Care Quality Commission

Royal Mencap Society

Mencap York Domiciliary Care

Inspection report

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Ratings

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

Overall summary

Mencap York Domiciliary Care provides personal care and support to people with a learning disability living in and around York. At the time of our inspection, the service supported approximately forty adults living in 12 supported living houses and bungalows. This accommodation was not owned or provided by Mencap York Domiciliary Care and people living in these supported living schemes were tenants of a housing provider. The housing provider was responsible for the buildings and their maintenance. Alongside this, Mencap York Domiciliary Care ran a small 'community service', which provided domiciliary care and support to people living outside these supported living schemes.

Summary of findings

We inspected this service between 10 November and 10 December 2015. This inspection was announced. The provider was given 48 hours' notice because we needed to be sure that someone would be in the location offices and supported living schemes when we visited.

This was the first inspection of the location. Mencap York Domiciliary Care was previously registered at a different location where the service was last inspected on 9 May 2013 and, at which time, they were found to be compliant with all of the outcomes assessed.

Before our visit, concerns were raised about a number of issues including medication management, the lack of support with activities for people using the service, concerns about poor communication and concerns about how risks were identified and managed. We have recorded our findings in relation to these concerns in the body of this report.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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.

During this inspection we found that the service was not always safe. Care workers we spoke with understood the types of abuse they might see and what action they would take to keep people using the service safe. However, we found that risk management was not consistent meaning that risks had either not been identified or, where risks had been identified, appropriate risk management was not always in place. This was a breach of Regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that staffing levels were not sufficiently monitored and maintained meaning that the level of staffing provided was sometimes less than the level assessed as required to meet people's needs. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the service had a safe recruitment process and an effective induction, however, on-going training had not been kept up-to-date and the system used to monitor and ensure that mandatory and service specific training was completed was not robust enough. This had led to gaps in training which impacted on care workers ability to provide effective care and support. This was a breach of Regulation 12 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people's privacy and dignity were not always maintained. This was a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the service was not always well-led as the systems used to monitor the quality of the service were not robust enough. This meant that concerns we noted had not been identified and addressed. This was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take in respect of these breaches at the back of the full version of this report.

We found that the safe storage of medication had not always been properly risk assessed and have made a recommendation about this in the body of the report.

People we spoke with told us that comments, concerns and complaints were not always well managed and told us that communication was not always effective. We have made some recommendations to the registered provider about the lack of staff training in how to support people to communicate and about improving the management of comments, concerns and complaints.

Relatives we spoke with raised concerns about the level of activities available to people using the service and staff we spoke with highlighted how staffing levels impacted on the availability of support to take people out.

We found that people were supported to make decisions in-line with principles of the Mental Capacity Act 2005 and that potential instances where people using the service were deprived of their liberty had been alerted to the supervisory body, which was the contracting local authority.

We found that people were supported to eat and drink enough and access support from healthcare professionals where necessary.

Summary of findings

People we spoke with generally reported that care workers were kind and caring. We observed a number of positive interactions during the course of our inspection.

People were supported to make decisions and express their wishes and views; however, we found specific examples where a lack of training meant staff could not effectively support people to communicate.

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?

Requires improvement

The service was not always safe.

Care workers understood the signs of abuse and knew what action to take if they had concerns.

Risk management was inconsistent across the supported living schemes we visited meaning that people using the service were put at risk of avoidable harm.

Staffing levels were not effectively monitored and maintained and this impacted on the support available to people using the service.

The risks around how medication was stored had not always been adequately assessed.

Is the service effective?

Requires improvement

The service was not always effective.

There was an effective induction system and care workers we spoke with told us that this equipped them with the skills and knowledge they needed to do their job.

The system used to monitor and ensure care workers training was up-to-date was not robust enough and there were gaps in training and gaps in records of training we were told care workers had completed.

People were supported to eat and drink enough.

Is the service caring?

Requires improvement

The service was not always caring.

People we spoke with told us that care workers were generally kind and caring and we observed a number of positive interactions throughout our inspection. However, feedback we received was not consistently positive.

People were supported to make decisions, however, care workers did not always support people to maintain their privacy and dignity.

Is the service responsive?

