

# Royal Mencap Society County Road

## Inspection report

99 County Road  
Swindon  
Wiltshire  
SN1 2EE

Tel: 01793643545  
Website: [www.mencap.org.uk](http://www.mencap.org.uk)

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### Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

The inspection took place on 2 and 9 August 2018 and was unannounced.

County Road is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The CQC regulates both the premises and the care provided, and both were looked at during this inspection.

County Road accommodates up to seven people with learning disabilities in one purpose-adapted building. There were five people living at the service during our inspection. The service is located in Swindon and has easy access to the local town centre. People are accommodated on the three floors of the building.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

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. The service was run by a manager who was to become registered with the Care Quality commission (CQC).

Maintenance and cleaning of the property was not always carried out promptly and the décor required updating.

Environmental checks such as lighting checks had not always been completed in accordance with the provider's policy.

People were not always provided with opportunities to engage in meaningful activities, which depended on the availability of staff.

There were not enough of staff on shift to keep people safe and to provide them with meaningful activities. There were mixed views from staff and the relatives of people using the service on the frequent use of agency staff.

The provider failed to put effective systems into effect to assess, monitor and improve the quality and safety of the service. Audits undertaken had not identified the issues of infection control, lack of activities provided to people and gaps in the records that we found.

Some staff told us that due to recent changes on the managerial level it was sometimes difficult to contact

the manager who had to split time between three services.

Records kept by the service were not always available, accurate or complete.

Staff knew the correct procedures to follow if they considered someone was at risk of harm or abuse. They had received appropriate safeguarding training and there were policies and procedures in place to follow in case of an allegation of abuse.

Appropriate risk assessments were in place to keep people safe. Medicines were managed and stored safely.

Records showed staff received the training they needed to keep people safe. The manager had taken action to ensure that training was kept up-to-date and future training was planned.

Staff sought people's consent before providing care and support. Staff understood the circumstances when the legal requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) should be followed.

People's needs in relation to nutrition and hydration were documented in their care plans. People received appropriate support to ensure they received sufficient amounts of food and drink. Meals, drinks and snacks provided to people suited their dietary needs and preferences.

People were supported to maintain good health and they either attended appointments themselves or were visited by healthcare professionals. Appropriate referrals were made when required.

Staff were supported by the management team and received regular supervisions, which helped to identify their training and development needs.

The service had prepared appropriate care plans to ensure people received safe and relevant care and support. Each person had a personalised care plan containing information about their likes and dislikes as well as their care and support needs.

Staff knew people well and interacted with them in a kind and compassionate manner. People's privacy and dignity were respected by staff who supported them.

People and their relatives knew how to raise concerns and make complaints. Complaints were recorded, investigated and the outcome was fed back to the complainant.

We found breaches of regulation 9 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have advised the provider to take at the end of this report.

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

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement** ●

The service was not always safe.

Environmental checks had not always been carried out in accordance with the provider's policy.

The number of staff on shift was not sufficient to keep people safe and to provide them with meaningful activities.

Staff understood their responsibilities to keep people safe and protect them from harm.

People received their medicines safely.

### Is the service effective?

**Good** ●

The service was effective.

Staff received training and support to continually develop their skills.

The provider ensured that where people's human rights were restricted, the requirements within the Mental Capacity Act (2005) were being followed.

The service worked closely with health professionals to ensure people received treatment they needed.

### Is the service caring?

**Good** ●

The service was caring.

People were treated with dignity and respect and staff adopted a kind and caring approach.

Staff knew people well and interacted with them in a kind and compassionate manner.

Staff supported people to maintain their independence.

### Is the service responsive?

**Requires Improvement** ●

The service was not always responsive.

People did not always have opportunities to engage in activities.

The service sought feedback from people and their representatives about the overall quality of the service.

People and their relatives knew how to raise any complaints or concerns and felt listened to.

### **Is the service well-led?**

The service was not always well-led.

There was no registered manager in post.

Records relating to the running of the service had not always been completed accurately. There were gaps in records.

Quality monitoring processes were in place. However, not all of the processes were effective.

**Requires Improvement** ●

# County 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.'

Concerns about lack of activities organised for people, and people's safety had been raised with us prior to the inspection. Having taken these concerns into consideration, we decided to bring our planned inspection forward. Before the inspection, we reviewed information we held about the service. This included any information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted commissioners (those who fund the care for some people) of the service and asked them for their views.

This inspection took place on 2 and 9 August 2018 and the first day of the inspection was unannounced.

During the inspection we observed staff supporting people who used the service. We spoke with four people who used the service, two relatives, two members of staff, area operations manager and assistant manager and manager of the service.

We reviewed care plans for four people, four staff files, training records and records directly relating to the management of the service, such as audits, policies and procedures.

