Royal Mencap Society

Mencap - East Cornwall Support Service

Inspection report

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Date of inspection visit:
17 October 2017

Date of publication:
13 December 2017

Ratings

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

Summary of findings

Overall summary

This focused inspection was completed to investigate concerns reported to the commission in relation to staffing levels in one of the houses where this service provides supported living care.

We found that although the service was safely staffed overall, there was a particular staff shortage in the house about which concerns had been reported. At the time of our inspection there were three staff vacancies at this house. We reviewed staff rotas and staff signing in sheets in detail and found that all planned care shifts had been provided. However, records showed that 22% of care shifts had been covered by MENCAP bank staff and 15% by agency staff. The service manager responsible for the house said, "We always make sure there is adequate staff there. No one lone works there during the day." The registered manager recognised that it could be unsettling for people to be supported by staff who they did not know well and had worked with agency staff providers to ensure that the agency staff had previous experiences of working in the house. Records showed that during recent weeks the same members of agency staff had been used regularly. One full time staff member who had worked at the service for over a year commented, "We have agency staff who have worked here longer than I have."

Prior to the inspection, managers had begun to address these staffing issues. An action plan had been developed and a targeted recruitment campaign had been launched. Staff told us this had resulted in the appointment of two new staff and that further interviews were planned. This demonstrated that the registered manager was responding appropriately to address and resolve the service's current staffing issues.

We looked specifically at staffing levels at the time of an incident where a person had been exposed to significant risk. We found that staffing levels had not contributed to this incident. Records showed at the time of the incident the house had been over staffed as two managers were visiting the service to review records. Following the incident, appropriate action was taken to prevent similar events from reoccurring.

This meant that although the service has some staffing issues these had not impacted on the quality of care people received.

There were systems and procedures in place to ensure people received their medication when required. Medicines administration records (MARs) had been completed and were regularly audited. Where medicines errors occurred these were investigated and staff were provided with additional training and support. A recent incident had occurred which highlighted that the service had not made appropriate arrangements for a new medicine to be available to a person at their day centre placement. This incident was being investigated and new procedures were being introduced. These were designed to ensure that in future everyone involved in a person's care was advised of any significant changes to their individual needs.

All staff had been recruited safely and understood their role in protecting people from abuse and avoidable harm. Risk assessments had been completed and staff had been provided with guidance on how to support

people to be as independent as possible.

Relatives were confident that the service met people's needs and told us, "I think they do the best they can for [Person name]" and "[My relative] is very happy there". Comments from staff included, "I think people are quite happy. People get to do whatever they want to."

Staff told us they were well supported by their managers who they described as, "brilliant". Records showed team meetings were held regularly to ensure staff were aware of any planned changes within the organisation and staff told us, "We had one [a staff meeting] just the other day." A number of changes had made in the service's management structure. New managers allocated to individual addresses had been provided with informative handovers from their predecessors. One staff member who's manager had recently changed commented, "The old manager and the new manager have been popping in together to do a hand over."

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

Agency and bank staff were used routinely to ensure sufficient numbers of staff were available to meet people's needs.

Staff understood local safeguarding procedures and their role in protecting people from harm.

There were systems in place to support people with their medicines.

Mencap - East Cornwall Support Service

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 focused inspection was completed in response to concerns received that indicated poor staffing levels at one address had exposed people to risk and impacted on the quality of care provided.

The inspection took place on 17 October 2017. One inspector undertook the inspection. Before visiting the service we reviewed notifications and other information we had received about the service's performance. A notification is information about important events which the service is required to send us by law.

During the inspection we went to the provider's office and spoke with the registered manager, three staff and two people's relatives. We looked at one person's care plan, staff rotas, duty rosters and staff signing in records to establish staffing levels at the address about which concerns had been raised.

Good

Is the service safe?

Our findings

This inspection was undertaken in response to concerns raised about staffing levels in one of the houses where this service provides supported living care. In addition, the commission had also received information that indicated a number of significant incidents had occurred at this house.

