Royal Mencap Society

Royal Mencap Society - 4 The Stables

Inspection report

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 31 August 2016 and was announced.

4 The Stables is registered to provide care and support for four people who have a learning disability. The house has been adapted to accommodate people who have restricted mobility. It is situated in a residential area of Crosby.

A registered manager was 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.

Medicines were not always administered in accordance with best-practice guidelines. There was no clear description or instructions for staff to assist them in establishing if the PRN medicine was required. Additionally, the service did not make use of body charts to indicate where topical medicines (creams and lotions) should be applied.

We have made a recommendation regarding this.

The registered manager implemented an approach to quality monitoring which was appropriate for the size of the service. The quality team also completed annual checks on the service. We saw that this process had been completed. However, none of these checks had identified the issues relating to the administration of medicines noted during the inspection.

The registered manager told us that open communication with families and staff was encouraged at all levels. However, some staff expressed concern about the consistency of management responses and said that they were sometimes reluctant to raise concerns.

Staff were vigilant in monitoring people's safety and family members spoke positively about the safety of their relatives. Staff clearly understood the different types of abuse and neglect and what signs to look out for. Staff also knew what action to take if they suspected that abuse was taking place.

Risk to the people living at the service was appropriately assessed and recorded in care records. Each risk assessment focused on maximising people's independence while safely managing any risks and had been recently reviewed.

Staff were safely recruited and deployed in sufficient numbers to meet the needs of the people living in the service. There was a minimum of two members of staff per shift with extra provision depending on activities. However, the registered manager acknowledged that the service regularly relied on staff undertaking overtime and used staff from other services to ensure that adequate staff cover was provided.

Staff were trained in a range of subjects which were relevant to the needs of the people using the service. New staff were required to complete an induction programme which was aligned to the Care Certificate. Staff were supported by the provider through regular supervision and appraisal. We saw from records that this had been delivered as planned. However some staff told us that they did not always feel well supported.

People's ability to consent to care had been assessed and recorded. DoLS applications had been submitted in accordance with good practice within the previous 12 months.

Staff had been trained to ensure that people received their food and drink in a safe manner. The people living at the service were not always able to demonstrate a preference for a particular meal or drink, but staff knew from experience what people preferred and provided food accordingly.

People's day to day health needs were met by the services in collaboration with families and healthcare professionals. Staff supported people at healthcare appointments and used information to update support plans.

Throughout the inspection we observed staff interacting with the people living at the service in a manner which was kind, compassionate and caring. We saw that staff spoke regularly with the people living at the service. They explained what they were doing and discussed their needs and activities.

Care and support were provided as required and not in accordance with a timetable. We saw that staff were flexible in the delivery of care and support and adjusted their practice depending on the responses they received from people.

Care records were appropriately detailed and respectfully worded. We saw examples of care plans relating to; staff support, professional support, community activities and relationships. We saw that care had been formally reviewed on a regular basis and following changes in care needs.

The staff that we spoke with were motivated to provide high quality care and understood what was expected of them. They spoke with great enthusiasm about the people that they supported and their job roles.

The registered manager that we spoke with was aware of the day to day culture and issues within the service. We saw that they knew the people using the service and their staff well. The registered manager understood their responsibilities in relation to their registration. Notifications relating to people who lived at the service had been submitted to the commission as required

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.

Some records relating to the administration of medicines were inaccurate or confusing.

Staff were recruited safely subject to the completion of appropriate checks and references.

Risk was appropriately assessed by experienced staff and reviewed on a regular basis.

Is the service effective?

Good

The service was effective.

Staff were suitably trained and supported to ensure that they could meet the needs of the people living at the service.

There was a good choice of food available and people were supported with specialised diets.

Is the service caring?

Good

The service was caring.

Staff interacted with the people living at the service in a manner which was kind, compassionate and caring.

The people living at the service were consistently consulted about their own care and contributed to making decisions based on information provided by staff.

Staff adapted their communication style to meet the needs of each person.

Is the service responsive?

Good

The service was responsive.

People's individual preferences and personalities were reflected in the decoration of their bedrooms.

The people living at the service had care delivered only when it was needed. They were encouraged to be as independent as possible and received staff interventions on request or when staff assessed that support was required.

Staff knew the needs and preferences of the people living at the service and responded with confidence when care or communication was required.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality audit systems had not been effective in identifying issues highlighted during the inspection.

Some staff expressed concern about the consistency of management responses and quality of communication.

Staff were motivated to do their jobs and enjoyed working at the service.

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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.

This inspection took place on 31 August 2016 and was announced. 24 hours' notice was given because the service is a small care service and the people who live there are sometimes out during the day. We needed to be sure that someone would be in.

