Care Quality Commission

Royal Mencap Society

Precinct Road

Inspection report

4 and 6 Precinct Road
Hayes
Middlesex
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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?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

The inspection took place on 2 and 5 June 2015. The visit on 2 June was unannounced and we told the provider we would return on 5 June to complete the inspection. We last inspected the service in January 2014 when we found no breaches of the regulations.

Precinct Road is a service providing accommodation and personal care for up to five adults with a learning disability. When we inspected, four people were using the service. The home's registered manager left the service in December 2014 and when we inspected, there was no 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.

We found six 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.

Summary of findings

People using the service may have been at risk of receiving care or support that was inappropriate or unsafe. This was because the provider did not report possible safeguarding incidents to the local authority or the Care Quality Commission, the provider did not maintain the premises and there were not always enough staff to meet people's needs.

The provider assessed risks to people using the service and others and support staff had access to guidance on managing identified risks.

Where people were not able to make decisions about the care and support they received, the provider did not meet the requirements of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process to make sure that people are only deprived of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them.

Support workers treated people with kindness and patience. They gave people the support they needed promptly and efficiently and individuals did not have to wait for staff to help them.

The provider produced all care planning and risk management documents in easy read formats to make the information easier for people using the service to understand.

The provider had not told CQC about changes to the management arrangements for the service.

One person's relative commented positively on the care and support their family member received but said they were sometimes concerned there were not enough staff to support people.

Staff described the organisation as a good employer.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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?
The service was not safe.

The provider did not assess or respond to risks to people using the service.

There were not always sufficient numbers of staff to support people using the service.

The provider did not notify the local authority or the Care Quality Commission of possible safeguarding incidents.

Inadequate

Is the service effective?
The service was not always effective.

The adaptation, design and decoration of the service did not meet people's individual needs.

Staff had the training they needed to work with people using the service.

People's healthcare needs were met.

Requires improvement

Is the service caring?
The service was caring.

Staff treated people with kindness and patience.

The provider produced information for people using the service in a format they could understand.

Staff respected people's privacy and dignity when they supported them with their personal care.

Good

Is the service responsive?
The service was not always responsive.

People did not have access to meaningful activities in the local community.

Staff reviewed people's support plans and made changes where these were needed.

Requires improvement

Is the service well-led?
The service was not well led.

The provider did not inform the Care Quality Commission of changes to the management of the home.

Checks and audits completed by the provider did not identify risks to people using the service or failures to provide the care and support they needed.

Inadequate

Summary of findings

During our inspection, the atmosphere in the home was open, welcoming and inclusive.

Precinct Road

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 2 and 5 June 2015. The visit on 2 June was unannounced and we told the provider we would return on 5 June to complete the inspection.

The inspection team consisted of one inspector.

Before the inspection, we reviewed the information we hold about the service, including the last inspection report and notifications sent to CQC by the service regarding significant events in the service.

During the inspection, we spent time with people using the service. While we were not able to speak with people due to their complex needs, we observed the care and support they received from the support staff working with them. We also spoke with four support workers, the manager of another service who provided management support and the provider's area manager. The records we looked at included two people's care records, recruitment records for three support staff and medicines management records for two people using the service. We also reviewed records relating to the management of the home, including accident and incident reports, risk assessments, records of checks carried out by staff and staff training records.

Following the inspection, we spoke with the relative of one person using the service and a speech and language therapist working with people. We also contacted the local authority's safeguarding adults and care homes monitoring team.

Inadequate

Is the service safe?

Our findings

People using the service may have been at risk of unsafe care. The service's record of hot water temperatures showed support staff regularly recorded temperatures in excess of 65 degrees Centigrade when they checked the hot water taps in both of the service's kitchens and the staff office. Records showed support staff had recorded these temperatures since March 2015 and they had taken no action to resolve the problem. During the inspection, we saw people using the service had unsupervised access to both of the kitchens.

The provider had fitted covers to most radiators in the home to prevent people burning themselves. However, one radiator in a dining room was uncovered and very hot. People with epilepsy using the service used the room unsupervised and may have been at risk if they had a seizure and fell against the radiator.

Flooring in some parts of the home was in poor condition and presented a trip hazard. For example, the carpet in the doorway of one lounge was torn and lifting. People used the room frequently during the days we inspected and may have been at risk of tripping.

These were breaches of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had systems in place to protect people using the service but these were not always effective. Support staff completed incident reports with details of accidents and incidents involving people using the service. Three incident reports completed between January and March 2015 included details of unexplained bruising and another had details of an unexplained scratch. The provider had reported one of these incidents to the local authority but there was no evidence the provider had reported two other incidents to the local authority or the Care Quality Commission as possible safeguarding concerns.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and regulation 18 Care Quality Commission (Registration) Regulations 2009.

