Royal Mencap Society

92 North Street

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 24 and 31 October 2017 and was unannounced. At the last inspection, we rated the service as good overall and asked the provider to make improvements to the systems used to monitor the quality and safety of the service. At this inspection, we found some improvements had been made but further action was still needed. We also found new concerns with the availability of staffing, the safe management of behaviour that challenged and supporting people who lack the capacity to make certain decisions.

92 North Street provides accommodation and or personal care for up to 12 people. People living at the home have a learning disability and receive varying levels of staff support dependent on their assessed needs. On the day of our inspection 12 people were living at the home.

There was a registered manager at the home. 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. On the first day of our inspection, the registered manager was absent from the service and we were assisted by the deputy manager. The registered manager was at the service on the second day of our inspection. We have referred to the deputy manager and registered manager in the body of the report.

We found some improvements had been made to the provider's quality assurance systems. However further action was needed to ensure the systems were consistently effective in identifying shortfalls and making improvements where needed. There were sufficient staff to keep people safe but staffing shortages meant people were not always supported to engage in activities that met their assessed needs and personal preferences.

Risks to people's safety and wellbeing were not consistently managed; improvements were needed to ensure staff were suitably trained and supported when people presented with behaviour that challenged themselves and that of others. People were kept safe from the risk of abuse because the provider followed recruitment procedures and staff understood their responsibilities to identify and report any concerns. People received their medicines when they needed them.

Staff obtained people's consent before providing care but improvements were needed to ensure the provider followed the legal requirements and people's rights were protected when they lacked the capacity to make certain decisions. Where people were restricted of their liberty in their best interests, for example to keep them safe, the provider had not always applied for the appropriate approval.

Staff had caring relationships with people, respected their privacy and dignity and supported them to be as independent as possible. Staff knew people well and provided personalised care. People were supported to

maintain important relationships with friends and family and staff kept them informed of any changes. People were supported to review their care to ensure it continued to meet their needs. People were involved in choosing and planning their meals and supported and encouraged to eat and drink sufficient amounts to maintain a healthy diet. People were able to access the support of other health professionals to maintain their day to day health needs.

There was an open, inclusive atmosphere at the home. People and their relatives were asked for their views on the service and this was acted on where possible. Staff felt supported by the management team and were encouraged to give their views on the service to improve people's experience of care.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take 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 consistently safe.

There were sufficient staff to keep people safe but staffing shortages meant people did not always receive one to one support to engage in activities that met their assessed needs. Improvements were needed to ensure that risks associated with people's safety and wellbeing were consistently assessed and managed. Staff were suitably recruited and understood their responsibilities to keep people safe from abuse. People received their medicines when they needed them.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Improvements were needed to ensure the registered manager and staff supported people to make decisions where they lacked the capacity to make decisions for themselves. Staff were not always effectively trained and supported to fulfil their role. People had sufficient amounts to eat and drink and were supported to access other health professionals when needed.

Is the service caring?

Good

The service was caring.

Staff had caring relationships with people and respected their privacy and dignity. People were able to make decisions about their daily routine and staff encouraged them to remain as independent as possible. People were supported to maintain important relationships with family and friends.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staffing shortages meant people were not always supported to receive care and support that met all their assessed needs and personal preferences. People's care was reviewed to ensure it remained relevant. People and their relatives felt confident raising any concerns or complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Improvements were needed to ensure the systems in place to monitor the quality and safety of the service were effective in identifying shortfalls and driving improvement. People and their relatives were encouraged to give their feedback on the service and where possible this was used to make improvements. There was a positive atmosphere at the service and staff felt supported by the management team.

92 North Street

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 checked 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 24 and 31 October 2017 and was unannounced. The inspection was carried out by one inspector and an expert by experience. This is a person who has experience of using or supporting someone who uses health and social care services.

We reviewed information we held about the service and the provider including notifications they had sent to us about significant events at the home. Prior to the inspection, the provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also spoke with commissioners who are responsible for arranging services on behalf of people. We used this information to plan our inspection.

