Care Quality Commission

Royal Mencap Society

# Royal Mencap Society - Drummond Court

**Inspection report**

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## Ratings

| Overall rating for this service | Inadequate |
|---|---|
| Is the service safe? | Inadequate |
| Is the service effective? | Requires improvement |
| Is the service caring? | Requires improvement |
| Is the service responsive? | Requires improvement |
| Is the service well-led? | Inadequate |

## Overall summary

This inspection took place on 26 and 28 August 2015 and was unannounced.

The overall rating for this service is 'Inadequate' and the service is therefore in '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.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not

# Summary of findings

improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

The service 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 last registered manager had left the service in February 2015 and the manager appointed to replace them has now 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.

The service has been in breach of a number of regulations over the last three years. When we last inspected the service on 3 and10 December 2014 we found there had been six breaches of regulation. The provider had supplied us with a detailed action plan outlining how they would improve the service and meet the regulations within an agreed timescale.

We met with the provider in January 2015 and were given assurances that the required actions would be put into place. The provider stated that all required actions would be in place and they would be operating in line with the regulations by the end of July 2015. We found that this was not the case at this inspection. Extremely high numbers of staff vacancies over the last year have not been successfully addressed and we have seen an increase in safeguarding concerns and alerts from people who used the service, relatives, professionals connected with the service and members of the public over this period. Many of these related to inconsistent or short staffing and the fact that staff were not familiar with people's needs.

Throughout this inspection we found evidence of both good and poor practice. Previous inspections had identified that certain units needed to make considerable improvements to keep people safe and meet their needs. We found that a lot of improvements had been made in these specific areas but other areas of the service now remained the focus of our concerns. Therefore, whilst we acknowledged the hard work that had gone into improving previously failing areas, we were concerned to find similar issues in other parts of the service at this inspection.

We found that the service did not always respond promptly to allegations of abuse and systems designed to protect people from financial abuse were not always adhered to.

Risk assessment was both good and poor in different parts of the service. Some risks had not been comprehensively assessed and left people at risk. We also found risks associated with the management of medicines and errors, related to the administration of medicines, were high and had not reduced significantly since our last inspection.

Staff received most of the training they needed to carry out their roles effectively but training around specific healthcare conditions was not in place for everyone. Staff understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) was not good. The MCA and DoLS ensure that, where people lack capacity to make decisions for themselves, decisions are made in their best interests according to a structured process. Where people's liberty needs to be restricted for their own safety, this must done in accordance with legal requirements. People's consent had not always been established in line with the MCA. The service was operating in accordance with DoLS.

There was a mixed picture with regard to supporting people with their eating and drinking with some excellent practice in some units in the service and concerns about practice in others.

# Summary of findings

Previously we had had a number of concerns about people's access to healthcare appointments. This was much improved across the service but we were concerned about the management of some people's epilepsy.

Most staff were caring and compassionate and supported people sensitively. Others demonstrated a less caring manner with their language and actions.

Opportunities for people to follow their own interests and hobbies had improved since our last inspection but staffing levels meant people did not have enough to do and did not go out as often as they wanted to.

Complaints were not managed well and formal complaints the service had received had not all been responded to promptly and resolved to people's satisfaction.

Ultimately the service has not been well led over a significant period. Several changes of management and a lack of a consistent strategy to deal with the serious issues facing the service have led some people who used the service, relatives and professionals to lose confidence in the service. Very recent management changes have made significant improvements but the staffing strategy involves redeploying staff on a temporary basis which is not a long term strategy. Whilst it is the case that additional permanent staff have been recruited, a number of staff expressed to us that they were intending to leave and morale remained low with some key members of staff. Support and guidance for staff, particularly new staff, had been poor during the last few months and demonstrated the lack of oversight the provider had of the issues facing staff and of risks posed to the people who used the service.

The leadership of the temporarily redeployed regional operations manager had begun to address longstanding issues at the service and people who used the service and staff were positive about the impact this had had in a very short time. Our concern, as a regulator, is about how the provider will ensure that this is sustained.

During this inspection we identified a number of 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 this report.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

**Inadequate**

The service was not safe.

There were not enough staff to meet people's needs.

Staff were trained in safeguarding people from abuse but systems designed to protect people from abuse were not robust.

Risks were not always well managed and medicines were not always administered safely.

**Is the service effective?**

**Requires improvement**

The service was not always effective.

Staff received training to assist them to carry out their roles but some had not received training related to specific healthcare conditions.