The inspection was conducted by an adult social care inspector.

We checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all of this information to plan how the inspection should be conducted.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

Because of communication difficulties we were unable to speak directly with people living at the service, but we were able to speak with two relatives, five staff and the registered manager. We also spent time looking at records, including four care records, four staff records, staff training plans, complaints and other records relating to the management of the service. We also observed the delivery of care at various points during the inspection.

Requires Improvement

Is the service safe?

Our findings

We checked the service's procedures for the storage, administration and recording of medicines. We saw that medicines were stored safely and securely in people's bedrooms and that staff maintained a record of administration. The Medicine Administration Record (MAR) sheets that we spot-checked were completed correctly. However, the stock check which was included as part of the record did not have the time when the check was completed. Because some people were on multiple medicines each day this made it extremely difficult to establish if stock levels were accurate. We attempted to check stock levels for two medicines. While it was clear that stock levels reduced at an appropriate rate over a period of time, we were unable to establish if the current stocks were accurate. We discussed this with the registered manager and staff. The registered manager agreed that the information was incomplete and agreed to amend the records in the future.

We also saw that instructions for the administration of PRN (as required) medicines were not complete. There was no clear description or instructions for staff to assist them in establishing if the PRN medicine was required. We discussed this with staff and they acknowledged that there was an over-reliance on experienced staff knowing when people required PRN medicines, for example, for pain relief. The registered manager and staff agreed that new PRN protocols should be produced which clearly explain under which circumstances PRN medicines should be administered. These protocols were produced from existing information before the inspection was completed.

Additionally, the service did not make use of body charts to indicate where topical medicines (creams and lotions) should be applied. The service relied on basic instructions on MAR sheets and staff knowledge. A suitable body chart diagram was printed for each person who required topical medicines before the end of the inspection. The provider's quality audit processes had not identified these issues.

We recommend that the service reviews its procedures for the storage, administration and recording of medicines to ensure that they comply with National Institute for Health and Care Excellence (NICE) guidance for care homes.

We asked relatives of the people living at the service if their relative was safe. They told us, "100% yes. We know [relative] is safe. We've got no concerns." One member of staff said, "We keep [people] safe by making sure there's always somebody with them and keeping support plans and risk assessments up to date." The staff that we spoke with demonstrated a good understanding of the risks associated with each of the people living at the service and had taken appropriate steps to reduce the likelihood of harm. For example, one person living at the service had developed a tendency to lean to one side when seated. Staff had taken advice from a professional regarding an alternative chair to ensure that the person's posture was improved. They told us that this would have benefits for the person's comfort and general health.

All of the staff had completed safeguarding training. Staff clearly understood the different types of abuse and neglect and what signs to look out for. Staff also knew what action to take if they suspected that abuse was taking place. A member of staff said, "[If you suspect abuse] you have to report and record. You can go

to the local authority or CQC."

Risk to the people living at the service was appropriately assessed and recorded in care records. We saw risk assessments relating to; specific health conditions, accessing the community and relationships. Each risk assessment focused on maximising people's independence while safely managing any risks and had been recently reviewed. A relative told us they were involved in decisions about care and taking risks. In one example, a person who required regular bed-rest was monitored remotely to ensure they were safe.

Accidents and incidents were recorded in appropriate detail and assessed by the manager. The manager was required to submit information electronically to the provider. The information was then analysed by a specialist team to identify patterns and triggers.

The service had sufficient staff on duty to meet the needs of the people living there. There was a minimum of two members of staff per shift with extra provision depending on activities. The registered manager and a deputy manager were available to provide or organise additional support as required. However, the registered manager acknowledged that the service regularly relied on staff undertaking overtime and used staff from other services to ensure that adequate staff cover was provided. The registered manager told us that the recruitment of additional staff was in progress.

Staff were recruited safely subject the completion of appropriate checks. This included a requirement for two references and a Disclosure and Barring Service (DBS) check. DBS checks are used to determine that people are suited to working with vulnerable adults. Staff records were held at a separate office and were not available during the inspection. However, we were provided with evidence that records of DBS checks and references were kept on file.

The service employed external contractors to service and check; gas safety, electrical safety and fire equipment. We saw that checks had been completed in each area within the previous 12 months. The service had a general evacuation plan in place and tests on emergency equipment were conducted and recorded regularly.

Good

Is the service effective?

Our findings

Staff had been recruited and trained to ensure that they had the rights skills and experience to meet people's needs. Staff were trained in a range of subjects which were relevant to the needs of the people using the service. Subjects included; safeguarding adults, moving and handling, administration of medication, Mental Capacity Act 2005 and equality and diversity.