We spoke with six people living at the home and with three relatives by telephone. We also spoke with four members of the care staff, the deputy manager and the registered manager. We spent time observing care in the communal areas to see how the staff interacted with the people who used the service. Some of the people living in the home were unable to speak with us in any detail about the care and support they received. We used our short observational framework tool (SOFI) to help us understand, by specific observation, their experience of care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at three people's care records to see how their care and treatment was planned and delivered. We also looked at records relating to the management of the service, including medicine records, staff recruitment and training records.

Requires Improvement

Is the service safe?

Our findings

People were safe as there were sufficient staff available to meet their assessed care needs. We saw that people did not have to wait for the support of staff when they asked for assistance. However, the provider was also commissioned to support people on a one to one basis, for example with activities, and we saw that this was not always provided. People told us that a number of staff had left and this sometimes meant there were not enough staff to support them to go out. Staff told us there were sufficient staff to support people with their personal care needs but at times, they were not always able to support people with activities. The registered manager confirmed there was a shortfall in staffing hours due to absences and vacancies. During October, the provider was regularly deploying agency staff to support existing staff. The registered manager told us four new staff had recently started work and recruitment and interviewing was ongoing to recruit more permanent and relief members of staff. They told us they tried to manage the one to one hours flexibly to ensure people were supported in accordance with their assessed needs. However, they agreed that the staffing shortages meant that people were not always receiving their one to one support in relation to activities that met their preferences. We have shared this information with commissioners of the service.

Risks to people's health and wellbeing were identified however, guidance was not always provided to mitigate the risk of harm to them and other people. Staff told us they had concerns for the safety of other people due to the nature of one person's behaviour following an incident that occurred the day before our inspection. The deputy manager told us the people involved were to be kept apart but we saw they were sitting together in the kitchen on two occasions and regularly came into contact in other areas of the home. However, the person's care plan had not been updated to reflect this and our observations showed that staff were not following this guidance. Staff told us and records showed they had not received training in managing behaviour which could physically challenge and did not always feel able to manage this person's behaviours safely. We saw that a small number of staff had received positive behaviour support training and this was to be arranged for all staff. The registered manager told us advice had been sought from the provider and the person's care and support was being reviewed. Whilst no harm occurred, the provider had not ensured that staff took appropriate preventative action to ensure risks of people suffering future abuse were minimised.

There were suitable arrangements in place to ensure people received their medicines when they needed them. We saw that medicines were administered and recorded and stored securely. Some people received their medicines on an 'as and when needed' basis. However, we saw there were no instructions on the administration of these medicines. These are known as PRN protocols and should be in place to assist staff in establishing if the medicine is required. Discussions with staff demonstrated they understood when people required these medicines, for example, for pain relief. We discussed this with the acting manager, who told us they had recently changed pharmacy and new protocols had not been put in place. They told us they would bring it to the attention of the registered manager. On the second day of our inspection, we saw that these protocols had been produced which clearly explained under which circumstances PRN medicines should be administered. This would ensure people received their medicines in a consistent way. Staff told

us and records confirmed that they received training to administer medicines and had their competence checked to ensure people received their medicines as prescribed.

People who were able to give us their views told us they felt safe and liked living at the home. Staff understood their responsibilities to protect people from the risk of abuse. Staff could identify the actions and behaviours which would constitute abuse, including describing the physical and emotional symptoms people who were unable to verbally communicate could exhibit if suffering from abuse. Staff told us they were comfortable with raising any concerns they had with the registered manager, and were confident that they would be protected under whistleblowing procedures. Whistleblowing is a way in which staff can report misconduct or concerns about wrong doing at work. Our records showed that safeguarding incidents were reported appropriately to the local authority and the CQC. However, we noted that a recent incident had not yet been reported to the local authority or CQC. We brought this to the attention of the deputy manager, who rectified this immediately following our inspection.