The service did not always establish people's consent in line with the Mental Capacity Act 2005. The service operated according to Deprivation of Liberty Safeguards.

There was a mixed picture as to how people were supported with their eating and drinking.

People were supported to access healthcare professionals but protocols and training related to epilepsy were not robust.

**Is the service caring?**

**Requires improvement**

The service was not always caring.

Mostly good relationships existed between staff and the people they were supporting. Some staff did not respond quickly to people's needs or talk about them in a caring manner.

Most people were supported to be involved in decisions about their day-to-day care and their privacy and dignity were respected.

**Is the service responsive?**

**Requires improvement**

The service was not responsive.

Most people had been involved in developing care plans which met their needs and reflected their choices and preferences.

Some people were supported to follow their own interests and hobbies but opportunities for others were limited.

Formal and informal complaints were not always managed well.

# Summary of findings

**Is the service well-led?**

The service was not well led.

Effective strategies were not in place to increase staff numbers or to monitor the quality of the service.

Staff were well not supported by the management of the service.

The provider had failed to put effective strategies in place to address previous breaches of regulation.

**Inadequate**

# Royal Mencap Society - Drummond Court

**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 26 and 28 August 2015 and was unannounced. The inspection team consisted of three inspectors, a pharmacist inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had experience of caring for someone who used this type of service.

Before we carried out our inspection we reviewed the information we held about the service. This included any safeguarding investigations and statutory notifications that had been sent to us in the last year. A notification is information about important events which the service is required to send us. We used the information we gathered to focus our inspection.

We spoke with thirteen people who used the service and observed others who were not able to communicate with us. We spoke with fourteen relatives, ten care staff, the manager and the regional operations manager. We also spoke with the local authority safeguarding team and contracts team.

We reviewed nine care plans, 11 medication records, three staff files, staff training records for all staff, staffing rotas for a period of six weeks and records relating to the maintenance of the service and of equipment.

Inadequate

# Is the service safe?

## Our findings

The service had staff vacancies which meant that approximately only 50% of staff were permanently in post. The service needed to cover 600 staff hours per week with overtime, agency staff and staff redeployed from other Mencap services. The service had recruited staff to fill 300 of the vacant hours and staff were due to start over the next few weeks following our inspection.

People who used the service and their relatives gave us a mixed picture of how the inconsistent and occasional short staffing had impacted on them or their relatives. One person told us, "It is mainly agency staff. I have no complaints or anything. It is the same agency staff every time". Another person said, "We keep getting new staff. I like my usual staff best". A relative commented, "Weekends concern me. I feel I have to go so [my relative] goes out. Staffing is a lot less". Another relative complained that the lack of consistent staffing meant they had not been confident that their relative's care and support needs were being met. They described the staffing as, "Absolute chaos. There are no regular staff".

Staff told us they had been working lots of additional shifts to help out and one told us, "We have done a lot of extra hours and we are tired". The manager told us that recent errors with the administration of medicines were, they felt, due to staff being "stretched and confused".

We saw that the regional operations manager had recently organised for staff to be temporarily redeployed from other Mencap services to increase the staffing numbers. This had been very helpful and had had a positive effect. However we were concerned about how these benefits would be sustained as many of these staff members were due to return to their own services in the weeks and days following our inspection. We also questioned why this action had not been taken earlier in the year as this issue had been identified at our last inspection on 10 December 2014.

Staffing rotas were unclear and the first set of rotas supplied to us was found to be inaccurate. In the six week rotas we viewed we saw that there had been occasions when the service had run at below the staffing levels it had set to ensure people were safe. On one occasion when staffing was lower than it should have been ,one of the people who used the service told us they had been unable to cook their dinner as the manager had said there were not enough staff to support them. We raised this issue with the management team and there was confusion about whether this person needed supervision to cook. We fed back that we had seen that their risk assessment for cooking stated that they need 'staff with [them] when [they are] cooking as [they] get distracted'.

The assessed staffing levels for each individual unit did not always ensure that people had their needs met promptly. In one unit we saw that eight people were routinely supported by two staff. Some people in this unit required a significant amount of support with personal care and mobility and needed staff to advocate for them to monitor and manage their health and wellbeing. A member of staff on another unit commented on the recent improvements in staffing numbers but added, "At the moment two of us have to look after everyone in the flats". This was confirmed by the rotas we saw, although the most accurate paper copy of the rota could not be located. The staff member told us that three of the five people should have one to one care. One to one shifts were not identified on the rota so we could not be certain they were always covered.

