people were involved in these processes. Financial records viewed during the inspection were accurate and balanced.

Is the service effective?

Our findings

The service had systems in place for the assessment of people's needs before agreeing to provide their support. This included inviting people to visit settings regularly before they moved in to meet people, their support staff and to see and get used to how each setting operated. This was done to ensure both that the service could meet the person needs and that they would get on with the people currently living in the setting. Information gathered during the assessment process was combined with details provided by the commissioners of the care package and information from relatives to form the basis of the person's care plan.

All new staff completed formal corporate induction training and a significant period of shadowing more experienced staff in specific settings before providing support independently. This training included details of the providers core values and formal training in topics necessary to enable staff to meet people needs. Staff told us this system worked well and their comments included, "I had two, three day weeks of training and then was shadowing for two or three weeks" "My induction was pretty good" and "You learn by doing things, I had three weeks of shadow shifts."

Staff new to the care sector were supported to complete the Care Certificate during their first 12 weeks of employment. This nationally recognised training package is designed to provide staff with an understanding of current good practice. During the shadowing period new staff were supposed to receive additional supervision and spot checks to assess competency with specific tasks from individual service managers. Staff told us this support had not been consistently provided in all settings and the impact of this in relation to medicines was discussed in detail in the safe section of the report.

Staff were sufficiently skilled and there were systems in place to ensure all staff received regular training updates in topics the provider considered mandatory. This included training in, safeguarding adults, moving and handling, food hygiene, fire safety, medicines and epilepsy awareness. Staff told us, "My training is up to date" and "The training is very comprehensive."

There were formal systems in place to provide staff with additional training and support on appointment to management and leadership roles. The provider's regional operations manager was meeting with the newly appointed area manager regularly and appropriate arrangements had been made to provide individual staff teams with additional leadership support while new managers completed their induction to their new roles.

Staff received regular support and supervision from their managers. Staff told us, "I had supervision a couple of months ago" and "We have supervision four times a year and an annual appraisal." These meetings were well documented and showed staff performance, training needs and development goals had been discussed and reviewed. As part of the appraisal process people were encouraged to identify how they would like to further their careers and the provider operated a variety of schemes to enable staff to broaden their experience through participation in project work and additional training to support staff to achieve their goals.

Staff team meetings for staff supporting people living in particular settings were also held regularly. Records showed these were well attended. The meeting minutes showed these were an opportunity for staff to share observations about people's changing needs and any specific concerns with their managers. These meetings also provided an opportunity for managers to share examples of best practice and details of any changes planned within the organisation with staff.

People's care plans included information for staff on how to support if the person became upset or anxious. This included details of events or situations likely to cause the person upset, indicators that the person was becoming anxious, guidance on how to communicate effectively and details of the support likely to be needed following any incidents. Records showed staff had received training in positive behavioural support and staff told us they felt confident they could meet people's needs and ensure people's safety if they became upset. One member of staff had received a national award from the British Institute of Learning Disabilities (BiLD) for innovative practice in supporting a person living in one of the service's settings.

The service was in the process of supporting people to identify new technologies which could be used to facilitate their independence. For example, the service was looking to support people to investigate the use of voice-controlled intelligent personal assistant technologies for prompts while cooking and to maintain links with friends and family.

Staff supported and encouraged people to prepare snacks for themselves, participate in meal preparation and to maintain a healthy balanced diet. In one of the settings we visited staff were supporting one person to bake during the inspection. Care records showed people had been supported to attend weight-loss peer support groups and to make healthy dietary choices. In some settings staff prepared communal meals and people told us "The food is very good, I get to choose." Staff commented, "Usually people have the same meal but they can make own if they would prefer." Where people were identified as at risk of choking this was clearly highlighted to staff in their care records.

People were supported to access external healthcare services as necessary. Staff told us they had good links to the local hospital's learning disability team which ensured people's support needs were met during any hospital admissions. People's care records showed appropriate referrals to health professionals including GPs, speech and language therapists and district nurses had had been made. Any guidance provided was followed by staff and incorporated into the person's care records.

We saw that staff sought people's consent before providing support. People were supported to make decisions and choices by staff who varied how they presented information to enable people to make meaningful decisions and choices.

