Royal Mencap Society

Royal Mencap Society - Drummond Court

Inspection report

Mill Road South
Bury St Edmunds
Suffolk
IP33 3NN

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14 January 2016

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We previously carried out an unannounced comprehensive inspection of this service on 26 and 28 August 2015 and found that the service was Inadequate in the two key areas Safe and Well Led. The overall rating for the service was Inadequate. This means that the service was placed into 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

In addition to placing the service in 'special measures' we also served warning notices as the service was in breach of regulations 13 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The regulation 13 warning notice was issued because the service had failed to protect people from the risk of financial abuse and staff had not responded appropriately to a possible safeguarding issue. These issues had also been identified at the previous inspection which was carried out on 10 December 2014. This meant that the service had not made the required improvements over a sustained period of time. The regulation 18 warning notice was issued because the service failed to ensure there were enough suitably qualified, competent, skilled and experienced staff on duty and had failed to provide them with the training and support they needed. The warning notices required the service to make the necessary improvements by 15 December 2015.

We undertook this focused inspection on 14 January 2016 to ensure that the service had made the required improvements. The inspection was unannounced. This report only covers our findings in relation to safeguarding and staffing issues and does not affect the overall rating of the service which remains Inadequate. The service will remain in special measures until we carry out our next comprehensive inspection. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Royal Mencap Society Drummond Court on our website at www.cqc.org.uk.

Drummond Court provides care and support for people with learning disabilities who live in bungalows and flats on the same site. Some people are quite independent while others have significant care needs and require more support and care. The service is registered to provide care for 36 people and at the time of our inspection 33 people were resident.

The service had no registered manager in place. The most recent registered manager had left the service in February 2015 and the manager appointed to replace them had also left the service without becoming registered. 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.

This report specifically focuses on the key area of Safe with regard to how staffing and safeguarding matters

were managed.

Staff reported that there was now a more consistent staffing pattern. Some temporarily deployed staff now had substantive posts and the service had recruited new staff. The regional manager, who had been redeployed to support the service, was also to continue to have line management responsibility for the service which provided further continuity. The vacant hours had reduced and those that remained were mostly being covered by regular agency staff who knew people well.

Staff told us they felt more supported and most staff were receiving regular supervision, although some concerns remained in one area of the service. Staff appreciated the fact that they were less likely to be asked to cover shifts in parts of the service they were not familiar with. New staff had been given a structured induction and had been supported throughout. There was a recruitment procedure in place but it was not followed in one instance.

Rotas showed that some areas of the service continued to operate with staffing levels which made it difficult for people with high care and support needs to access their local community and follow their own interests and hobbies. The service was waiting to see if increased funding could be secured to assist with this on-going issue. Staff had been redeployed to mitigate the low staffing levels, however service managers remained office based.

Staff had received training in keeping people safe from abuse and knew how to identify the possible signs of abuse and take action. Systems were in place to protect people from financial abuse and staff were working in accordance with them.

Staff demonstrated a good understanding of how to manage incidents where people became distressed and behaved in a way which may have placed others at risk. There were processes in place designed to keep people safe from physical harm. Incidents of physical harm caused in this way had reduced but all risks had not been mitigated and the service continued to notify us and the local authority safeguarding team of new incidents.

Overall, although there was clearly still some work to do, we found that the service had made sufficient progress to meet the requirements of regulations 13 and 18.

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.

Staffing in some areas had increased and there was a more consistent staffing picture.

Staffing for people with high care needs remained low in some areas of the service.

Staff received a structured induction and most staff were well supported in their roles.

Staff were trained in keeping people safe from abuse and systems were in place which were designed to protect people.

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Detailed findings

Background to this inspection

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

The inspection took place on 14 January 2016 and was unannounced.

The inspection team consisted of two inspectors.

Before we carried out our inspection we reviewed the information we held about the service. We looked at any statutory notifications that had been sent to us. A notification is information about important events which the service is required to send us by law. We also gathered feedback from staff from the local authority adult social care team, contracts team and safeguarding team.

We spoke with three people who used the service, two relatives, twelve care staff, one senior member of care staff and the regional manager.

We reviewed daily records and care plans for three people, three staff files, staff training records and staffing rotas for the previous ten weeks.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection on 26 and 28 August 2015 we found that only 50% of staff were permanently in post. Rotas were unclear and it was not possible to be sure that people were receiving the support they needed. The service was attempting to cover 600 vacant hours a week with overtime, agency staff and staff redeployed from other Mencap services.

Despite the various actions taken to limit the impact of the staffing shortfall we found that the inconsistent staffing was having a negative impact on the people who used the service. People's needs were not being met because there were not enough staff. We found that people were confused about who would be supporting them and were not being supported to do everyday activities such as cooking or going out into the community with staff support. Staff were tired and were making mistakes with medicines. Relatives told us that they were concerned that staff did not know people well enough to meet their needs.

At this inspection we noted there had been improvements with regard to staffing. Some of the temporarily deployed staff had stayed on and some, including the regional manager, had been permanently transferred. This was designed to ensure a more consistent approach to staffing. The service still had vacancies but these had reduced to 20% of the staff team and vacant posts were being filled, in recent weeks, by regular agency staff, some of whom had also been recruited into substantive posts. We saw that some parts of the service had more agency use than others. One bungalow was using agency staff to cover all the night shifts but we saw that the same two agency staff members had been used over a ten week period. This meant that there was more consistency in terms of staffing.