In another unit we saw that three out of the four people living there needed help with their mobility and used a wheelchair to go out. Staff told us they could only take people out if there were three staff on duty and this rarely happened. They said that if they had to attend a healthcare appointment with a person who used the service this left one member of staff to support the other people. At least one person living there required two people to assist with their mobility and staff needed to find help from staff in other units at the service. This meant we could not be assured that this person's support needs were always met promptly.

**This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).** At our last inspection on 10 December 2014 there had been a breach of the 2010 regulations (Regulation 22) with regard to staffing. This meant that staffing concerns had not been addressed adequately following our inspection despite the service's action plan stating that they would have been resolved by the time we next inspected.

We saw that the service helped to support people with their money and protect them from financial abuse. Policies and procedures were in place which were designed

# Is the service safe?

to protect people who had their money safeguarded by the service. We looked at three financial records and found that although balances were correct, procedures, such as two staff signing for each transaction, were not always followed. Records were confusing and contained notes of monies loaned to the person from the service petty cash. It was not always clear why this had happened and we could not be sure that procedures were sufficiently robust to safeguard people's money.

Most people who used the service told us they felt safe and would speak to a member of staff if they did not. One member of staff told us they had been using a workbook about keeping safe with some people who used the service. Two people told us they did not always feel safe because of the behaviour of other people who used the service. We saw that the staff had responded to recent incidents of physical abuse appropriately but the people told us they remained concerned. During our inspection we found that some care plans and protocols related to supporting people who posed a risk to others did not contain sufficient detail to guide staff and keep people safe.

Two relatives were concerned that they had not been informed of a risk to their relative from another person who used the service. At the start of our inspection we asked if there were any service users who might pose a risk to us and were told that there were not. During our inspection we saw that there was a record of an incident where a service user had made a serious threat of physical harm to an agency member of staff. The care plan for this person documented that they did not like new staff but this information was not shared with us in order to ensure our safety.

We saw that staff had completed training in keeping people safe from harm. One member of staff alleged to us on our first inspection visit that they had witnessed psychological abuse by another member of staff. They told us they had attempted to report this to senior staff but had not felt able to do so. We spoke with their line managers and found that rigid lines of communication may have made it difficult for them to share their concerns and they had not persisted. They, and their line managers, had not followed the service's own procedures with regard to responding to this allegation of potential abuse. We passed on the information about the allegation to senior staff.

We were concerned that, when we visited on 28 August for our second visit, the staff member was still at work with the person they were alleged to have abused even though investigations had not yet been completed. This meant we could not be assured that the service's systems and processes fully protected people from any potential abuse and improper treatment.

**This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).** At our last inspection on 10 December 2014 there had been a breach of the 2010 regulations (Regulation 11) with regard to safeguarding people from abuse. This meant that safeguarding concerns had not been addressed adequately following our inspection despite the service's action plan stating that they would have been resolved by the time we next inspected.

We found that medicines were not always managed safely. Medicines were stored safely for the protection of people who used the service and at the correct temperatures. Audits were in place to enable staff to monitor and account for medicines. The service had been asked by the local authority to notify them and the Commission about medicine-related incidents that had placed the safety of people who use the service at risk, however minor. The incidents had arisen regularly since our previous inspection and had continued until the time of our inspection. Some errors that had been identified related to the accuracy of medication charts, however, there were no checks of medication charts in place at the time of our inspection. This meant that we could not be assured that people received their medicines as prescribed.

Supporting information was available to assist staff when administering medicines to individual people. There was information about known allergies/medicine sensitivities for people living at the service. When people were prescribed medicines on an as required basis, there was information to show staff how to administer these medicines to people prescribed them in a consistent way to meet their needs. However, there were discrepancies and inaccuracies between people's medication profiles and their medication charts which could have led to confusion and error when staff administered medicines.

For some people who managed their own medicines there were infrequent reviews of risk assessments and a lack of recorded evidence showing that staff supported people who are self-medicating to manage their medicines safely.

Inadequate

# Is the service safe?

Staff had received training and had been assessed as competent to administer people's medicines. However the service had not been to be proactive with regard to investigating if people could benefit from being prescribed specific medicines such as buccal midazolam for the treatment of recurrent epileptic seizures. People who had epileptic seizures were often admitted to hospital when this may have been avoided by the administration of such medicines. Similarly some protocols relating to people who were reluctant to take their medicines directed staff to observe a 'two hour window' and if the person continued to refuse they were advised to contact a GP and/or take them to hospital. We did not see that sufficient consideration had been given to managing medicines without the need for people to attend at hospital as an emergency.