# Is the service safe?

## Our findings

On the first day of the inspection we found the premises were not clean. There were no paper towels in the communal bathrooms, the carpets had not been hoovered and the bath tub on the middle floor was left unclean after being used on the previous day. We saw that the kitchen cleaning checklist was not always completed. One of the relatives told us that the service did not always take appropriate steps to maintain cleanliness in people's bedrooms. One of them said us, "When I helped with moving [person] to another bedroom I could see how dirty her mattress was and how worn the furniture was. I wouldn't let a dog sleep there". This means that the service did not always take necessary steps to reduce the risk of the spread of infection.. We raised this issue with the management team. The service premises were clean on the second day of the inspection.

The number of staff providing support to people was insufficient. While some staff told us there were enough of them on shift, one person's relative told us, "Sometimes they could do with more staff". We noticed that when one person went out in the company of staff, only one member of staff was left to look after four people. This issue had a negative effect on activities provided to the people who were unable to go out as there were not enough staff to support them with these activities.

Due to the sickness and absences of the regular staff, the service was mainly staffed by temporary agency workers. People and staff's relatives felt the continuity of care was not always maintained. On the first day of the inspection there was one permanent member of staff and one agency staff member on shift and on the second day of the inspection the shift was run by two agency staff members. A member of staff told us, "I think the agency staff are OK. I do not have any issues with them". However, one person's relative pointed out, "[Person] likes continuity of care. He struggles with communication and he has got his routine. Agency staff are fine as long as they know him. And this is my only concern, if the agency staff know him enough. If the shift is run by two agency staff members, there is no one permanent to guide them if needed". Another member of staff remarked "Agency staff are not that reliable. Those sent here are not the best people that they have". We raised this issue with the manager who provided us with evidence of on-going recruitment and plans to reduce the use of agency staff.

We saw there were systems in place to assess the safety of the whole service, with regard to such hazards as fire risk or the risk of legionella. However, these environmental checks had not always been carried out in accordance with the provider's policy. This had been identified by the manager and brought to the attention of staff during one of regular team meetings.

People were protected from the risk of harm because staff knew how to recognise signs of potential abuse and how to report their concerns appropriately. For example, they said they would stay alert to signs of bruising, changes in behaviour or signs of neglect. Staff knew how to escalate concerns about people's safety to the provider and other external agencies. A member of staff told us, "I would record everything and report immediately to my manager".

The service identified and managed risks appropriately. We saw the care plans included a comprehensive

set of personalised risk assessments that identified hazards which individuals might face. These included any risks associated with people's personal, social and health care needs, such as accessing the community, preparing food and drink, and managing their own money. Staff told us the care plans provided them with detailed guidance on how they should be supporting people to manage these identified risks of harm. There were also assessments specific to a person's condition or disease: for example, there were risk assessments in place for people with diabetes and coeliac disease.

Appropriate staff recruitment processes helped to protect people from those who may not be suitable to care for them. All the recruitment files inspected showed that appropriate checks had been carried out before staff were employed. Clearance from the Disclosure and Barring Service (DBS) had been requested. A DBS request enables employers to check the criminal records of employees and potential employees, in order to ascertain whether or not they were suitable to work with vulnerable adults and children. References had been sought from previous employers and employment histories had been requested. Reasons for any gaps in the employment histories of prospective employees had been explained at job interviews and appropriately recorded in staff files. Background check records and references were stored electronically by the provider's human resources department.

People's accidents and incidents were recorded and monitored so that reoccurring themes and triggers could be identified. This helped staff to take proper action to prevent further reoccurrences. For example, when a person had suffered unexplained dizzy spells, the matter had been looked into and the person had been immediately referred to a GP.

People were supported by staff to take their medicine safely. Staff had received training in safe management of medicines. Staff competence to follow the relevant procedures was assessed on a regular basis to ensure individual practice reflected the provider's policy. The medicine administration records (MAR) we reviewed had been completed accurately.

We saw evidence of Personal Emergency Evacuation Plans (PEEP) for all of the people living at the service. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency.

There were robust contingency plans in place in case of an untoward event. The contingency plans assessed the risk of such events as fire or bad weather conditions.



# Is the service effective?

## Our findings

People's needs were met by staff who had relevant skills, competencies and knowledge. People and their relatives told us that staff were well-trained and knew people's needs thoroughly. One person replied, "Yes" when asked if staff were appropriately skilled and trained. One person's relative told us, "They know what they are doing. Every time we got in staff were brilliant with [the person]".

We looked at the training records which showed staff had completed a range of training courses which included: health and safety, data protection, safeguarding adults and the Mental Capacity Act. The training records showed that staff's training was up-to-date. The manager said training was booked in advance to ensure staff's practice remained up-to-date. A member of staff told us, "So far training has been good. We have plenty of face-to-face training opportunities".

