National Centre for Young People with Epilepsy

NCYPE - College Residential Services Lingfield

Inspection report

The National Centre for Young People with Epilepsy
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Ratings

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

Summary of findings

Overall summary

Young Epilepsy formerly (The National Centre for Young People with Epilepsy) is a specialist college situated on the outskirts of Lingfield village. Young Epilepsy provides specialist education and residential provision for children and young people with neurological conditions, learning and physical disabilities. Around 60-65% of the students receiving care had a primary diagnosis of epilepsy and other students had autistic spectrum disorders and neurological conditions without epilepsy.

Up to 110 young people can be accommodated across the provision for further education. There are 15 houses, with between four to 12 young people living in each house. Around 85% of people live on site. Some people go home for the school holidays whilst others stay on site for 52 weeks of the year. Five of the houses have people that stay 52 weeks of the year. At the time of the inspection 108 people were living in the houses.

The age range of students is 18 - 25 within the college provision. There is also the Neville Childhood Epilepsy Centre (NCEC) which supports the assessment and diagnosis of up to 12 children from the age of two years old. There is a residential school for children and young people which is regulated by Ofsted. Ofsted is the Office for Standards in Education, Children's Services and Skills. They inspect and regulate services that care for children and young people, and services providing education and skills for learners of all ages.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was only responsible for the regulated activity of accommodation for persons who require nursing or personal care. The nurse manager is in the process of applying to register with CQC for the regulated activity of treatment of disorder disease and injury (TDDI) and diagnostic and screening procedures.

We carried out an unannounced comprehensive inspection of this service on 20 and 21 July 2015. At this inspection, a breach of legal requirements in relation to staffing was found. After the inspection, the registered manager wrote to us to say what they would do to meet the legal requirements in relation to the breach of staff deployment.

We undertook this focused and responsive inspection to check that they had followed their plan and to confirm that they now met legal requirements. We also had concerns bought to our attention that staffing deployment continued to be an issue, there had been a high number of incidents and accidents and the management of risks for people was not always safe. This report only covers our findings in relation to these areas. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk.

While improvements had been made, there was still some work to be done. We saw that sufficient action

had been taken to meet the legal requirements.

There were improvements with staff deployment. There were enough staff to keep people safe. However, sometimes people missed out on activities off campus as there were not always enough staff. Some staff were confused as to whom needed one to one support. We have made a recommendation about this.

Risks to people were identified and managed appropriately. Staff were aware of individual risks and how to keep people safe. Staff had detailed risk assessments and the right training to keep people safe who became distressed or anxious.

People were protected from avoidable harm. Staff understood and recognised what abuse was and knew how to report it if this was required. However, they were not always aware of external agencies they could contact. Staff felt excluded from the safe guarding process. We have made two recommendations.

The registered manager of the residential services had oversight of incidents and accidents. Actions were put into place to reduce the risks of them occurring again.

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 safe.

Staff deployment had improved and staffing levels kept people safe. However, sometimes people missed out on activities as there were not always enough staff.

Risks to people were identified and managed appropriately. Staff were aware of individual risks and how to keep people safe.

Staff understood and recognised what abuse was and knew how to report it if this was required. However, they were not always aware of external agencies they could contact.

The registered manager had oversight of incidents and accidents. Actions were put into place to reduce the risks of them occurring again.

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Detailed findings

Background to this inspection

.We undertook an unannounced focused, responsive inspection of the service on the 3 March 2017. This inspection was done to check that improvements to meet legal requirements had been made since our comprehensive inspection on the 20 and 21 July 2015 and because of some concerns that had been raised. We inspected the service against one of the five questions we ask about services, which is 'is the service safe'. This is because the service was not meeting some of the legal requirements.

The inspection team consisted of five inspectors who were experienced in supporting people with learning disabilities and autism.

Before the inspection we gathered information about the home by contacting the local authority safeguarding and quality assurance teams. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR) as this was a focused inspection.

During the visit, we spoke with 12 people, one relative, the registered manager, the safeguarding manager and the nurse manager. We also spoke with 14 members of staff, including house managers and care staff. We spent time observing care and support provided throughout the day of inspection, at lunch time and in the communal areas.

We looked at seven people's care records, staff rotas and training records. We looked at records that related to the management of the service. This included minute's incident and accidents and some policies and procedures. We asked the registered manager to send us some additional information following our visit

which they did.

Requires Improvement

Is the service safe?

Our findings

At the inspection from July 2015 we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities 2014) as we had concerns that there were not always enough staff deployed to keep people safe. We found that improvements had been made, some work still needed to be done.