One person's relative told us they felt confident their family member was safe in the home but added, "Sometimes we are concerned there aren't enough staff." Rotas showed there were two support staff on duty between 7:00 am and 10:00 pm. At night, one support worker was awake in the home and they could call for assistance from a second support worker who slept in the home. The rota for May 2015 showed one support worker completed 11 waking night shifts from 10:00 pm – 07:00 am without a day off. The rota also showed, on three occasions, a support worker worked from 2:00 pm – 10:00 pm, then slept in the home on call and worked the next day from 7:00 am – 8:00 pm, a total of 30 hours in the service. This may have placed people using the service at risk, as support workers did not have sufficient rest periods between shifts.

The provider's area manager told us the local authority had completed assessments of the care needs of each person using the service that showed all four people needed support from two members of staff to access activities and facilities in the local community. However, these assessments were not available during the inspection. The provider did produce evidence to show they were discussing staffing levels with the local authority.

The provider assessed risks to people using the service. People's support plans included risk assessments that covered aspects of their health and personal care. For example, risk assessments covered personal care, challenging behaviour, use of the kitchen, epilepsy, medicines management and community inclusion. All risk assessments had been updated in January 2015. Where assessments identified possible risks to people using the service, the provider gave support staff clear guidance on how they should manage these. For example, one person's risk assessment for medicines said, if they refused their medicines, staff should wait and a different member of staff should then attempt to give them. Support staff had updated a second person's risk assessment to include the use of equipment to monitor them at night in the event of a seizure.

Support staff had access to pan-London guidance on safeguarding adults. The provider updated their safeguarding procedures in April 2014 and their whistle blowing procedures in September 2013. Support staff were able to tell us about the actions they would take if they had concerns a person using the service was being abused. Their comments included, "If I had any concerns I would tell my manager straight away. If they were not available I would tell their manager," "We have a whistle blowing policy if we think our concerns are not being taken

Inadequate

Is the service safe?

seriously" and "Our job is to keep people safe, if I thought someone was being abused I'd make sure they were safe and report it immediately." Support staff told us they had completed training in safeguarding adults and the training records confirmed this.

The provider carried out checks to make sure support staff were suitable to work with people using the service. Staff records included applications forms, interview records, proof of identity, references and criminal records checks.

People using the service received the medicines they needed. Support staff stored medicines safely in a lockable cupboard in most people's rooms. Other medicines were stored securely in the service's office. The records of medicines received and administered to people were up to date and this provided a clear audit trail to show people had received their medicines as prescribed. We found no errors in the balances of medicines we checked.

Requires improvement

Is the service effective?

Our findings

The adaptation, design and decoration of the service did not meet people's individual needs. During the inspection, we saw all communal parts of the service and people's bedrooms. Walls in all parts of the service, including bedrooms, lounges, dining rooms and bathrooms needed redecorating. Flooring was damaged in some communal areas and the paintwork on staircases, bannisters and doors was in a poor condition.

These were breaches of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The law requires the Care Quality Commission (CQC) to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process to make sure that providers only deprive people of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them.

The provider's Area Manager understood their responsibility for making sure staff considered the least restrictive options when supporting people and ensured people's liberty was not unduly restricted. However, there was no evidence that the provider had submitted applications to the local authority for authorisation to restrict people's liberty. Three people using the service were unable to leave the home without support from staff. The provider had recognised this was a restriction but there was no evidence they had applied to the local authority for authorisation, as required by the Safeguards.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider made sure staff completed the training they needed to work with people using the service. Training records showed all staff were up to date with training the provider considered mandatory. This included safeguarding adults, fire safety, medicines management and food safety.

Support workers told us they felt well trained to do their jobs. Their comments included, "The training is good," "I've always been able to get on training I felt I needed" and, "The manager tells me when training needs to be repeated and it's arranged."

One person's relative told us, "The staff seem to know what they're doing."

Where people were not able to make decisions about the care and support they received, the provider acted within the law to make decisions in their best interests. Where a person was unable to make a decision about their care and support, the provider had arranged meetings with relatives and other people involved in their care to agree decisions in the person's best interests, a requirement of the Mental Capacity Act 2005. For example, the provider had worked with one person and their family to agree arrangements for the person's end of life care, in the event of a serious illness. Records we saw confirmed this.