New staff were required to undertake a twelve-week induction process comprising of a mix of training, shadowing and observing more experienced staff. The manager told us that the induction not only prepared new staff for their roles, but also allowed the organisation to get to know new staff members and identify what role in the service they would best "fit into". The induction process had recently been updated to include the new Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. Staff told us their training covered all areas of the role and was relevant.

Staff told us they felt well supported by their line manager and received supervision and annual appraisals. This gave them an opportunity to discuss any changes in people's needs and exchange ideas and suggestions on how to support people best. A member of staff told us, "Our supervision meetings are really good".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA. Mental capacity assessments and best interest meetings had taken place and were recorded as required. External healthcare representatives, social workers and the internal psychologist were involved to help ensure the person's views were represented. For example, we saw evidence of a best interest meeting for a person who needed to undergo a blood test. Staff recognised the principles of the MCA. A member of staff told us, "The MCA is about assuming that people have a capacity to make a decision and about in their best interest if they lack the capacity".

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection, there were five applications in place to deprive people of their liberty. Staff members described why and how people could

be deprived of their liberty and what could be considered as a lawful and unlawful restraint.

People had assessments of their needs written up before they moved into the service. People, their families, social workers and other services had been involved in the assessment process. People's care plans showed that their views had been sought in creating the care plans to reflect their individual preferences and needs.

People's nutritional needs were assessed and monitored. Staff were aware of people's dietary requirements and preferences and were able to provide specialist diets as needed, for example, a gluten-free or a diabetic diet. During the inspection we observed that staff supported people according to their care plans. For example, staff were offering grapes to people. One person liked them so much that a member of staff needed to stop the person from overeating, as stated in the person's care plan. One person told us their favourite food was toad in the hole and they "Always had a roast on a Sunday".

People were supported to stay healthy. One person told us, "They take me to the doctors, to the dentist and the hospital". Records showed that people had regular access to healthcare professionals such as GP's, psychiatrists, podiatrist and dentists. Each person had an individual health action plan which provided details about a person's health and how they would like to be supported with their medicines.

The décor of the service was worn. One person's relative told us, "I raised concerns about six weeks ago regarding [person's] furniture. Her bed was broken and there was no headboard. The handle on her door was broken so she was unable to shut it. One of the cupboards in her room was used as file storage for old audits". Another person's relative told us, "The place needs decorating". We raised this issue with the area operations manager and the manager who showed us the evidence that there were plans to re-decorate the bedrooms and the communal areas. We found the service had started re-decorating the premises, however, at the time of the inspection this was still at its initial stage.

# Is the service caring?

## Our findings

People and their relatives told us staff were polite, caring and compassionate. One person nodded when we asked them if the staff were kind to them. One person's relative told us, "Staff were always good with [the person]".

People were treated with respect and their dignity was preserved at all times. Staff showed kindness and compassion whilst providing people with care and support. We saw staff took time to talk to people to make them feel supported and comfortable at the service. For example, we observed that one person got anxious and started repeating they were "not a naughty girl". Staff comforted the person and de-escalated the person's behaviour in a calm and caring manner.

Staff promoted people's privacy and we saw they knocked on people's doors to ask for permission before entering their rooms. Staff excused themselves when they needed to leave the room and explained why they had to go and when they would be back. People were addressed by their preferred names. A member of staff told us, "We always knock on the door before we enter. During personal care we make sure the door is closed and people's dignity is maintained".

People and staff took great pride in the development of people's life skills and the promotion of their independence. A member of staff told us, "We promote people's independence by offering them a choice. For example, they can choose what to eat, what to wear or how to spend their time". Each person had a key worker whom they met on a regular basis to review and discuss their achievements and goals. A key worker is a member of staff who works closely with a person to assist them in working toward their aspirations and to meet their individual needs.

Staff were able to tell us about people's likes and dislikes and demonstrated a good understanding of people's routines and preferences. We saw staff were responsive to people's needs and tried to anticipate situations that may cause people anxiety and responded appropriately.

People were involved in the planning of their care as much as possible and could voice their views on how their care should be delivered. In order to facilitate communication, most information was provided in a format that was easy to read, with symbols and pictures.

People's diversity was respected as part of the strong culture of individualised care. For example, the service had offered one person their assistance to help them attend meetings at a local minority club.

We saw that records containing people's personal information were kept in the main office which was locked and no unauthorised person had access to the room. People knew where their information was and how to access it with the assistance of staff. Some personal information was stored within a password protected computer.