New staff were required to complete an induction programme which was aligned to the Care Certificate. The Care Certificate requires staff to complete appropriate training and be observed by a senior colleague before being signed-off as competent. Shadowing provided the opportunity for competence and suitability to be assessed as part of the induction process. Staff training was planned and recorded on an electronic system that provided reminders when training was due for renewal. We saw that all of the training required by the provider was up to date or had been booked. One member of staff told us, "The training is good. I've always had face to face." Another member of staff said, "My training is up to date. I've just completed my team leader and dementia."

Staff were supported by the provider through regular supervision and appraisal. We saw from records that this had been delivered as planned. However some staff told us that they did not always feel well supported. For example, when they had raised concerns about the quality of care provided. We spoke with the registered manager about this and they were aware of the issue. The appropriate procedure had been implemented to resolve the matter although it was acknowledged that completion of the process had been delayed. Other staff told us that they felt well supported by the provider.

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.

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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People's ability to consent to care had been assessed and recorded. DoLS applications had been submitted in accordance with good practice within the previous 12 months. In one example an application had been submitted for the use of bed-rails. Staff demonstrated a good awareness of the MCA and associated legislation.

People living at the service had specific health conditions which required their food and drinks to be prepared and consumed in different ways. For example, one person required thickeners to be used in drinks to help them swallow safely. Another was fed through a percutaneous endoscopic gastrostomy (PEG) tube. Staff had been trained to ensure that people received their food and drink in a safe manner. The people

living at the service were not always able to demonstrate a preference for a particular meal or drink, but staff knew from experience what people preferred and provided food accordingly. One member of staff said, "We don't have a fixed menu. We know what people like. People tell us [if they like certain foods] by their behaviours or refusal." During the inspection we saw that people refused food and were offered alternatives. Another member of staff told us about one person who was on a diet, but didn't like too much salad. Alternative, low-calorie foods were used as substitutes. This demonstrated that staff understood the individual needs and preferences of the people living at the service. People were also supported to eat at local pubs and restaurants on a regular basis.

People's day to day health needs were met by the services in collaboration with families and healthcare professionals. Staff supported people at healthcare appointments and used information to update support plans. We saw evidence in care records that staff supported people to engage with community and specialist healthcare organisations to support their wellbeing. One staff member told us, "We organise appointments with GP's etc. and go with them. Each person has a health needs support plan." We saw evidence of these plans in care records. A relative told us how the staff worked effectively with community specialists to help manage their family member's pain medication.

Good

Is the service caring?

Our findings

Throughout the inspection we observed staff interacting with the people living at the service in a manner which was kind, compassionate and caring. When asked if staff were caring one relative told us, "Without a doubt." They also said, "They organised a birthday party early because some staff were on holiday on the day itself and wanted to be there." We saw that staff spoke regularly with the people living at the service. They explained what they were doing and discussed their needs and activities. Staff knew the needs of people well. For example, one member of staff was able to outline what one person's preferred routine would be once they woke. All of the staff were able to describe people's needs and preferences in good detail. We saw that they used this knowledge when they talked with people or provided support.

We saw that staff involved people in conversations and decisions about their own care. Staff adapted their communication style to meet the needs of the individual. Throughout the inspection staff spoke in a manner which was gentle and respectful. When the situation warranted, they used language and tone that was positive and encouraging. For example, when one person woke and appeared to be slightly disorientated, staff offered reassurance, encouragement and direction. We saw that the people had choice and control over their life and that staff responded to them expressing choice in a positive and supportive manner. One member of staff said, "People regularly refuse my support." They provided examples when people had refused support with personal care. In each case staff had explored if the refusal related to an individual staff member or the activity and responded appropriately.

Care and support were provided as required and not in accordance with a timetable. We saw that staff were flexible in the delivery of care and support and adjusted their practice depending on the responses they received from people. For example, because the weather had improved there was a discussion about whether lunch should be eaten in the main lounge or the garden. People were asked where they would prefer their lunch to be served.

Privacy and dignity were protected and promoted by staff. Staff spoke with respect about the people living at the service and promoted their dignity in practical ways. We saw that staff understood people's rights in relation to privacy and dignity. Personal care was provided discretely in bathrooms and bedrooms. Staff told us that they always closed doors and curtains when providing personal care. We saw one example where a person's behaviour may have compromised their dignity. Staff responded in a clear, positive and caring manner to re-direct the person.

Each of the people living at the service had a family member to advocate on their behalf. The registered manager was aware of independent advocacy services in the area, but confirmed that none of the people currently living at the service was making use of them.

Relatives were free to visit at any time. A member of staff told us, "Families can visit at any time. Some visit at regular times. Others just pop-in." The property was set-up as a family service with a shared lounge and kitchen. People could access their bedrooms where they could receive visitors in private if they chose. Decoration, fixtures and furniture made the building feel homely and welcoming.