The provider followed procedures to ensure staff were suitable to work in a caring environment. Staff had undergone detailed recruitment checks as part of their application process and these were documented. These records included evidence of references from previous employers and a Disclosure and Barring Service (DBS) check. The DBS is a national agency that keeps records of criminal convictions. People were kept safe as they were assisted by staff who had been assessed as suitable for the role. The provider managed staffing centrally and when used, the same agency staff were deployed wherever possible to ensure continuity of care for people living at the home. Staff told us and records confirmed that agency staff received an induction, which ensured they had a knowledge of the needs of people living at the home. Staff told us the registered manager sought their feedback on agency staff and when concerns were raised, this was fed back and the individual staff concerned did not return to the service. This meant people were assisted by staff who had been assessed as suitable for the role.

Requires Improvement

Is the service effective?

Our findings

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.

We found that the provider was not consistently working within the principles of the MCA. We saw that assessments were carried out to determine if people had the capacity to make key decisions about their care, for example to manage finances or to be supported with their medicines. For some people, these assessments did not clearly demonstrate they lacked capacity to make the decision for themselves. We saw that best interest decisions had been made for them. However, the registered manager could not demonstrate how this was in the person's best interest and who had been involved. This meant decisions may have been made for people where they had the capacity to do so themselves.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards. (DoLs). We saw two people had authorisations in place and the registered manager had made applications for other people who were being deprived of their liberty. However, they had not identified restrictions being placed on another person who lacked capacity because they could not leave the home without the continual support and supervision of staff. This meant the person was at risk of having their liberty deprived unlawfully. Staff we spoke with were aware that two people had a DoLS in place. However, they could not tell us how these people were being restricted in their best interest and there was no information in the care plans to show how they should be supported. This meant we could not be sure that the legal authorisations were being followed.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Discussions with staff showed they recognised their responsibility to support people to make their own decisions as far as possible. We saw staff offered people choices with their day to day care and obtained their consent before providing support. Care plans we looked at showed that staff had guidance on assisting people to make day to day decisions. This showed us that staff understood the importance of gaining verbal consent.

Although we have identified improvements were needed to ensure staff received training to manage behaviour that challenged, we found that staff received ongoing training to enable them to fulfil the requirements of their role. Staff told us and records confirmed staff completed training in a range of areas that were relevant to people's needs. For example, training in safe moving and handling and managing medicines. New staff completed an induction programme which met the Care Certificate standards. The Care Certificate is a nationally recognised qualification which supports staff to gain the knowledge and skills

required to work in a care environment. Staff told us they did not always have the opportunity to meet with the manager to discuss their performance and any concerns about their work. The registered manager told us that the provider's 'Shape your Future' programme included an annual appraisal and a one to one meeting every three months to discuss the performance and work. However, the registered manager confirmed that they were behind schedule with the three monthly meetings. This meant staff had not had the opportunity to discuss their training needs in relation to managing behaviour that challenged. This showed us staff were not always supported to fulfil their role effectively.

People were supported to have enough to eat and drink to maintain their health. People told us they enjoyed the food. Comments included, "Food is brilliant", and "If I don't like it, they'd get me something else". People's dietary needs and preferences had been assessed. We saw that staff understood people's dietary needs and followed guidance in their care plans, for example, we saw some people had a fork-mashable diet to minimise the risk of choking. Where people needed support and encouragement to eat their meals, we saw this was provided. Mealtimes were flexible and at lunchtime we saw the atmosphere was relaxed and pleasant. People were offered drinks throughout the day and those able to make their own drinks were observed doing so.

People were supported to access other health professionals to maintain their day to day health needs. One person told us a 'foot' person came to the home every six weeks and another told us they had seen the optician for new glasses. We saw that people had hospital passports which provided information on how they should be supported when accessing health care services.

Good

Is the service caring?

Our findings

People liked living at the home and told us the staff looked after them well. One person said, "It's good here". Another said, "I've told my social worker I don't want to be moved. This is my home". Some people described the staff as friends and we observed they had developed positive and caring relationships. Relatives told us the staff were kind and caring and took an interest in how they were. One told us, "Staff really care about people, and they are compassionate with me too". We saw that staff members greeted people when they came into a room and people responded positively. Staff treated people as individuals, for example one person liked to be hugged when they greeted staff and another liked to shake hands. Staff spoke with people in a caring and encouraging way and observed staff reassuring people if they were upset or anxious. This showed us that staff cared about people's wellbeing.