**This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).** At our last inspection on 10 December 2014 there had been a breach of the 2010 regulations (Regulation 13) with regard to medicines. This meant that concerns related to medicines had not been addressed adequately following our inspection despite the service's action plan stating that they would have been resolved by the time we next inspected.

We saw that there was a mixed picture with regard to how the service assessed risks and supported people to take risks .The more independent people who used the service were supported to take risks as part of the service's commitment to increasing people's independence. We saw examples of where risks were assessed and actions taken in order to minimise these and enable people to access the community safely or take part in specific activities.

We also saw that people with higher care needs had risks they faced assessed. For example one person had fallen out of bed and been badly bruised. We saw that their risk assessment had been reviewed and a falls mat placed by the side of their bed to reduce the risk of further injury.

People's risks related to falls, eating and drinking, finances, accessing the community and health, amongst others, were assessed and actions put in place to reduce these risks. However some risk assessments were not always sufficiently detailed. This was particularly so with regard to the shortage of staff and the addition of many new and temporary staff to the service. Staff described to us how new staff unsettled people in one particular unit. We found that the potential impact of this on people had not always been recognised. Robust action had not always been taken to reduce any additional risks related to staff being unfamiliar with people's needs, their routines and their medicines. People, or their relatives, had mostly been involved in risk assessments and assessments were reviewed six monthly or annually, although we did find that some were overdue for review.

The service had a recruitment procedure in place. We saw that staff had received a Disclosure and Barring Service check to make sure that they did not have any criminal record which would exclude them from working in this type of setting. Staff records confirmed that appropriate checks of references and previous employment history had taken place before people started to work at the service.

Requires improvement

# Is the service effective?

## Our findings

The regional operations manager had recently redeployed a number of staff from other Mencap services to assist with the shortage of staff and to role model good practice and provide leadership and support to staff. These new staff were only in post temporarily, with some staying for a period of four weeks and others for several months. The impact of this action was beneficial and the people who used the service and staff commented positively about the recent changes.

Prior to the addition of the redeployed members of staff, staff supervision and support had been lacking. We asked to look at staff files for two of the newer members of staff. One had been in post nine weeks and the other six months. Although both had undertaken a comprehensive package of relevant training we saw that neither had received any documented one to one meetings since they started or had any probationary meeting with their line manager. Given the particular stresses the service had been facing due to staff shortages it was a concern that new staff had not received the support they needed. One member of staff described starting employment at the service as being utterly chaotic although they also wished to point out that there had been recent improvements with regard to staff support and staff numbers. Whilst support for new staff may have been lacking we did see that staff underwent an induction which included completing a workbook and a period of a few days shadowing more experienced staff.

Staff were positive about the quality of the training provided but this did not adequately match the health and care needs of the people they supported. Although several people at the service had regular epileptic seizures, staff were not provided with additional training regarding epilepsy. Staff only covered epilepsy as part of their emergency first aid at work training. Not all staff had received training in dealing with people's behaviour which could place others at risk, supporting people's mental health needs and or needs related to diabetes. Regarding training for people's mental health needs one member of staff said, "We learn from each other what works and what does not work…. Training is being sorted out for us". This lack of training and guidance placed people at potential risk.

There was a mixed picture with regard to staff understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). Many staff were yet to complete this training and we saw examples of good and poor practice.

**This was a further breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).**

We observed that in general people's consent was asked for before care and treatment was provided. We saw that staff were patient and used humour appropriately to help establish if a person had given their consent during everyday interactions

We saw that people's capacity to understand things, such as their finances or taking their own medicines, had been assessed and clearly documented. However we also saw that sometimes outcomes of these assessments were not known by all staff. For example one person's capacity to manage money had been assessed. The assessment documented that the person was 'unable to handle monies or recognise the value of money'. One staff member told us that the person had capacity to understand but would need a stamp to sign financial transactions as they could not write. Another member of staff said the person did not understand. We were not assured that all the people supporting this person were clear about the person's capacity to understand money which may have placed them at risk of financial abuse. Records of financial transactions for this person had not always been completed correctly – for example there were several occasions where two staff should have signed a petty cash voucher but only one person had.