Requires improvement

The service was not always responsive.

Care plans contained person centred information and were updated regularly, however, care workers did not always communicate information where there were gaps or changes needed to the care plans.

Relatives of people using the service raised concerns about the amount of activities and support available to take people out.

Summary of findings

People we spoke with told us that concerns and complaints were not always dealt with.

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

We received a range of views about whether individual supported living schemes and Mencap Domiciliary Care York as a whole was well-led.

People we spoke with raised concerns about communication and a negative atmosphere within the service.

The systems used to monitor the quality of the service provided and to drive improvements were not robust enough meaning there were inconsistencies in the quality of care and support provided.

Specific concerns, for example around risk management, the quality of records and staff training had not been identified and addressed.

Requires improvement

Mencap York Domiciliary Care

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.

We visited the location offices on 10 November and 10 December 2015, visited five supported living schemes and spoke with people who used the service and their relatives in between. The inspection was announced; the provider was given 48 hours' notice, because we needed to be sure that someone would be in when we visited.

This inspection was carried out by one Adult Social Care Inspector. Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and what improvements they plan to make. We looked at information we held about the service, which included notifications sent to us since the last inspection. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also sought relevant information from City of York Council's safeguarding and commissioning teams.

As part of this inspection we visited five supported living schemes. We spoke with five people who used the service and we spoke with 10 relatives or friends to ask them for their views. We spoke with the registered manager, the area operations manager, seven service managers, two assistant managers and 11 care workers. We also spoke with four health and social care professionals.

We looked at six care plans, five staff recruitment and training files as well as a selection of records used to monitor the quality of the service.

As people using the service often had complex needs that meant they were unable to tell us about their experiences, we spent time in five of the supported living schemes observing interactions between staff and people using the service.

Requires improvement

Is the service safe?

Our findings

People using the service told us "I am happy here" and "I feel safe." Other people we spoke with used non-verbal communication including smiling and nodding when we asked them if they felt safe. We observed interactions between care workers and people using the service in each of the five supported living schemes we visited. We saw that people using the service were relaxed and at times confident and outgoing around staff, showing that they felt safe and at home in their surroundings.

The registered provider had a safeguarding vulnerable adult's policy in place at the time of our inspection. Care workers we spoke with understood the types of abuse they might see and described what action they would take if they had concerns. Comments included "I would tell my manager or, if I felt I could not do that, I would talk to another manager or ring the Police", "I would document it. Record and report it" and "I would speak to my line manager." We could see from notifications sent to us that safeguarding concerns were referred to the local authority safeguarding team.

Care workers we spoke with told us "I feel that people are safe...we've got risk assessments in place to outline and manage risks, but it's as much about knowing the person and understanding risks" and "We follow support plans and risk assessments to keep people safe." We reviewed care plans and saw that people's needs were assessed before they moved into a supported living scheme. We saw that personalised risk assessments had been put in place to manage identified risks to keep people and care workers safe. We found examples of very detailed, specific and person centred risk assessments on managing the risks associated with epilepsy, providing assistance with hoisting people in and out of bed and managing and responding to people who may become anxious or upset and behaved accordingly. These provided detailed instructions to guide care workers on how to minimise risks and prevent avoidable harm. A health and social care professional told us "In my experience of working with Mencap, they have good risk assessments and support plans in place to monitor people's safety/risk and these are reviewed as needed."

However, whilst we found evidence of effective risk management in places, this was not consistent across the supported living schemes we visited. We found examples where risk assessments were brief and lacking in detail, where risks had not been identified or where risks had been identified, but risk assessments were not in place.

We noted that one care plan identified risks around mobility and risks associated with a person's epilepsy, the care plan referred care workers to the relevant risk assessments, but these were not in the clients file. This meant that information about how these risks would be managed was not available to the care worker providing support. Another care plan contained an Epilepsy Pen Picture with details about that persons health needs, but not a support plan or risk assessment regarding the support provided or how the associated risks would be managed. We saw that where personal care was provided to people who did not live in the supported living schemes, there were no environmental risk assessments in place to assess and manage any risks associated with providing personal care in that environment.