We saw that staff promoted people's privacy and dignity. Staff spoke discreetly with people when assisting them to go the bathroom. One person needed assistance to thread a belt onto their trousers; a member of staff took the person to a more private area to support them with this. We saw staff supported people to change their clothing after eating to maintain their appearance. Staff knocked on people's doors and waited to be asked in. Staff told us how they promoted people's privacy and dignity. One member of staff told us, "We make sure the door is always closed and that people are covered with a towel when we are providing personal care and always check they are comfortable".

People were encouraged to make decisions about their daily routine, for example they could get up when they wanted and we saw that some people had a lie-in and a late breakfast. People moved around the home freely and were able to spend time alone in their bedroom if they wished. People were encouraged to maintain their daily living skills and there was a rota for cleaning their rooms, tidying the communal areas and helping with their laundry. We saw that people clearly enjoyed these responsibilities, which were displayed on charts in the kitchen and in the laundry room. Staff told us they encouraged people to do as much for themselves as possible. This showed people were encouraged to develop and maintain their independence.

People were encouraged to maintain important relationships. One person went twice weekly to cook a meal for their relative and showed us the ingredients they were taking with them. Staff told us, "It's the kind of normal activity you and I would do to care for our own elderly parents". Relatives told us they could visit whenever they liked and were kept informed of any changes in their family members. People were supported to celebrate their birthdays. One person showed us they had displayed their birthday cards in one of the communal lounges and was very excited when an off-duty member of staff called to wish them a happy birthday. This showed us staff had caring relationships with people.

We saw that the bathrooms and kitchens at the home had recently been refurbished and people had been involved in choosing the colour scheme and furnishings. People had been supported to make choices using an electronic tablet. This showed us people were encouraged to have choice and control over their home environment. We saw that people were able to access advocacy support if they wished. An advocate is an

independent person who is appointed to support a person to make and communicate their decisions.

Requires Improvement

Is the service responsive?

Our findings

People were not always supported to receive care and support that met all their assessed needs and personal preferences. As noted in the Safe domain, the provider was commissioned to support some people on a one to one basis, for example with activities, and we saw that this was not always provided. People told us that a number of staff had left and this sometimes meant there were not enough staff to support them to go out. For example, we saw that a person with sensory needs was funded to receive one to one support to use the spa bath at the service and to visit a specialist sensory centre. We saw that during September and October 2017, they had only visited the sensory centre once and had not been supported to use the spa bath at all. Another person was funded to receive one to one support to go swimming on a weekly basis but their diary showed that they had been supported on average less than once a month since February 2017. Staff told us, "We sometimes struggle to take people out and do the activities; the last couple of months it's been quite difficult". The registered manager told us they had a rota system for one to one activities, but due to the problems with staffing, this was not always completed and some people's activities were not planned on a regular basis. Staff told us some people had been supported to discuss their holiday plans but no decisions had been made in relation to staffing support. The registered manager told us that management changes had meant that any decision on making staff available for this had been delayed.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We did see some examples that showed how people received personalised support. People told us they took part in a range of activities, including voluntary work, which they spoke positively about. One person showed us a mobile they had made from wools and CD's and the stones they had painted at the home's craft club. Some people had been supported to attend a nightclub for people with disabilities and they were looking forward to going again. We saw people were supported to leave the home to participate in shopping activities and to go for a birthday meal.

People could tell their keyworker or another member of staff if they were worried or had any concerns. Relatives we spoke with told us they knew how to make a complaint but had not had to do so. A relative told us, "I have no reason to be concerned about anything". There were systems in place to deal with concerns and complaints, which included providing people with information about the complaints process in a format they could understand. Records showed that people were supported to raise any concerns during keyworker meetings and resident's meetings. However, we saw that concerns and complaints discussed during these meetings were not always recorded and monitored for any themes and trends, to ensure improvements could be made where possible.