On the day of our inspection the service provided supported living care to 44 people living in 11 addresses in the east of Cornwall. The service employed 93 care staff and had 4 staff vacancies. However, three of these vacancies, totalling 60 day time hours and 24 waking night hours were at the house where concerns about staffing level had been raised.

We completed a detailed analysis of staff shifts patterns for three weeks including the week of our inspection at this house. We found that commissioned staffing levels had been routinely achieved through the use of significant numbers of agency and bank staff. The service manager responsible for the house said, "We always make sure there are adequate staff there. No one lone works there during the day" and "For the last three months Agency staff have been required consistently." Staff said, "We are quite low on staff at the moment", "There are enough staff to keep people safe" and "There are always enough staff but sometimes there are no drivers so we can't go out. It only happens occasionally." A relative of a person living at the address about which concerns had been raised told us, "There are always staff there". Of the 130 planned staff shifts we reviewed all had been provided. However, 22% had been provided by agency staff, 15 % by bank staff and 64% by staff employed to support the people living in the home. This meant that although overall the service was staffed at a safe level in the particular house where concerns had been raised that there was a significant staff shortage.

Prior to our inspection managers had recognised that staffing in the particular house was a significant issue. They told us, "We know we are quite short staffed at [the address]". An action plan had been developed and a targeted recruitment campaign, including radio advertisements, had been launched. Staff told this had resulted in two new staff being appointed and records showed another six prospective staff were in the process of being interviewed. This demonstrated that the registered manager was responding appropriately to address and resolve the service's current staffing issues.

In order to ensure that agency staff understood people's needs, a briefing and information pack had been developed. This included one page profiles about each person living in the house and detailed information about their individual care and support needs. This meant that agency staff were able to quickly gain an overview of people's support needs and their responsibilities.

The registered manager was working with agency staff providers to try to ensure people were wherever possible supported by staff they were familiar with. During the period of our analysis we saw individual members of agency staff had been used repeatedly and one staff member who had been employed at the service for over one year told us, "We have agency staff who have worked here longer than I have." Another staff member commented, "We are starting to see the same ones (agency staff) more often. The mangers have been trying to get the same agency staff to come." The use of this consistent group of agency staff

meant people were normally supported by staff who they were familiar with.

Prior to the inspection the commission received information about an incident where a person had been exposed to significant risk when they had left home without staff support. We specifically looked in detail at the staffing levels in the house at the time of this incident. We found that the house had been fully staffed and that two additional managers had been present at the time of the incident completing audits of financial records. This indicated that staffing levels were not a significant contributory factor in relation to the incident.

Following this incident the managers took immediate action to prevent similar incident reoccurring. This included the installation, the following day, of an appropriate alarm system and changes to procedures at the house to prevent similar incidents from occurring. This showed the service had responded promptly when incidents occurred and where necessary took timely action to ensure people's safety.

There were systems and procedures in place to ensure people received their medication when required. Medicines administration records (MARs) had been completed and were regularly audited. Where any issues with people's medications where identified these were investigated by managers. Records showed staff had been provided with additional training and support as a result of these investigations to ensure errors were not repeated.

A significant change to one person's medicine had recently occurred. A day centre this person visited regularly had been informed of the change but systems had not initially been introduced to enable the person to access their new medicine at the day centre. An incident subsequently occurred which had highlighted this issue. At the time of this inspection the service was in the process of investigating this incident but recognised it had failed to ensure the medicine was available at all times. Action had been taken to address this issue and a new procedure had been introduced. In addition, as part of the learning from the incident managers were now taking on responsibility for ensuring information about changes to people's medicine was shared with other care providers when necessary.

People were supported by staff who had been safely recruited. Staff had undergone checks to ensure they had the appropriate skills and knowledge required to meet people's needs. Staff recruitment files contained all the relevant recruitment checks to show staff were suitable and safe to work in a care environment. This included Disclosure and Barring Service (DBS) checks and references from previous employers.

All staff understood their role in protecting people form abuse and avoidable harm. Staff told us they would report any concerns to their managers and information about how to report safeguarding concerns outside of the organisation had been provided to staff. Assessments of risks to individuals and staff had been completed. These documents provided staff with guidance on how to safely support people to be as independent as possible.