The provider arranged for and supported people to access the healthcare services they needed. People's support plans included details of their health care needs and details of how staff met these in the service. Where support staff identified people needed support to meet their health care needs they provided this. For example, one person's support plan included clear guidance for support staff on the medical support the person needed and the support they needed to attend appointments. Another person's support plan had clear information for support staff on managing epilepsy. The provider had produced all health care information and assessment forms in an easy read format to make the information easier for some people using the service to understand.

A speech and language therapist told us the provider had referred people appropriately to the service and they were in the early stages of agreeing with the provider the support they could provide to the staff team and people using the service.

Records showed support workers supported people to attend appointments with their GP, dentist, chiropodist and hospital appointments.

Support staff understood people's nutritional care needs. The weekly menu included a variety of different and interesting meals.

Support staff were able to tell us about people's special diets and the way they supported people to eat and drink. People had the support they needed to eat and drink. For example, at lunchtime, support staff encouraged people to choose what they wanted to eat and to be involved in preparing their meal.

Good

Is the service caring?

Our findings

One person's relative told us, "Yes, the staff do care, they have some very good staff there."

During the inspection, we saw staff treated people with kindness and patience. They gave people the support they needed promptly and efficiently and individuals did not have to wait for staff to help them.

Support staff demonstrated a good knowledge of each person's care needs. They were able to tell us about significant events and people in each person's life and their individual daily routines and preferences.

People were able to choose where they spent their time. We saw people spent time in their rooms when they wanted privacy and spent time in the lounge or kitchen when they wanted to be with other people. One person spent most of their time standing outside the service watching the traffic that passed.

Staff respected people's privacy and dignity when they supported them with their personal care. For example, staff made sure they closed bedroom doors when they supported people with their personal care and always knocked on the door and waited for people to invite them in.

Staff offered people choices about aspects of their daily lives throughout the inspection. We saw people made choices about what to eat and how they spent their time. Staff made sure people understood what they were being offered and gave them time to make a decision. If staff were not able to respond immediately to a person's request, we saw they explained the reasons why and agreed a time when they would be able to support the person.

The provider produced information for people using the service in a format they could understand. We saw the provider's care planning and risk management forms included pictures and symbols to make the information easier for people to understand. An easy-read version of the provider's complaints procedure was also available.

We saw staff recorded people's needs in respect of their gender, religion and culture in their support plans. For example, people's support plans included information about their preference of the gender of staff who supported them with their personal care and this was respected and reflected in the staff rotas we saw. Staff also recorded people's religious needs, and support staff had arranged for one person to attend a place of worship with their family.

Requires improvement

Is the service responsive?

Our findings

People's care plans included information about activities they enjoyed, based on their assessed likes and interests. However, there was no evidence people took part in these activities. Staff completed daily care notes that showed each person spent most of their time each day in the home, with little or no access to activities and facilities in the local community. Daily care notes were mostly task based, concentrating on people's personal care and support needs.

We looked at the daily logs for May 2015 for two people using the service. These showed one person had gone out with staff support on five occasions, three times to a local park, once for a drive and once for house shopping and the park. This person's support plan said they liked to watch traffic outside the home and the daily logs showed they spent extended periods each day doing this. The second person had gone out seven times during the month, shopping with staff three times, once to a Sunday Club, once to buy a take away meal, once out for a drive and once for a walk in the park. This person's support plan stated they enjoyed 10 pin bowling but there was no evidence this activity took place.

A support worker told us, "We don't have enough staff to take people out. Each person should have two staff to support them outside but this is not possible so people spend most of the time in the house." A second support worker said, "People need two staff to go out and we can't do it."

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider assessed people's health and social care needs and reviewed these regularly or when a person's needs changed. For example, the provider gave support staff clear guidance on how to manage specific health conditions, including epilepsy and people's support plans included details of medical appointments. Following a review of another person's care and support, staff had changed their support plan to include the use of a monitoring device at night to keep the person safe.

Support staff reviewed and updated people's care plans regularly and they had reviewed both people's support plans in January 2015. Where support staff identified changes were needed to a person's support plan, they made these. For example, to encourage one person to be more independent, their plan included "I now have a house key."

The provider also produced support planning information in an easy-read format and used photos, pictures and plain English to make information easier for people using the service to understand.

The provider had systems in place to respond to comments and complaints from people using the service and others. A relative told us, "There is a complaints procedure, but we've never needed to use it."

The provider had reviewed and updated their complaints policy in November 2014 and their procedures in February 2014. An easy read version of the procedure was available to support people using the service to comment on the care they received. The provider's area manager told us there had been no complaints about the service since our last inspection.