## Is the service responsive?

### Our findings

We looked at the arrangements in place for people to participate in leisure pursuits and activities they enjoyed. We saw one person was going out with one-to-one support, however, there were no activities planned for other people on the day of the inspection. One person told us they spent their time watching church services on their tablet. We asked the person what else they do to keep themselves occupied and they said, "Tidy my room". We asked the person if they had ever gone out for a day and they said, "We went on a day trip to Weymouth and we have been to Bristol Zoo, but I don't like the animals being locked up – it's cruel". We looked at the daily logs and saw instances of no activities recorded for one person for a period of 16 days. There were no activities recorded for another person for a period of nine days. Sometimes it was noted that a person had refused to join in an activity. However, it was not recorded if any alternative activity had been offered to the person. It was clear from the daily logs that for some people tablets and TVs became a substitute to any meaningful activities.

One person had a TV set in their room and asked us if we could get it working. The person had had the TV for a week and was still waiting for someone to repair an aerial. The person enjoyed watching TV and had to use the TV in the communal area instead of watching television in the comfort of their own room. We saw the person's TV set was not connected until the second day of the inspection.

People had opportunities to contribute during meetings organised by the service. We saw these meetings had been organised in the past and people had been able to discuss activities, holidays, trips and had been encouraged to raise their concerns. However, no meeting was organised for people in 2018. This means people did not always have opportunity to voice their opinions, make suggestions or provide feedback on the quality of care.

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care plans provided detailed information about people's care needs and specified how staff were supposed to help people maintain their abilities as long as possible. Some of the life histories included in the care plans were particularly detailed so that staff had a good understanding of people's background and interests, even if people's ability to communicate was limited. This enabled staff to respond appropriately to people's wishes and treat them as individuals.

Staff were provided with clear guidance on how to support people in line with people's wishes and preferences. All the staff members we talked to were able to describe the care needs of people they provided with support. This included individual ways of communicating with people, people's preferences and routines.

People were enabled to choose their own keyworker who took the lead on overseeing their individual needs, their care planning and reviews. A key worker is a member of staff that works with and in agreement with the person who uses the service and acts on behalf of that person. The key worker has a responsibility to ensure

that the person has maximum control over aspects of their life. It was evident from interactions between staff and people that staff members were familiar with the needs and preferences of the people they supported. As a result, they identified changes in people's wellbeing promptly and sought medical assistance or other advice in a timely way.

People knew what to do if they had any concerns. We saw the evidence that people were reminded of the complaint procedure at every 'tenants' meeting. People and their relatives told us they would speak to staff or the manager if they had a problem or a concern. There was a complaints procedure written in an 'easy-to-read' format to ensure people knew how to raise concerns.

People's wishes relating to aging, illness and death were recorded and respected. End of life care plans were in place, detailing how people like to be buried, if they would like an advocate to write their will and if they would like their favourite objects buried with them. No one was receiving end of life care at the time of our inspection.

## Is the service well-led?

### Our findings

There was no registered manager in post since April 2018. 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 was run by a manager who was to become registered with the Care Quality Commission (CQC).

We asked people, their relatives and staff about their opinion on the management of the service. While some people and relatives told us they did not know the manager, some members of staff told us they were not happy with the current management arrangements. A member of staff told us, "The old manager was here almost every day. The current manager needs to split their time between three services so now you need to call the on-call manager, a person that does not necessarily know the service. It is difficult to get through to the manager". Some staff told us that the communication within the service was poor and sometimes they were left without proper guidance or support.

Records relating to monitoring the quality and safety of the service were not always available, accurate or complete. An infection control audit had been planned and it could have identified the issue of the service not being cleaned properly. However, this audit had not been carried out since April 2018. There were gaps in the kitchen cleaning checklist, daily logs and health and safety files.

One person's consent document was signed only by their key-worker but the signatures of the person and the manager were missing.

At this inspection we found the quality and safety monitoring of the service to be ineffective at identifying where the quality of the service was being compromised. Even though the systems for monitoring care quality were in place, the concerns identified at this inspection regarding lack of activities offered to people, cleanliness of the place or staff shortages had not been identified and addressed by the management team.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The culture of the service was mainly task-focused with a lack of attention on enhancing the daily lives of people and providing care which put the needs, wishes and choices of people at the core of how the service was run.

People were provided with easy-to-read questionnaires on the quality of care provided by the service. These were returned to the manager and they were going to analyse them. As a result, a reflection meeting would be organised at which actions to be taken to tackle the identified issues would be explained and introduced.

The service held regular staff meetings to ensure staff were provided with opportunities to share information and ideas on how the service could improve. The team meetings concerned people's needs, the day-to-day running of the service and information sharing within the organisation such as training, policy updates or

changes.

Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. The service had informed the CQC of significant events in a timely way which meant we could check that appropriate action had been taken.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care  10 (2) (b) People did not always have opportunities to engage in activities.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  Registered persons did not ensure sufficient systems were in place to assess, monitor and improve the quality and safety of service provision. Regulation 17 (1) (2) (a)  Registered persons did not ensure accurate, complete and contemporaneous records were kept of each service user was maintained. Regulation 17 (1) (2) (c)