People were supported to have a personalised care plan which detailed their preferences for how they wanted to receive their care. Each person had a keyworker who acted as the first point of contact for family members and supported people during reviews of their care. Discussions with staff showed they knew people well and had a good understanding of people's needs and routines. This included individual ways of

communicating with people, for example they told us how a person who was unable to communicate verbally showed when they were happy or sad and we saw this matched what was written in their care plan. Staff said they found the support plans useful and they gave them enough information and guidance on how to provide the support people wanted and needed.

Systems were in place to ensure that the staff team communicated effectively about people's needs when the staff changed at the end of each shift. Communication books were in place for the staff team which detailed information about appointments and activities. This meant that staff had the information they needed to be responsive to people's changing needs .

Requires Improvement

Is the service well-led?

Our findings

The registered manager carried out checks to monitor the quality and safety of the service. However, these were not always effective in identifying shortfalls and driving improvements. Medicines audits were not being carried out on a regular basis and records showed that a check had not been carried out since November 2016. We checked the medicine administration records (MAR) for everyone receiving medicines in the home and found no concerns, for example missing signatures. We saw that stock control measures were in place and staff told us they followed up any missing signatures to ensure people received their medicines as prescribed. However, the lack of monitoring meant that the registered manager had not identified that PRN protocols had not been put in place following the change in pharmacy. This meant we could not be assured that errors would be identified and prompt action taken to protect people from the risks associated with medicines.

Following our last inspection, the registered manager had introduced checks to monitor the accuracy of care plans. However, we found that some care plans we looked at were not up to date. For example, two people's care plan had not been updated to reflect that they no longer needed to be weighed on a monthly basis as their weight loss had stabilised and they were no longer being monitored by the GP or dietician. We found there were no checks of daily records. This meant that people's 1:1 support was not being accurately recorded and monitored to ensure that their assessed care needs were fully met.

At the last inspection, we asked the provider to make improvements to ensure accidents and incidents were monitored for any patterns and trends. We saw that the registered manager had made improvements and monitored the records each month and this showed that where needed, action had been taken. However, we saw that the records did not identify if the incident had been reported to us in order to ensure that requirements of registration with us were always met. This enables us to check that appropriate action has been taken. Our records showed that the provider and registered manager notified us of other incidents in accordance with the requirements of registration with us.

We recommend the provider considers ways to improve their quality assurance systems to support the drive for continuous improvement.

The registered manager carried out other checks to monitor the safe management of people's personal monies and to ensure that the environment and equipment was clean, well maintained and safe for people. The registered manager showed us a new audit tool they had introduced This included carrying out checks of fire safety and evacuation systems.

People were encouraged to have a say in the planning of the service. Potential staff members were invited to spend some time at the service to meet people they would be supporting. The registered manager told us, "People were shy at first but soon got into the process. We need to do more work to get more people involved and giving feedback ". Residents meetings were also held, which gave people an opportunity to discuss issues such as meal planning and activities. Relatives told us they were asked to give their views

through an annual satisfaction survey, which was provided in an easy read format for people living at the home. The registered manager told us that activities including a tea party had been organised in response to comments made.

There was an open, inclusive atmosphere at the home. Relatives we spoke with told us the registered manager and staff were approachable and they felt able to speak to them at any time. Comments included, "Staff support everyone" and "Everything is superb". Staff told us they felt supported by the management team. One member of staff said, "Both managers are supportive, I'd be happy to go to them about anything". Staff told us they had regular team meetings to keep them updated about changes in the service that affected them and felt able to give feedback on the running of the service.

The provider had published the service's performance rating on their website and a copy of the latest rating and inspection report was on display at the entrance to the home. This is so that people, visitors and those seeking information about the service can be informed of our judgements.

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
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that people using the service received person-centred care and support that met all their their needs and preferences. Regulation 9(1)(3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not acting in accordance with the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards where people lacked the capacity to make certain decisions. Regulation 11(1)(2)