We found other examples where risks had not been appropriately managed. We saw that the radiator in one person's room had broken. This room had three external walls and was noticeably colder than the rest of the house. Although this issue had been reported to the housing provider and a portable heater was in the person's room, the person using the service was reliant on staff to monitor the temperature and turn this on. We noted that there was no thermometer in the room and no formal system for monitoring the temperature throughout the night. The service manager told us the portable heater was not left on overnight. We were concerned that reasonable steps had not been taken to make sure the room did not get too cold at night. We also observed in this scheme that a bedroom used by night staff contained a number of trip hazards including an extension lead across the middle of the floor. This room was not locked, but accessible to people using the service and so the extension lead represented a trip hazard to them. Although the registered provider did not provide the accommodation and was not responsible for maintaining the home environment, they had a duty of care to identify risks and take reasonable steps to minimise these risks to keep people using the service safe.

Service managers we spoke with told us that care workers checked and disposed of out of date food. However, there were no records of when food was opened so we could not be certain that food with a limited expiry on opening was

disposed of if not eaten within the recommended period. We concluded that where people may be unable to manage the risks associated with eating out of date food, and staff were responsible for preparing their meals and drinks, staff needed to risk assess this and consider how best to manage these risks on their behalf.

We reviewed health and safety records in the supported living schemes we visited and found that these were inconsistent and incomplete in places. We observed that a monthly health and safety checklist used to identify risks and monitor the safety of the home environment had not been completed eight times in 2015 in one of the schemes we visited and four times in another. We observed that fire alarms had not been tested regularly. We visited one scheme where records showed the weekly fire alarm test had been completed four times in 2015.

By not always identifying risks or taking sufficient steps to monitor and respond to risks, the registered provider was putting people who used the service at risk of avoidable harm.

This was a breach of Regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that accidents, incidents and near misses were logged electronically by staff and could be reviewed remotely by the registered manager. We checked eight accident and incident records and found that staff had documented information about the incident. The service manager of that supported living scheme had then signed this record and included details of any follow-up action taken. For example, one accident and incident report showed that a person using the service had been given the wrong medication. The electronic record showed that staff had contacted the out of hours G.P for advice and the member of staff responsible had been booked on refresher training for medication management.

We spoke with the registered manager who showed us how they could review the electronic records of all accidents and incidents and filter the results to analyse for patterns or trends. The registered manager told us that they reviewed accident and incident reports approximately every three months, but said that they did not keep any records of this. We were given a copy of a new medication policy that we were told had been implemented in response to a high number of medication errors in one of the supported living services. This showed us that accident and incident analysis had occurred. We spoke with the registered manage about the importance of documenting and evidencing all accident and incident analysis in future.

Staffing levels varied across the supporting living schemes we visited depending on the needs of the people living there. People using the service were assessed by the Local Authority and/or Clinical Commissioning Group who funded a certain number of support hours each week. This was the number of hours assessed and agreed as required to meet that person's needs. Some of these hours contributed towards a 'pot' of hours used to support the people living in that scheme; whereas some hours were to provide one to one support for individual people only. This meant that each supported living scheme had a certain number of hours available each week to meet the needs of the people living there. However, we noted that the number of hours of care provided was sometimes less than the number of hours assessed as needed to meet people's needs. During the inspection we were given information which showed one scheme we visited had a total of 449.5 care hours available per week. However, for the four weeks starting week beginning 19th October 2015 the scheme had provided 395 hours, 374 hours, 390.5 hours and 426.5 hours of care and support. Another scheme had 538 care hours available per week and, for the same four week period, had provided 540.5 hours, 502 hours, 478.25 hours and 529 hours of care and support. The registered provider subsequently told us that the actual number of care hours provided in these supported living schemes was less than the available hours, because people using the service were away or spending time with relatives. The registered provider told us that staff sickness and staff leaving also impacted on staffing levels although told us that they maintained a minimum safe staffing level.