Good

Is the service responsive?

Our findings

We saw from our observations that people living at the service were involved in discussions about care on a day to day basis, but communication difficulties meant that their involvement in more formal reviews of care was limited. Family members represented their needs and one commented, "I've been actively involved in meetings about [relative's] care." A member of staff told us, "[As a keyworker] I always keep the family involved and let them know about meetings." Care records showed that assessment and care planning were completed in the presence of the individual where possible and involved family members, staff and other professionals. Care records were appropriately detailed and respectfully worded. We saw examples of care plans relating to; staff support, professional support, community activities and relationships. We saw that care had been formally reviewed on a regular basis and following changes in care needs.

We saw that the people's individual preferences and personality were reflected in the decoration of their bedrooms and in shared areas of the service. The people living at the service were supported to follow their interests and to maintain relationships with family members and other people in the local community where appropriate. Activities were organised on an individual and group basis and reflected people's personal preferences. Activities were recorded and assessed to establish what worked well and what didn't. A member of staff said, "We discuss activities and interests at team meetings." While another member of staff told us, "Managers used to be risk averse, but now [person living at the service] goes swimming and on holiday."

We observed that care was delivered only when it was needed. People's health conditions and care needs limited their ability to be to fully independent. However they were encouraged to be as independent as possible and received staff interventions on request or when staff assessed that support was required. Staff knew their needs and preferences and responded with confidence when care or communication was required. Communication was improved because staff had access to information about non-verbal communication held in care records.

The service had a complaints procedure and a complaints book available to people living at the service and visitors. We saw evidence that the service had recently distributed a copy of the complaints procedure to families. A copy of the complaints procedure was displayed in the hall. One relative told us, "I've got a copy of the complaints procedure at home. It gives me all the contacts I need." The records that we saw indicated that one formal complaint had been received in the previous 12 months. This complaint had been recorded and responded to in accordance with the relevant procedure. Relatives were also able to communicate with staff and raise concerns on visits or by telephoning the service.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in post and was available throughout the inspection. The registered manager was supported by a deputy manager in their absence.

The registered manager implemented an approach to quality monitoring which was appropriate for the size of the service. In conjunction with the deputy manager they undertook regular monitoring of; staff performance, satisfaction and the physical environment and addressed issues as they arose. They were required to complete a standardised quality assurance check which was analysed by the provider's quality team. The quality team also completed annual checks on the service. We saw that this process had been completed. However, none of these checks had identified the issues relating to the administration of medicines noted during the inspection. The registered manager agreed to review their audit processes to ensure that they were more effective in relation to the administration of medicines.

The registered manager told us that open communication with families and staff was encouraged at all levels. The registered manager organised the distribution of surveys to families and staff. The results of the most recent surveys were held at a central office and were not available on the day of the inspection. Staff told us that they received a magazine with information about the organisation. A member of staff also said, "We have team meetings every month or two months. We talk about everything." However, other staff expressed concern about the consistency of management responses and said that they were sometimes reluctant to raise concerns. We spoke with the registered manager about this. They said, "I really think about how I support individual staff members. Some of the issues raised are genuine, but I'm not always in a position to give them information [feedback]."

The organisation had a clear set of visions and values which were communicated in brochures and other promotional materials. These visions and values were linked to organisational strategy and used as one of the criteria on which quality was assessed. Staff were able to explain the visions and values of the service and applied them in their practice. The core values reflected people's rights to equality, opportunity and independence. The registered manager said, "They're such a great team. They all understand that they're here for one thing."

Regardless of the issues previously identified, the staff that we spoke with were motivated to provide high quality care and understood what was expected of them. They spoke with great enthusiasm about the people that they supported and their job roles. Each of the staff was positive about the support and quality of care offered by the organisation. One member of staff told us, "Yes I feel motivated. My job role is clear. It's to keep people safe and help them to be as independent as possible." Another member of staff said, "I'm motivated for the people living here. I do what I do for them."

The registered manager was aware of the day to day culture and issues within the service. We saw that they knew the people using the service and their staff well. The registered manager understood their responsibilities in relation to their registration. Notifications relating to people who lived at the service had been submitted to the commission as required.

The registered manager had robust systems and resources available to them to monitor quality and drive improvement. The provider had an extensive set of policies and procedures to guide staff conduct and help measure performance. The registered manager was knowledgeable about their role and responsibilities. They were able to provide evidence to support the inspection process in a timely manner and facilitated meetings with family members and staff. They spoke with enthusiasm about working for the organisation. They said that they were supported by senior managers. They understood their role in relation to the assessment and monitoring of quality and coordinated the collection and collation of data in relation to quality and safety audits.