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.

The area manager and staff teams had an understanding of this legislation and sought during our inspection to support people to make meaningful decisions and choices. We observed that staff varied how information was presented to aid people's understanding and facilitate their decision making. Care records showed that staff had respected people's decisions and that people were able to decline planned care and activities if they wished. However, people's care records did not consistently included assessments of their capacity in relation to complex decisions and issues. Managers had recognised this issue and in one of the

settings we visited work was underway to complete these necessary assessments.

One person was the subject of a community deprivation of liberty order due to the restrictive nature of their care plan. We identified a second person who had previously been assessed as lacking capacity to make a decision in relation to their accommodation. Staff told us this person was not able to access the community independently as they would be at significant risk and that they would follow the person to ensure their safety if they left the building without support. This was highlighted to the service manager at the conclusion of our inspection who advised they would complete the required assessments for the person promptly and involve the relevant professionals where the need was identified.

We recommend that the provider reviews its current procedures for assessing people's capacity and any restrictions to people's liberty in accordance with published guidance.

Is the service caring?

Our findings

People told us they were happy and enjoyed the company of their support staff. Their comments included, "They do look after me", "The staff are nice" and "Staff are OK, not too bad, good fun." During our inspection we visited three different supported living settings where people received support. In all three settings we saw staff providing support with kindness and compassion.

Staff told us they took pleasure from their role in supporting people and their comments included, "The guys we support are amazing", "I love them all to bits" and "I am loving the job to be quite honest." People were supported at a relaxed pace and staff took time to encourage and support people to engage with activities. Staff and managers spoke warmly of the people they supported and took pride in describing their individual achievements.

Staff had a good understanding of equality and diversity issues and acted to ensure people were protected from all forms of discrimination.

Care plans included guidance for staff on how to support and encourage people to be as independent as possible. During our inspection people were supported to prepare their own lunch, make drinks, answer doors and complete other domestic tasks.

Staff in different settings used individualised techniques to support people with limited verbal communication to make routine decisions and choices. For example, one person used a clock based tool to plan and prepare for activities throughout the day. This person's care plan included detailed guidance for staff on the use of this tool and how to recognise the person's decisions and choices. People's care plan's instructed staff to support, encourage and respect people's choices. For example, one person's care plans stated, "[Person's name] is to be given choice on as many occasions as possible" and daily care records showed people's decision not to attend planned events or appointments had been respected by staff. During our inspection people choose how to spend their time, the domestic chores they completed and activities they engaged with.

Where staff had found that people's support needs had significantly changed appropriate referrals had been made to service commissioners for additional support. For example, from daily care records it was clear that one person now needed additional support from staff due to a decline in their health and records showed these concerns had been raised with care commissioners, GP's and specialist health professionals. Managers told us, "I have requested re assessments from commissioners as I feel the hours are not enough."

People were supported to maintain relationships that were important to them. Records showed staff regularly supported people to visit and meet with friends and relatives. In addition, training in, "friendship, sexuality and relationships" was planned for all staff at the end of September 2018. In each setting, a staff member had been nominated to champion these issues and the service was successfully supporting two people whose relationship was blossoming.

Records were stored securely when not in use and staff ensured people's privacy and dignity was respected at all times. Where people required this support it was provided discreetly and all personal care was provided within the privacy of the person's own room. Where possible people were encouraged to take on responsibility for their own personal care with prompting and support from staff.

Is the service responsive?

Our findings

People's care needs were assessed by the service's managers before new packages of care were agreed. Managers met with people in their homes as part of the assessment process and people were encouraged and supported to visit the supported living setting they intended to move into. This enabled people to look around their proposed new home and meet people and staff before deciding to move in. This helped people to manage any anxiety around the move and enabled staff to gain a detailed understanding of the person's needs. Relatives and health professionals were appropriately involved in the assessment process to ensure all parties understood the level of support the service was able to provide.

People's care plans were significant and lengthy documents and staff in the house which had experienced significant staff turnover did not fully understand them. Staff told us, "I know the care plans are not accurate. The information is out of date." Care records showed incidents had occurred as staff had not consistently followed guidance within people's care plans.