At the time of our inspection, the registered manager told us there were 15 full time equivalent vacancies across the service (equivalent to approximately 560 hours per week). The registered manager told us that there had been on-going problems recruiting new care workers, but they used agency care workers where necessary, had relief care workers to provide cover and service managers provided care and support to fill gaps in the rota due to sickness and absences. However, rota's we saw showed that not all shifts were covered. Service manager's we spoke with told us "Whilst there are vacant positions there will be shifts not covered" and "We have regular agency if needed, but they

Is the service safe?

are not always available." Another service manager said shifts were not covered because they had a limited agency budget. The registered provider told us that there was not a limited agency budget; however, we were concerned that a service manager, responsible for organising rotas, was working under this impression.

The registered manager said that the number of care hours provided each week was flexible and there was an "Ebb and flow" from week to week.

Care workers we spoke with told us "Some days there are not enough staff, we could do with more. Sometimes there are only two staff on for four tenants, we do our best, but we are stretched", "There have been some shifts when it's felt like there is not enough staff" and "Staffing levels are terrible; there is a lot of lone working." We asked care workers what the impact was for people using the service when shifts did not get covered; comments included "It's some of the activities and hours for going out that get missed." One care worker told us that shifts not getting covered meant "At the weekend everyone stays in the house, we can't take people out." Although we saw evidence that people were supported to go out at the weekends, a member of staff also showed us gaps in the rotas where shifts had not been covered, including gaps at weekends. They explained that these shifts were to provide one to one support to people and to take them out if they wished. A relative of someone using the service reported "Around 15 permanent members of staff have left…low staffing levels are a worry…The often low staffing levels at [supported living scheme] mean that they are unable to go out when they want and this can sometimes cause distress and isolation."

Two care workers we spoke with described how staffing shortages meant they felt obliged to work long hours. Comments included "I don't think there is enough staff at the moment. One person is on annual leave, I'm now doing 59 hours this week…I'm doing 7:00am – 9:30pm this evening, I get tired, then I'm back in tomorrow at 7:00am" whilst another care worker said "It is unfair after a certain amount of time on shift, your brain's not working properly. We cannot walk away, but your brain's not functioning properly. If we're tired it's not right for the tenants." The registered provider told us that care workers were not required to work long hours and appropriate legal safeguards were in place.

Other care workers we spoke with told us "I feel like there is enough staff" and "There's enough staff, but it can be a rush." Likewise some relatives of people using the service told us they felt staffing levels were good. This reflected the fact that some supported living schemes had more vacancies than others and/or benefited more from relief care workers covering shifts. However, this demonstrated that staffing levels were not being monitored and maintained across the supported living schemes we visited to ensure that there were sufficient care workers to meet everyone's needs.

At the time of our inspection service managers told us they were not required to send information about the actual number of care hours provided to the registered manager. We found information on the number of care hours provided was not always readily available and in some instances had to be worked out on request. The registered manager told us that they had introduced a new computer system called Office Base that allowed them to monitor the number of care hours provided. They told us that they needed further training to enable them run specific reports that could provide an overview of the actual number of care hours provided in each of the supported living schemes. We concluded that the system used to monitor staffing levels was not sufficiently robust. We concluded that there was a lack of clarity and accountability around staffing levels and the system used to ensure that gaps in rotas were covered was not robust enough.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had a safe recruitment process. We looked at five staff recruitment files and saw that in each instance, new staff had completed an application form and had an interview before being offered a job. We saw that references were taken and Disclosure and Barring Service (DBS) checks completed. DBS checks return information from the Police National Database about any convictions, cautions, warnings or reprimands. DBS checks help employers make informed decisions about whether it is safe for a person to be working with vulnerable client groups. By completing these checks, we could see that the registered provider was taking appropriate steps to ensure that only care workers considered suitable to work with vulnerable people had been employed.

Requires improvement

Is the service safe?

We noted that there had been eighteen incident reports involving medication across the Mencap York Domiciliary Care supported living schemes since May 2015. Of these there were seven instances where people using the service missed prescribed doses of medication, two incidents where people were given medication at the wrong time and two incidents where prescribed medication was found "Lying around/hidden". We saw that where medication errors occurred these were investigated by the service managers and actions taken, for example, further training provided or the introduction of a new medication process in one of the supported living schemes.

We saw that the registered providers had a medication policy in place and provided training to care workers on medication administration. Medication competency checks were completed to ensure that staff safely administered medication in line with guidance on best practice. We reviewed the registered managers training action plan and saw that medication observations had been completed or were scheduled to be completed for all staff by the end of January 2016.