We saw that some decisions had been taken appropriately in people's best interests according to the required legal processes. However when we asked how staff would establish people's capacity to consent to have an influenza vaccination for example, staff told us that people's parents would consent on their behalf. One person's care plan stated that should they refuse to take their medicines staff should contact their parents who would come in to assist staff. As well as this not being an effective strategy for future support it was not clear that this had been established as being in the person's best interests. Staff told us that relatives of several people who used the service had power

# Is the service effective?

of attorney for their welfare or finances. The regional operations manager confirmed that only one person had this in place which meant that we remained concerned that people's consent was not always correctly established.

At our last inspection on 10 December 2014 we found that some people were being unlawfully deprived of their liberty by the provision of keypads and locks in certain areas of the service. At this inspection we saw that all such locks had been removed and appropriate applications had been made when the manager felt that a person's liberty might need to be restricted in order to keep them safe. Appropriate interim arrangements were in place while the local authority considered these applications. We found that staff knowledge about people's rights related to DoLS was not always good with some staff admitting they did not know how to ensure people did not have their freedom restricted.

We saw staff supporting people to prepare and eat their meals and ensure they had appropriate access to food and drink. People were encouraged to make their own choices about food and drink. Care plans documented people's food likes and dislikes and staff demonstrated to us that they knew and respected people's preferences. One person who used the service told us, "The meals are ok. I get plenty to eat. I make a list of shopping with the staff who make sure we buy the things I like to eat". Another person told us, "I have my meals cut up into small pieces so I can feed myself".

We observed people who needed more support with their eating and drinking were encouraged to make choices. We saw one member of staff very patiently encouraging one person to choose between two kinds of food and, when the person could not choose, they waited a while and tried again later. Although we saw that people with higher care needs were mostly supported to make choices about their diet we also noted occasions when little or no choice was given. For example one person asked for more soup in one unit but was told there was no more and no alternative or pudding was offered.

We saw that some people had been promptly referred to the dietician when there were concerns about their weight. Care plans were put in place and weights were monitored. We also found that one person, who staff felt could be at risk of being malnourished, refused to be weighed. No further action had been taken and no alternative methods of establishing weight loss, such as measuring the upper arm circumference, had been tried. Food and fluid charts were used to monitor people's eating and drinking if they were thought to be at risk of eating or drinking too little. Charts were reviewed by senior staff to ensure people had met their food and fluid targets.

A relative told us about a person whose weight had increased considerably in the last few months. They felt this was having a very negative impact on the person's health. Whilst it was understood that the person had the right to buy whatever foods they chose, the relative was concerned that there had been no referral to a dietician or any consistent support to help the person maintain a healthy diet.

We saw that where people required food to be pureed or of a particular consistency, such as soft, this was understood by staff. Food was not always individually pureed and presented attractively which would make it more pleasant for people to eat. Staff supported some people who had a diagnosis of diabetes and monitored their eating and drinking, although many staff had not received training related to eating and drinking or diabetes.

We saw that there was something of a mixed picture with regard to the support people received with their healthcare needs. We were concerned that the support for people with epilepsy did not always ensure that people received treatment promptly which then led to possible hospital admissions. However, overall we found that people were referred to healthcare professionals quickly when they became unwell, appointments were made and kept and care plans were updated to reflect any changing needs they may have had in relation to their health. One person who described themselves as quite independent commented, "The staff are good at reminding me of important things like my dentist appointments".

Other people with higher care needs were also seen to have been well supported with regard to their health. We saw that one person had had their medication changed as staff had noticed that the medication was not working well for that person and had requested a medication review with the GP. People had been supported to attend GP, optician and dentist appointments and where this had proved difficult we saw that healthcare professionals had been asked to visit the service. On the day of our inspection

Requires improvement

# Is the service effective?

we noted that one person had become unwell and staff advocated well for the person and escalated their concerns with the local GP service until they were seen by a healthcare professional.

Requires improvement

# Is the service caring?

## Our findings

People we spoke with were happy with the way staff provided care and support. One person told us, "The staff are always kind, helpful and always here to talk to you". Another person said ,"The staff listen to me if I am unhappy, or I tell them". A person who required a lot of support explained to us, "I trust my staff because they know me well and do not make me do things I do not want to".