In addition, where significant risks had been identified staff had not always been provided with detailed guidance within the care plan on how these risks should be managed. For example, some people had been identified as being at significant risk of choking and their risk assessments included detailed guidance on how this risk should be managed. However, their eating and drinking care plan did not include any specific guidance on how food should be prepared to manage these risks or details of the support the person required at meal times. This information was available in other documentation including the one-page summary care plan, risk assessments and advice provided by Speech and Language Therapists but had not been incorporated into the person's care plan. An audit completed on 30 August 2018 had identified these issues but they had not been resolved by the time of our inspection.

In other houses we also found that people's care plans had not been consistently reviewed and updated to ensure their accuracy. For example, records showed one person's medicines care plan had been reviewed and updated on the day before our inspection. However, when we asked staff about the support they provided this person with their medicines it was clear staff had not been providing the support described in the care plan for a significant period.

A one-page summary care plan had been developed for each person the service supported. These documents had been regularly updated and did provide staff with accurate guidance on people's current care and support needs. These summary care plans were used by agency staff used to gain an understanding of people's needs before providing support

People's care plans did not consistently record details of the person's background, interests and hobbies. We found the provider had been supporting some people for a considerable time and that established staff had highly detailed and extensive knowledge of their life history and background. However, this information had not been consistently documented within care records and there was a risk important knowledge could be lost during periods of staff change. In the setting where there had been significant staffing and management changes, knowledge of one person's interest in horse riding had been lost. While providing

support with cleaning tasks staff had found items of horse riding equipment in this person cupboard. When subsequently asked about this equipment the person had said they would like to go riding again. The failure to record details of this person's interest in riding meant they had not been recently supported to participate in this activity.

Although the information contained in people's full care plans was not entirely accurate, this had limited impact as the summary one-page care plans did provide staff with accurate and current guidance. However, the numerous issues identified in relation to the accuracy of people's care records forms part of the breach of regulation 17 of the Health and Social Care Act 2005 (Regulated Activities) regulations 2014 discussed further in the well led section of the report.

Records were completed each day recording details of the care and support staff had provided. We saw a variety of slightly different recording systems were used in the settings we visited. In the setting which had experienced significant staffing and management changes the record keeping systems had been recently reviewed and updated by the new management team. Staff were now being provided with additional specific guidance on the level of detail to be included in daily care records and completed records had been annotated to highlight where additional information was required. Staff recognised that the quality of record keeping had improved following the changes made to recording system and told us, "The new daily logs are starting to work really well".

Some people were supported to attend a variety of day centre placements during both days of our inspection. Where people chose to spend the day at home staff encouraged and supported people to engage with a variety of activities and tasks throughout the day. We observed staff supporting people to play games, bake cakes, access the local community and to prepare meals during our inspection. Staff told us, "One lady goes to the ballet quite regularly and one gentleman goes canoeing every week." Records throughout the service showed people regularly participated in a wide variety of activities.

One person told us they would like to have a befriender who could visit and support them to access the community. This person had previously raised this with staff who had investigated resources available from within MENCAP to meet this need. However, it was unclear if any attempts had been made to access support of this type from the wider community.

People's care plans included information about their specific communication needs and preferences. We observed staff using individualised approaches and communication aides effectively to share information with people during the inspection. In addition, we saw the provider had produced documents in accessible formats to aid people's understanding in relation to significant decisions and choices. This demonstrated the service had appropriate systems in place for supporting people's communication needs in accordance with the Accessible Information Standard.

The service had appropriate systems in place for the investigation and resolution of any complaints received. People told us they understood how to make a complaint and tenants meeting minutes showed people were regularly asked for feedback and reminded how to make a complaint if they wished. Where complaints had been received they had been fully investigated. Where these investigations had identified failings in the service's performance these issues had been acknowledged and systems and procedures changed to prevent similar incidents reoccurring.

Where people had expressed preferences in relation to how they would like to be cared for at the end of their lives this information had been recorded within the person's care records.

Is the service well-led?

Our findings

The service did not have sufficiently robust systems in place to ensure accurate and complete records were maintained. People's care plans did not consistently reflect their current needs and how support was to be safely provided. In two of the settings we visited issues were identified with the quality and accuracy of the information included in people's care plans. Staff had not been consistently provided with accurate information on people's interests and important information on the management of specific risks was not included in relevant sections of some people's care records.