Inadequate

Is the service well-led?

Our findings

During this inspection, the provider's area manager told us the service's registered manager had left the home in December 2014. While the provider notified the Care Quality Commission (CQC) in November 2014 that they had appointed a new manager, the registered manager did not cancel their registration and the new manager did not apply for registration with the CQC. The area manager confirmed the manager appointed In November 2014 left the service in January 2015 and the provider appointed a new manager in February 2015. The provider failed to notify CQC of these changes and the new manager did not apply for registration with the CQC.

When we inspected the home, the manager was on sickness absence and the area manager told us they would not be returning to the service. Although the provider had arranged for staff to access support from other registered managers, they had failed to notify CQC of significant changes to the management of the service and the arrangements they had put in place to provide management cover.

The provider had systems in place to monitor the day to day operation of the service but these were not always effective. For example, staff recorded dangerously high hot water temperatures for a period of more than three months, from March to June 2015. When we brought this to the provider's attention during the first day of this inspection, they took action and the problem was resolved the next day. However, people using the service had been at risk of injury due to the lack of staff knowledge and the failure of monitoring by the registered manager and the provider. The provider did not note other risks to people's safety, including hot radiators that were uncovered and damaged flooring that presented a trip hazard, in their Continuous Improvement Plan for the service.

Other issues of concern we noted during this inspection, including the lack of activities for people using the service, staffing levels, the condition of the environment and the failure to notify the care Quality Commission of changes to the management of the service, were also not included in the Continuous Improvement Plan for the service.

These were breaches of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection support staff worked well as a team to meet people's care and support needs. During our inspection, we saw examples of good team work where staff supported each other to make sure people using the service did not wait for support or attention. One support worker said, "It's enjoyable but hard work. You have to work well with colleagues to get things done." A second support worker told us, "There aren't enough staff to do the things we want to with people but we try our best."

The provider's stated priorities were included in "Our BIG Plan" for the next five years. Priorities included, "raising awareness and changing attitudes", "making a difference to the lives of people with a learning disability here and now," "supporting friendships and relationships" and "improving health." Support staff were aware of the organisation's values and told us their role was to help people to live the life they chose.

The provider had systems in place to gather the views of people using the service and others. Both of the support plans we saw included a consultation form in an easy read format that staff had completed with people using the service. Support staff told us the provider also arranged three meetings each year for staff working with people using the service to review progress in implementing the provider's strategy.

The registered manager and support staff carried out checks and audits to monitor the service. These included a daily check of each person's medicines and finances.

The provider's area manager visited the service each month to review aspects of the care and support provided to people. Records confirmed the visits took place and the area manager carried out a review of people's finances as part of the last visit in May 2015. The provider had also developed a Continuous Improvement Plan that identified actions for the registered manager to take, including a review of staff training. However, there was insufficient evidence the registered manager had taken action to address issues identified in the provider's improvement plan.

During our inspection, the atmosphere in the home was open, welcoming and inclusive. Support staff spoke with people in a kind and friendly way and we saw positive interactions between staff and people who used the service. Staff told us that they enjoyed working in the

Inadequate

Is the service well-led?

home. One support worker said, “It’s good, [provider name] is a good organisation to work for.” A second support worker said, “[provider name] tries to support people to be as independent as possible but it’s hard sometimes.”

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 9 HSCA (RA) Regulations 2014 Person-centred care **The care of people using the service did not meet their needs or reflect their preferences.** **Regulation 9 (1) (b) and (c).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The provider did not ensure all premises and equipment used by the service provider were clean, suitable for the purpose for which they are being used and properly maintained.** **Regulation 15 (1).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The registered person did not notify the Commission of any abuse or allegation of abuse in relation to a service user.** **Regulation 18 (2) (e).**

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 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others were at risk as the provider did not assess and mitigate risks to their health and safety. Regulation 12 (2) (a) and (b).

The enforcement action we took:
We have served a warning notice and the provider was told they must become compliant with the Regulation by 31 October 2015

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 The provider did not operate effectively systems and processes to investigate and allegation or evidence of abuse. Regulation 13 (3). The provider did not ensure people using the service were not deprived of their liberty without lawful authority. Regulation 13 (5).

The enforcement action we took:
We have served a warning notice and the provider was told they must become compliant with the Regulation by 31 October 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not operate effectively systems or processes effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).

This section is primarily information for the provider

Enforcement actions

Regulation 17 (2) (a).

The enforcement action we took:
We have served a warning notice and the provider was told they must become compliant with the Regulation by 31 October 2015.