Where people using the service needed support to take prescribed medication this was documented in their care plan and a separate medication file was held. This contained that person's Medication Administration Records (MARs). MARs were used by staff to record medication administered to people using the service. Medication folders also contained stock balance sheets used to record the amount of medication in stock and other relevant information about people's health needs or care plans relating to specific medications.

We carried out sample checks of medication in stock and found that medication stock sheets were accurately completed and matched the number of tablets still in stock. We reviewed MARs and found minor gaps in records at one of the supported living schemes we visited. We discussed this with the service manager who told us they would check the MARs as part of their weekly medication audit and respond to gaps in recording to ensure that all medication given to people using the service was accurately recorded in future.

We reviewed how medication was stored in the supported living schemes we visited. We identified that a significant amount of prescribed medication was stored in an unlocked cabinet in an office open and accessible to people using the service. A care worker we spoke with told us "People are always leaving keys in the medication cabinet or keys on the desk." They told us this meant medication was not stored securely as it was accessible to anyone in the supported living scheme. We also found inconsistencies around how medication with limited expiry on opening was monitored to ensure that it was discarded when past its expiration date.

We recommend that the safe storage of medication is routinely risk assessed to identify and address concerns.

Requires improvement

Is the service effective?

Our findings

People using the service said "Staff are all right; they do their job and keep everyone in order." Relatives of people using the service told us "It's a marvellous place; I cannot fault the care provided and cannot see what else staff could do to improve people's quality of life."

New care workers told us they had to complete induction training and shadow experienced care workers before starting work. We reviewed the induction schedule and workbooks used to support taught courses. We saw that induction training covered a range of topics to provide a general induction to Mencap and equip staff with the basic skills and knowledge needed to perform their roles effectively. We spoke with a new member of staff who told us "The training was absolutely fantastic." Another person said "I had a lot of shadowing, about two weeks shadowing and then they asked me how it was going and I insisted I had more and they were ok with it." New staff told us alongside this, they were introduced to people using the service and encouraged to read their care plans and speak to other care workers to find out more about the people they were supporting. This showed us that the service had a system in place to provide an effective induction and support new care workers in their role.

Alongside induction training, the registered provider required staff to complete mandatory refresher training on topics including first aid, moving and handling, fire theory, safeguarding vulnerable adults, medication management and managing finances. The registered manager told us that care workers were responsible for updating their own training files. We found this meant that training files did not always contain certificates of training completed and in this respect did not evidence that care workers training was up-to-date.

We reviewed a training action plan that had been implemented by the registered manager following a quality assurance visit by the local authority. This showed that at the time of our inspection, there were 92 gaps in mandatory training including 11 staff who needed to update their service user finance training, 14 staff who needed to update their fire theory training, nine staff who had needed to update their food hygiene training and 18 staff that needed to complete refresher training on safeguarding vulnerable adults. We could see from this training plan that 102 gaps in training had already been addressed with training completed since September 2015 and that it was planned that all training would be up-to-date by the end of January 2016. We asked the registered manager how they monitored training needs and how they would monitor training in the future to prevent these gaps in staff training occurring again. The registered manager told us that training was monitored by service managers, but they planned to arrange regular training sessions in the future to ensure that staff could update their training when necessary.

We noted that some supported living schemes required staff to complete a range of service specific training to meet the needs of individual people using those services. Examples of service specific training included training on specific types of epilepsy, buccal midazolam training (a medicine administered during an epileptic fit) and percutaneous endoscopic gastrostomy (PEG). The registered manager told us that service specific training needs were identified when people moved into one of the supported living schemes or at review. We found that there was no clear guidance about whether service specific training needed to be refreshed or if so how often. In one of the supported living schemes we visited, we found that records of service specific training were unclear and did not evidence recent training that we were told staff had received. Without up-to-date records and clear guidance on if/when service specific training needed to be refreshed, we could not be certain that care workers were maintaining their skills over time.