The provider had appropriate systems in place for the documentation and reporting of all accidents and incidents that occurred within the service. However, some incidents that had occurred and were documented in daily care records had not been recorded in these systems. This meant managers were unaware of some incidents that had occurred.

In one setting care records were disorganised and had not been completed in a linear and logical way. The 'running records of significant events' designed to provide a chronological, immediate summary of all incidents, involving individuals had not been accurately completed. In one person's file the most recent entry appeared to have been completed on 10 August 2018, however we found that entries had not been made consecutively and proceeding pages contained information about later incidents. For example, an incident that had occurred on the 12 August 2018 had been added to a page where details of incidents that had occurred in March 2018 were documented. Other significant incidents we identified during our review of daily care records had not been recorded in summary documentation. An effective governance system to monitor the completion and accuracy would have identified the concerns we evidenced at our inspection.

Staff in this setting told us they found some of the service's record keeping systems difficult to use and commented, "The paperwork is quite repetitive". One member of staff described the record keeping systems in this setting as chaotic and told us, "The paperwork is a mess, it got to the point in July and August where I was having to copy paper work at home to use." This failure to accurately record information on summary records meant managers were unaware of significant events that had occurred and opportunities to develop and improve the service had been lost.

These failures to ensure care records accurately reflected people's needs and to document incidents that had occurred meant the service was in breach of the requirements of regulation 17 of the Health and Social Care Act 2005 (Regulated Activities) regulations 2014.

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. The service did not have a registered manager in post and there had been significant management changes within the service since our last inspection in 2017.

The provider aimed for the service to be led by an area manager who was registered by the commission. The

area manager was responsible for the overall leadership of the service and was supported by service managers who were responsible for managing individual settings. The area manager and service managers were not normally based within the settings they managed but visited regularly. Where individual settings supported larger numbers of people or individuals with particularly complex needs assistant managers had also appointed. Assistant managers were based full time in specific settings and their time was split between providing care and supporting their service manager.

A new area manager for the service had been appointed prior to our inspection. Staff were complimentary of the new area managers approach and told us, "[The new area manager] is very supportive and very communicative." The new area manager was receiving regular support and supervision from the regional operation managers and there was a formal six month induction and training plan in place for the new area manager. Managers told us they felt well supported by the provider and commented, "We do see a lot of [the regional operations manager]." Following our inspection the Commission received an application from the new area manager to become registered.

At the setting where concerns had been raised prior to this inspection, there had been a lack of consistent leadership. Numerous individuals had held the service manager role for relatively short periods and this had impacted negatively on the quality of support the service provided. Comments from staff and managers included, "Continuity is key and this has not been there. I think there has been a horrible perfect storm to destabilise the [setting] with the lack of continuity", "Staff feel the support and nurturing of the team has not been there for a little while", "There was a change of area manager and change of manager here. it felt like we did not have anyone to contact" and "They have had a lack of consistency in managers which impacts on the whole service."

The provider's quality assurance and monitoring systems had identified these issues prior to our inspection. As a result significant additional management support had been provided. An assistant manager had initially moved from another service in August 2018 and as the scale of the issues within the house became clear further management support was provided. An experienced service manager from another house had been allocated to provide day to day leadership to the staff team and responsibility for the oversight of the service had been moved to a registered area manager from another Mencap registered service.

Action plans had been developed which identified the improvements required in this house and progress against these plans was being monitored. The new management team in this house had reintroduced appropriate staff planning tools which had improved staff morale and work / life balance. Additional medicines training had been provided to all staff in the house and issues in relation to the suitability of the flooring in shared areas of the house had been recognised and resolved. Staff told us the new management team had made a significant positive impact and their comments included, "Management had been a nightmare but since [the additional managers] have been here it is definitely getting better", "The new managers are brilliant. I can go to them with anything and they will help. They are there for the staff as well which is a big thing" and "Those three ladies are doing an amazing job."