Relatives gave a mixed, and generally more negative picture, about the staff. Some praised individual members of staff but were unhappy that the frequent changes and shortages of staff meant that their relatives did not receive consistent care from people who knew them well. Others described a task led service, with one person describing it as, "Almost institutionalised care – nobody goes out". Another relative described, what they called, a 'minor glitch'. They told us, "[My relative] sometimes comes home unkempt – not looking cared for". Although this was an issue of concern to them they also told us that their relative was very happy at the service and looked forward to returning back there after visits to family. They told us,"[My relative] asks to 'go home now'. I am happy that [they] are settled".

Again we saw a slightly mixed picture with regard to the way staff responded to the people they were supporting. In one unit we observed that staff did not interact with people much and people were seen to wait to have their needs acknowledged. Staff on this unit were not able to tell us about the condition of one person, who was very sleepy, saying, "[They're] always like that.[They were] born like it. I don't know what it's called".

However we saw good practice in most areas of the service. We observed that most permanent staff knew the people they were supporting and caring for well and had built good relationships with them. Staff worked in the same units as much as possible which was designed to help them get to know the needs and preferences of the people living there. Staff working on one to one shifts demonstrated an in depth knowledge of one person's needs and were skilful in using reassurance and distraction when they became anxious.

Care plans documented how people would express their needs if they were unable to use words. Plans covered how people expressed pain or anxiety and gave staff guidance on what action to take. We spoke with staff about the needs of some people who did not communicate verbally and found that they had a good knowledge of the people they were caring for. We did not see any member of staff using Makaton signs. Symbols or pictures were not always used to help communicate with people and find out their choices and preferences.

We observed some decisions being made for people rather than asking the person and waiting for their response. We also observed that pictorial menus were not always accurate which meant those who could not read were not independently able to find out what the next meal would be. We saw that an advocacy service was used but no staff member was able to tell us how they were used or who they supported. People were encouraged to maintain and increase their independence, although some staff told us that this had been more difficult recently due to the staff shortages.

People were able to discuss their care needs informally with their keyworker or regular staff members. One person who used the service said, "I helped to write my plan" and we saw that they had contributed to the daily records section and had described how they had spent their day. Another person said, "I have help with everything I need and the staff ask me how I like things done. I am asked by the staff to choose what I wear and what I eat. If I say no to anything they would not make me". During the second day of our inspection we observed one service user assisting staff to paint the dining room in one of the units. The people who lived there had chosen an American diner theme and the person was very proud of their involvement in the new décor.

People were mainly treated with respect and their dignity was maintained. Staff asked people discretely if they needed support with their personal care and we saw that people's private information was kept confidential. Staff did not discuss people's private business in public areas.

Requires improvement

# Is the service responsive?

## Our findings

People had limited opportunities to give feedback about the service they received. Surveys and questionnaires had not been conducted since May 2014 and resident meetings had not been happening regularly but were now starting to be promoted once again. One person said, "We have resident meetings and can say what we like. Yes we are listened to and if we make a suggestion that the staff agree with, the thing is done".

One member of staff told us that informal complaints were discussed during the handover period to ensure that the issues were resolved. It was not clear if records of informal issues were logged. Two relatives told us that their relative was not happy with the people they were sharing with and had raised the issue in person on more than one occasion but had not received a positive response to their concerns and nothing had changed.

The service had a complaints policy and each person who used the service had been given information about how to make a complaint and we reviewed one complaint which had been made by a person who used the service. It was clear that some people would need advocacy to make a complaint.

The service had a record of three formal complaints since our last inspection. One had been responded to in writing, investigated and resolved. There was no record of the other two, one from March 2015 and one from 10 August 2015, being responded to and resolved in accordance with the service's own complaints policy. Since the inspection the service sent us evidence of how the complaints were managed and we saw that matters had been resolved. Although these complaints had been responded to, records were not detailed and the investigations and feedback had taken a long time, several months in one case. In addition to this two relatives told us that they had raised concerns about the service and had met with staff to discuss these but had not received any written response and both people felt the matter remained unresolved. This meant we could not be assured that both formal and informal complaints and concerns were always responded to, investigated and resolved to people's satisfaction.

**This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).**

People's needs were assessed before they moved into the service and this initial assessment helped to formulate their care plan. Care plans documented people's choices and preferences and made clear what people's skills and abilities were as well as the things they needed help with. Care plans were subject to on-going review and but we found they were not all reviewed to reflect any changes in people's needs promptly. Care plans in some parts of the service were overdue for review and some had not been reviewed for a year which meant that there was a risk that they did not reflect people's current needs. For example one person's plan documented the support they needed with regard to particular disabilities but had not been reviewed in the light of their short term memory loss which had been documented in another part of the care plan.