We noted that care workers in another supported living scheme we visited had not received training on British Sign Language (BSL) despite this being the main form of communication for a person living there. The registered manager told us that training had been provided, but the trained staff had since left and a request had been submitted for new staff to complete the training. Care workers we spoke with said that previously arranged BSL training had been cancelled and not rescheduled. One care worker without BSL training explained the difficulty they had in communicating with people that used it and told us "I could not support them in the slightest as I did not know what they wanted…You just have to watch and pick it up as you go." We observed this care worker providing support to the person and discussing how to sign 'sorry', demonstrating the difficulties they faced trying to communicate with them.

Requires improvement

Is the service effective?

Another member of staff we spoke with told us that they had not completed training on positive behaviour management since they started work and felt "Behaviour management training would be useful to help look out for warning signs so things don't escalate." They explained the difficulties they and other care workers had faced trying to manage the behaviour of people that were anxious or upset and explained how not managing this had negatively impacted on other people using the service. We spoke with the registered manager who told us behaviour management was covered during the induction process.

We concluded that staff training had not been kept up-to-date and staff did not always receive training to enable them to perform their roles effectively. Although this was now being addressed through the training action plan, the system used to monitor and ensure that mandatory and service specific training was completed was not robust enough. This had led to gaps in training, which impacted on care workers ability to provide effective care and support.

This was a breach of Regulation 12 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had a supervision and appraisal process to support staff development. This was called "Shape Your Future" and involved four meetings per year between care workers and their manager. The registered manager told us that care workers were responsible for keeping their own "Shape Your Future" records and showed us various examples of records relating to these meetings.

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 MCA 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. At the time of our inspection the registered manager explained they had sent a list of people who may be deprived of their liberty to the MCA supervisory body for their advice, guidance and further assessment.

We checked whether the service was working within the principles of the MCA. We talked with staff about how they sought consent particularly where people were unable to communicate verbally. Staff explained "We support people to make decisions by asking them and getting to know people and what their responses mean. They let you know one way or another. If something needs to be done we have a meeting to discuss it." We saw that care plans contained information about people likes, dislikes and personal preferences and information about non-verbal forms of communication to enable care workers to support people using the service to make decisions. Where people were unable to communicate their decisions a care worker told us "We talk as a group and sometimes involve parents and ask them if it's ok if we take people somewhere or do something with them."

People using the service told us "It's nice food" or nodded and smiled when we asked them if they liked the food provided. We observed that people were given appropriate support to eat and drink throughout our visits. Relatives of people using the service said "They seem to be nice meals, well presented" and "The food is nutritious, they plan menus and involve the tenants in shopping. They have individual preferences, I can see that when I visit." Another relative told us "The meals are good…they eat pretty well. [Name] has just had a medical check and they are watching their diet as they may have diabetes." However, feedback was not consistently positive and one person told us "Food is a constant issue, giving the wrong food, wrong textures, giving the same food with no variety, there's no thought."

We noted that some supported living schemes had planned menus for the week ahead and, where this was the case, these were displayed in communal areas. However, in these schemes, care workers we spoke with said that they prepared alternative choices if people did not like what was being cooked that day. Other schemes did not have menus and care workers told us they spoke with people using the service on a daily basis to find out what they wanted to eat and to plan meals. All the schemes we visited had a variety of food, fruit and vegetables available from which care workers could prepare meals. Care workers told us they visited local shops or the supermarket if they needed any additional items.

We noted that care plans contained some basic information about people's food and drink likes, dislikes and personal preferences. However, where people required

Is the service effective?

a specialist diet or PEG feeding, there were detailed care plans in place providing instructions and guidance to care workers on how to manage this safely. Care workers documented what people using the service had eaten; these records showed that people were supported to eat a variety of meals. We saw that in one scheme the service manager had discussed the importance of reviewing the daily logs of what people had eaten that day and that week. This was to ensure that they prepared a variety of meals and drinks to maintain a balanced diet.

In one of the schemes we visited there were no weight records for one of the people using the service and the last weights available for another person were from 2012. Two other people's records showed that they had been weighed recently, however, prior to this there were either no other weights available or they had not been weighed since 2013. The service manager and registered manager told us there was no formal policy in place about how often people should be weighed as this depended on people's needs. We discussed how care plans needed to provide guidance to staff on whether or how often each person using the service needed to be weighed.