Staff understood that the provider had systems and procedures in place designed to ensure people received consistent high-quality care and support. However, they recognised these systems had not worked effectively during the period where the service had experienced significant management change. Staff told us, "Mencap have all this in place but somewhere it has been lost", "It has been frustrating" and "Things are being taken a bit more seriously and they know what needs to be done."

A new permanent service manager for this setting had been appointed in the week before our inspection. This manager had previous experience of managing supported living services and was due to complete a

significant training package as part of their induction into their new role.

There had also been management changes at to other settings since our last inspection and records showed the service had received formal complaints from relatives in relation to the quality of management within the service. These complaints had been investigated and the provider had accepted that, "There has been a lack of managerial oversight and guidance for staff."

The regional operations manager told us the current additional management resources were to remain in place until the new area and service managers had completed their induction as, "We do not want any more management turnover." In addition, there were plans in place for the appointment and training of two additional assistant managers so that in future there would be additional leadership capacity available to provide staff teams with support during periods of management change. The new area manager told us, "The bottom line is that we've been stretched managerially and a little bit more managerial support is needed. We've addressed this now and there will be more oversight." While the regional operations manager told us resolving the service's leadership issues, "Has taken longer than I would have liked."

There was an on-call manager system in place to enable staff to access management support outside of office hours. Staff told us these systems worked well and in response to concerns about staff confidence in one setting additional support arrangements had been introduced. The on-call manager was currently contacting staff in this setting twice each day to offer additional support and guidance and to ensure all issues were appropriately recorded.

Each individual setting had its own staff team and culture. We found there were significant variations in staff morale between settings. In some settings staff told us they were considering their positions while in other settings staff said, "I think they are a genuine caring organisation", "I am very proud of [Setting name]" and "I like working for them." The provider recognised that action was needed to improve staff moral and retention in some settings. Learning and listening exercises were planned to gain feedback from staff on what could be done to address and resolve these issues.

Staff team meetings for each setting were held regularly. The minutes of these meetings showed they had been used to update staff on proposed changes within the service and gather feedback from staff. In addition, resident meetings were also held regularly when any proposed changes within the settings could be discussed. These meetings also provided additional opportunities for people to provide feedback on the quality of support they received.

Mencap - East Cornwall Support Service is a supported living service and is registered to provide personal care. Supported living services provide support to people living in accommodation that is provided separately from their care. People should be able to make choices and decisions in relation to which provider meets their care needs, which carers provider their support, who they live with and where they live. In two of the three settings we visited the service was providing appropriate supported living care. However, in one setting which had previously been a registered care home the service was not providing individualised supported living care.

We found this particular setting continued to be managed as if it were a care home. For example, people did not have individually allocated staff, pooled money was used for the purchase of food, and notices were displayed reminding staff of important safety measures. On the first day of our inspection we saw a menu board was in use to advise people what was planned for dinner. We asked staff about this and how people were supported to make individual decisions and choices in relation to their meals. These questions were

not adequately answered but by the second day of our inspection the menu board had been removed. It was unclear if people had been involved in the decision to stop using the menu board or if the decision had been made by staff in response to the questions raised by the inspector.

Another example of the lack of individualised support and decision making was evidenced by the provider's actions during a temporary closure of the setting to enable communal areas of the ground floor to be refloored and redecorated. Staff told us one person had stayed with their parents during this closure while the remaining people had all moved into two caravans in a nearby holiday park. We asked to see details of what other options people had been offered during this period and of any records to demonstrate individual decisions had been made in people's best interest. However, these records were unavailable during the inspection and were not subsequently provided.

Staff in this setting recognised that they were not providing personalised supported living care. Their comments included, "It is in transition from residential to supported living but I don't think it will happen", "Yes, it is supported living but there is a bit of residential as well. It can't be completely supported living" and "I can't see it in five years' time being supported living." While managers told us "We recognise that it is very care home like and we are challenging staff to recognise this is the people's house."

We recommend that the provider seeks advice and guidance from reputable sources on how a supported living model could be used in this setting, to meet people's needs.

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The service had failed to ensure people's care plans accurately reflected their needs and that all incidents had been appropriately documented.</p>
Regulated activity	Regulation
Personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>The service had failed to ensure there were sufficient staff available to provide planned support and enable people to participate in activities they enjoyed.</p>