Some people told us they had been involved in developing their care plans and were able to make choices about their life. They said, "We can do what we like here. We can get up and go to bed at any time". Another person said, "I go on a trip to the seaside or zoo once in a while. I plan things on the morning I get up". A relative said, "We feel fully involved and are happy with every aspect of [our relative's] care".

However this was not the case for all people who used the service or their relatives. One person told us, "I have seen my care records but I am not asked to give my opinion of the care I receive". Another said, "When something is being arranged for us to do we are asked what we would like to do. Not much is planned". We asked staff if any activities or outings were planned for the bank holiday weekend and there were not.

We found that although people's interests and hobbies had been identified and documented in their care plans, people were not always able to be supported to take part in them as much as they would have liked. One person told us, "[There's] not much for me to do here. I go shopping with staff sometimes but would like to go out more". Another person said, "Most of the time there's nothing to do here all day". Another person said, "We only go out in the minibus if we have a doctor, hospital or other appointment". Several relatives expressed concern about the lack of opportunities for people to have social interactions within the local community. One relative said, "[They] are stuck in their rooms watching television – that's no life". Another relative said, "Nobody goes out on the bus anywhere. There's no fun there- no atmosphere".

Requires improvement

# Is the service responsive?

Several members of staff expressed to us how difficult it was to provide social outings for people given the staffing levels. One said, “It’s a bit of a stretch. We can’t get them out. We can take care of the basics but not extras like going into town”. We noted that some people had gone out from one unit on the second day of our inspection. Staff told us this was because one person was in hospital which meant staff were free to provide additional support to the rest. We saw that another person liked to go swimming. Their relative told us that this rarely happened now as there were no staff to take them and records confirmed that they had only been once in the last three months due to a lack of consistent staffing which made the person unwilling to take part.

We saw that in one unit, where we had had previous concerns about the lack of social interaction and hobbies, there had been a real improvement in the provision of onsite activities for people. We saw that people were supported more frequently to go into town if they wished. We saw that one person had been supported to go and buy a new mouse for their computer, another had some external one to one staffing in place and had been out, and a third had some sensory games to occupy them. Records confirmed that people were going out more often, although one person was mainly recorded as walking around Drummond Court.

Inadequate

# Is the service well-led?

## Our findings

When we last inspected the service on 3 and 10 December 2014 we found there had been six breaches of regulation. The provider supplied us with a detailed action plan outlining how they would improve the service in order to meet the regulations within an agreed timescale.

We met with the provider in January 2015 and were given assurances that the required actions would be put into place. Some key changes were made to the management structure and we were sent regular Service Improvement Plans in the intervening months to document progress. The provider stated that all actions would be in place and they would be operating in line with the regulations by the end of July 2015.

When we inspected we found that this was not the case. We had been kept updated with the chronic shortages of staff and were aware that the service had tried a number of different strategies to recruit new staff and keep staff already in post. These strategies had not been successful and we found the service was operating with 50% staff vacancies. The impact of this was a lack of consistent, safe and person centred care and a lack of support for staff. We found staff morale had been low and structured support and training for staff had been largely absent over the last few months.

Staff told us that recent months had been challenging for them. We received comments such as, “Staff are too busy to cover each other for breaks” and, “Some shifts are only partially covered because a staff member has stayed on longer when their shift is finished or come in early”. The issue of the low staff numbers was further exacerbated by the lack of support and guidance for staff. Staff did not receive regular supervisions and new staff did not receive the support they needed during their induction and probationary period. Lines of communication had been confused and staff had looked to their colleagues for support rather than their line managers. Some new staff told us they were not clear about the expectations of their roles. One described their role as, “Jack of all trades” and another said, “I have been very confused and overlooked”.

The most recent changes of management at the service, which has not had a registered manager in post since February 2015, had meant that a regional operations manager from another area had been brought in to oversee the service. They had firstly sought to address the very low staff numbers by redeploying staff from other local Mencap services. This was intended to boost staff numbers and the redeployed staff were expected to act as role models, introducing new systems and providing staff support. Whilst this had undoubtedly had a positive effect we remained concerned about how the provider intended to sustain the good practice being introduced as many staff were only redeployed for three or four weeks. We also remain concerned about the lack of effective oversight of the service regarding staffing, safeguarding, management of complaints, records and the management of medicines by the provider. This meant that issues identified at previous inspections had still not been addressed by the time we carried out this inspection.