Staff were mostly positive about the changes that had been made with regard to the numbers of staff on shift and the deployment of staff. One person told us, "Things have improved. We are not called to work in other homes. It is a lot less chaotic". Another commented, "Staffing levels are good, always enough staff and we are not called in to support in other homes as much now – only in an emergency". A third staff member said, "Rotas are managed much better". This was in contrast to the experience of most staff at our last inspection and meant that there was an improvement in the consistency of staff and of staff morale.

However we also found that some staffing concerns remained . We found that there was regular use of agency staff in one part of the service. Relatives told us that this continued to be a problem as staff did not know people well. One relative said, "They have another new manager now. It's all agencies. The service is not improving".

We observed two agency staff supporting people in this area of the service and found a mixed picture. One member of agency staff clearly knew the person they were supporting very well and was able to talk to us in detail about the person's needs and preferences. They also demonstrated a very caring and patient attitude when one person became distressed. The other agency staff member did not know the person they were supporting well and the relationship was very strained and the person who used the service was clearly distressed. We observed that the agency member did not have the skills and understanding required to meet the person's needs at that time. We brought the matter to the attention of the regional manager.

The service had assessed a safe staffing level for each part of the service. A review of some people's funding had taken place in recent months and the provider hoped that, in time, this would lead to additional funds to support higher staffing ratios. In the meantime the provider had sought to deploy staff more effectively. Service managers remained office based and only went on shift in an emergency but the more junior management level worked alongside care and support staff to offer additional support and to act as a role model. Staff told us this worked well.

Staffing levels in some areas of the service were still low. For example in two bungalows where people with high care needs were living we saw that often there were still only two staff on duty. This number was occasionally increased by an 'ad-hoc' shift but in some cases this was only for two hours. Some of these ad-hoc shifts were carried out by the service managers who, we had been told, did not cover shifts unless in an emergency. This meant we were not assured that the additional member of staff was spending the entire shift supporting other staff. In one two week period the staffing in one bungalow increased to three on six occasions and on only one occasion in another bungalow. This level of staffing continued to make it very difficult for staff to support some people with interests and hobbies outside of Drummond Court. We saw that the service had tried to address this by giving one of the people who used the service an unofficial role with regard to activities and involvement in leisure opportunities. This had already had a positive impact on them and on others who used the service.

Overall the staffing picture remained mixed. For example staff in one bungalow said, "[Person who uses the service] doesn't go out because you need two people to take [them] out". Another staff member said, "We have one person [who] it is difficult to take out on your own". We saw that people were less likely to go out in this bungalow. One person had only been out once in the last month other than on trips to the local daytime activity hub. However daily records showed that other people were regularly able to socialise in the local community and access leisure opportunities for themselves. One person had been to the cinema four times, been clothes shopping and had visited their family in the last month. The issue was that those people who were more independently mobile were much more able to access the local community than those who required significant amounts of staff support.

We found that there had been improvements to the way new staff were supported through their induction and permanent staff were supported to carry out their roles effectively and safely. Most staff told us they were now having regular supervision sessions and were feeling more supported. One staff member told us, "I had one to one meetings during my induction to see how things were going". Another said, "There is always someone around for support". Where staff members continued to feel a lack of support and had not received sufficient supervision we were assured that management plans were in place to discuss this with them, although this had not yet taken place.

The service operated a recruitment procedure which ensured that each member of staff received a Disclosure and Barring Service check before they started to work at the service. This check ensured that people did not have a criminal record which would exclude them from working in this type of setting. We noted that, although people were interviewed and references checked, one person had been employed who had a personal connection to a senior member of staff. We saw that this staff member had provided their reference. This meant that on this occasion the recruitment procedure had not been robust. This issue had not been identified by the provider and could have posed a potential risk.

With regard to how the service managed its safeguarding responsibilities we saw that improvements had been made. Staff were knowledgeable about safeguarding matters and were able to tell us how they would recognize the signs that people may be at risk of abuse and how they would raise a concern both within Mencap and with external agencies such as the local authority safeguarding team. Staff had received

training in keeping people safe from abuse.

At our last inspection we found that procedures that were in place to protect people from financial abuse were not being followed. At this inspection we found that procedures had been reviewed and staff were working in accordance with them. We checked the money records for two people and found them to have been completed accurately. We noted that one person had a £30.00 gift token in their tin which was not recorded anywhere, making it vulnerable to theft. We brought this to the attention of the service manager who assured us they would include this in the person's records in future.

Most people told us they felt safe at the service. One person had contacted us prior to our inspection as they were concerned about the behaviour of another person who used the service. They had found their behaviour threatening. We discussed the incident with the regional manager and were assured that measures were in place to support this particular relationship. We were also aware that in one area of the service the reactions displayed by some people when they were upset or distressed were a concern for others who shared their home with them. Plans were in place which were designed to ensure that people were safe at all times and staff demonstrated a good knowledge of how to support people when they were distressed. We have noted that incidents involving service users being physically abusive towards each other had decreased, although we are still informed of occasional incidents and the service still needs to take action to reduce these incidents further.

The service had asked a local advocacy agency to hold regular surgeries each month. People who used the service were able to book a slot if they wanted to bring up any issue and advocacy workers were proactive in talking to people in the various parts of the service if nobody had booked a slot. This provided another way for people to raise any issues they may have about concerns for their safety or for others.

We had been informed, prior to our inspection, that the service's minibus had been involved in two road traffic accidents and had been written off after the second. We saw that, although staff completed a driver's declaration with regard to their suitability to drive the vehicle, no formal training was given to them. A new vehicle is being purchased for the service and we discussed with the regional manager how the service will ensure that people are kept safe when being transported in this in the future.