People told us that they felt safe. One person told us "I do feel safe here but there are times when I need some space. "There were enough staff to keep people safe. Staff told us that they felt that the staffing levels had improved and people were safe. A staff member said "There is usually enough staff. I don't feel it has had any impact to safety." Another said "Staffing is getting better." However, staff told us that sometimes people have missed out on activities due to some gaps in staffing levels. One person told us "There is not always enough staff. When we are doing trips we can't always do things." Another person said "Sometimes we can't do separate trips because there aren't enough staff." The rotas and our observations on the day confirmed that staffing levels were not always consistently maintained, however people's safety was not compromised. We saw that care or support was provided when it was required and staff were always available in communal areas. Where people required one to one support, the same staff member remained with the person to ensure consistency of support to the person.

The registered manager and the provider told us that people were safe and confirmed what people had told us that sometimes activities for people were affected. The registered manager told us that they were working hard to recruit new staff and to retain existing staff. The registered manager had introduced a monitoring tool to enable greater oversight of where the staff shortages may occur. The monitoring tool enabled the management to move staff around as required to ensure that there were safe staffing levels across all the homes.

Some staff were not clear about which person needed one to one support and when. A staff member told us that in their home all people required one to one support when they were not at college. Another staff member told us that no one in their home needed constant one to one support, but they provided it for one person. When we spoke with the registered manager they told us that there was not one person living in the homes that needed continuous one to one support during the day and night. She confirmed that where people needed one to one support this was for specific times for support with tasks, such as personal care and eating and drinking. This confusion could mean that staff are not clear what support people need.

We recommend that the registered manager ensures that staff are aware of the times and needs of when a person requires one to one support.

People were protected from avoidable harm because staff had a good understanding of what types of abuse there were, how to identify abuse and who to report it to. All staff told us that if they had concerns about a person's safety they would contact the safe guarding officer who was available 24 hours a day seven days a week. A staff member said "First thing to do is phone the safe guarding manager. Their contact details are on the front page of the intranet (and they showed us)." The safe guarding officers would report to the local authority safe guarding teams as necessary. There was guidance and information provided to staff, relatives

and people about how to report concerns to outside agencies. However, some staff were not aware of outside agencies that they could contact to report concerns to should they want to.

Staff had clear reporting systems in place for incidents, accidents and any concerns about safe guarding however some staff told us that they felt excluded from the safeguarding process. They told us that once they had reported a concern to the safeguarding officers, they were unable to access information about this on the IT system. Some staff said they were not involved in any subsequent decision making about this which meant they were unclear at what stage any investigation was at.

Safeguarding information was displayed around the campus and in people's homes. The registered manager had notified us when safeguarding concerns were identified and ensured that plans were in place to reduce the risks of harm to people.

We recommend the provider reviews its processes to ensure staff are clear about reporting to external agencies and to make sure that staff are aware of the progress of any reported safeguarding concern.

The registered manager had oversight of incidents and accidents which were analysed to monitor for trends and contributing factors. Actions had been taken to minimise incidents and accidents from occurring again. People had access to on-site services that provided psychology, psychiatry, therapies, nurses and Neurologists. Referrals were made to the appropriate service for people should they need them to review their health and well-being. Staff told us that they had training in first aid and emergency response for epilepsy. Staff training records confirmed this.

Risks to people were managed to ensure that people were safe. Individualised guidance was available to staff so they could provide support to people when they needed it to reduce the risk of harm to themselves or others. Staff were able to describe individual risks to people and how to address these to keep people safe. Person centred plans contained detailed risk assessments in relation to certain activities, medicines, bathing, road safety and accessing the community.

Where needed, there were risk assessments in place for people with individually identified risks and an action plan on how to manage them. For example, some people could become anxious or distressed. There were guidelines in place to tell staff what the triggers were to avoid the anxiety and how best to support the person to keep them safe and calm. We saw that staff supported people in line with their guidance. Staff told us that they had training in supporting people to understand what could trigger distress and how to support people safely when they were distressed or agitated. This was confirmed by staff training records.

Staff supported people to take positive risks in their lives to encourage great independence. For example, one person was supported to walk to college on their own and back without staff. A risk assessment had been drawn up which enabled the person to phone the college to say they were on their way and phone the house when they had arrived at college. The person was very proud of this achievement and said "I walk to school on my own. I have to phone them, see I can use the phone."

Staff had information about how to keep people safe who had certain health conditions. For people who had epilepsy there was very clear guidance on how staff should monitor people and how they should respond if an emergency occurred.