Although the additional staff were a benefit they also brought about confusion for people who used the service and their relatives, many of whom had little confidence in the management of the service. One relative said, “The turnover of managers and staff is mad. It has been a worry for three years. We have sleepless nights over this”. Another relative told us, “I am seriously concerned. I would not trust things with Mencap…I asked one of the new staff ‘Are you here long?’ and they said ’I’m not sure’”. Four people told us they were considering removing their relatives from the service as they had lost confidence in it. One told us, “Staff keep leaving in droves. It is extremely alarming. [My relative] is not happy there” A member of staff described the situation over the last few months saying, ”With every manager it changes – [and] not for the good of [the people who used the service] anyway”. The provider had communicated with the people who used the service, staff and relatives about the issues facing the service and the proposed changes to management. However we found that several relatives did not feel that the provider had been honest and open about the issues.

Staff understood the primary role of senior staff to be monitoring and paperwork tasks. This was confirmed by the regional operations manager and records of rotas that we viewed showed that the majority of senior staff’s time was not spent in the units. One staff member told us, “[The senior staff member] floats in and out. They are not on the rota”. Another staff member commented, “[The senior staff] mostly do paperwork but they do pop in first thing to make sure we are ok and then go off and do their paperwork”.

Inadequate

# Is the service well-led?

Another told us, "We involve a manager if one is free". It was not clear to us why this was considered the best use of their time given the staff shortages the service had been experiencing over the past few months.

Record keeping at the service was mixed. In some units records were well set out and clear, with information easy to find but in others this was not the case. We found elements of duplication within the records meant that staff often had to record the same information in a variety of places. In some parts of the service records were confusing, not up to date or could not be located promptly when we asked to see them. Some, including some rotas and information in staff files, could not be located at all. Handwritten rotas, which were used in each unit, were confusing and sometimes incomplete. This made it difficult to establish if people had always received the staff support they required. Records relating to the financial transactions of the people who used the service were not always completed fully and this had not been picked up by the service's audit procedures

Health and safety checks, such as checks on the fire equipment and the emergency lighting, had not been carried out regularly in recent months but a clear improvement had been noticed in the last few weeks. Other audits carried out to monitor the quality of the service were not always effective. Medication audits had not identified all the issues we found related to the administration of medicines. We noted that there had been 37 medication errors notified to us since the last inspection. Some of these errors had been very minor and some had the potential to pose a serious risk to people's health. It was not clear why it took this inspection visit from the pharmacy inspector to prompt a change in the way medicines are to be administered at the service in future.

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

People who used the service, their relatives and staff had been given little opportunity to help develop the service. Surveys or questionnaires had not been sent out inviting feedback since May 2014. We noted that staff and relatives had been written to regarding the recent staffing concerns and some relatives told us they had been able to discuss their concerns with staff. One relative was unhappy as they had fundraised last year to equip and decorate an activity room which was now turned into offices. They had received no explanation as to why this had been put in place.

Although relatives generally did not feel that they had noted any improvement at the service in the last few weeks, the people who used the service and staff felt more positive. One staff member said, "Communication is getting better and we have started to have team meetings and supervision again". Another staff member told us, "More managers seem around now and they will sometimes help if we are short staffed". Another member of staff said, "Mencap, over the past few weeks, have finally upped their game. The management finally makes us feel we are being listened to". People who used the service made positive comments about being able to have the same members of staff more often.

Whilst we recognise that recently implemented management strategies seemed to be having a positive effect on the service, we remain concerned about the ability of this provider to sustain these improvements and build on them given the history of this service over the last three years.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>**The provider had failed to ensure the proper and safe management of medicines.**<br><br>**Regulation 12.2. (g)** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints<br><br>**The provider failed to effectively operate a system to record, investigate and respond to complaints.**<br><br>**Regulation 16 - 2.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>**The provider failed to establish and effectively operate systems to assess, monitor and improve the quality and safety of the service or to maintain complete and accurate records relating to people who used the service, person's employed and the management of the service.**<br><br>**Regulation 17 - 1, 2 a, c, and d (I) and (ii).** |

This section is primarily information for the provider

# Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider did not effectively operate systems and processes to prevent abuse or to immediately investigate any allegation of abuse.<br><br>Regulation 13 - 2,3 |

**The enforcement action we took:**
We issued a warning notice.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>The provider failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff and failed to provide them with appropriate support, training and supervision.<br><br>Regulation 18 - 1,2a |

**The enforcement action we took:**
We issued a warning notice.