People using the service had care plans detailing how their health and wellbeing would be maintained. These documented health needs and contained information about healthcare professionals involved in supporting people who used the service. We saw evidence that information and advice from healthcare professionals was incorporated into people's care plans to ensure that the care and support provided was based on knowledge and information from specialists. A health and social care professional we spoke with explained that they had been asked to review the person's care plan to make sure the relevant parts were up-to-date and incorporated their advice and guidance.

We observed that during our inspection, people using the service were visited by and supported to visit healthcare professionals. We saw that care workers kept records of professional visits, which included consultations with people's G.P, physiotherapist, clinical psychiatrist, dentist, speech and language therapist, dietician and chiropodist. A health and social care professional we spoke with explained that they worked closely with staff and could trust that they would be contacted if there were issues or concerns, saying "Staff call and ask for guidance…advice is followed, they are very good." Another health and social care professional told us "As an agency Mencap are good at reporting issues and are not afraid to ask for multi-disciplinary team meetings or input from health colleagues to discuss things." A multi-disciplinary team (MDT) meeting is a meeting between a group of professionals, which could include health and social care professionals. The purpose of an MDT meeting is to share information and discuss options to ensure people are receiving effective care. This showed us that there were systems in place to ensure that people had access to healthcare services and received on-going healthcare support.

Requires improvement

Is the service caring?

Our findings

People using the service said "I like the carers" and "They do treat us well and are kind sometimes." Other people smiled and nodded or used non-verbal communication to tell us that they liked the care workers and that they were kind to them. Throughout our inspection we observed that care workers were generally kind, attentive and responsive to people's needs and we observed a number of positive interactions between care workers and people using the service.

We asked people's relatives if they thought staff were caring, comments included "[Name] loves it here, they are cared for", "They do care, they are all very pleasant and, as I observe them with other residents, their relationships seem to be good, very caring." Other relatives we spoke with said "I think staff care, a lot of original staff are still here, they all have banter and know them well", "Some of them are brilliant" and "The carers are all nice people, some are better than others."

We asked care workers if the people they worked with cared for the people using the service; they told us "Staff care, you can tell by how they approach the tenants, you can tell they have a good rapport with people." However, other care workers told us "Some people care more than others, staff relate well to the tenants, but sometimes they do not follow through with things or get involved" and "I think some of the staff do care, but not all of them...You can tell by the way they act, not much communication, they don't talk to people or give them much encouragement."

We found that each care worker was based at one of the supported living schemes and generally only worked in that scheme. This enabled people using the service and care workers to develop meaningful caring relationships. One care worker told us "The longer you work with a person, you learn how they tick", whilst another said "I feel I've got to know people, we work closely with people so you build up friendships." However, staff we spoke with and some relatives highlighted high staff turnover and the impact this had on people using the service with comments including "There's been a lot of change of staff and it takes [Name] a while to adjust to new faces. Communication is difficult so they [care workers] need to know them."

We observed that people using the service were encouraged to make decisions and communicate their wishes and views throughout our inspection. A relative told us "Staff do as much as they can without taking away people's independence. . .they do things at their pace, do not rush things and let people do what they want to." However, we also noted that the lack of training in, for example, British Sign Language, impacted on care workers ability to communicate with and support people using the service to express their wishes and views.

We asked care workers how they supported people to express their views and be involved in decision making. Comments included "We ask people and give them choices" and "We offer as wide a choice as possible, for example, breakfast choice. We present people with options and they will hit with their hand which one they want." Another care worker gave us examples of how they supported people to make decisions: "We show people leaflets of places they might want to visit, use pictures and hand gestures to support people to make simple choices and ask yes and no questions. If people don't answer we leave and go back again and ask later."

A visiting health and social care professional told us they always observed positive interactions commenting "[Name] is supported in the most fantastic way. The way they are talked to and included about what they wanted to eat - it was demonstrative and exuberant the way they were supported."

During our inspection we observed that appropriate care and support was provided in communal areas and people were taken to the bathroom or their bedrooms and the doors were closed when staff provided personal care. One care worker we spoke with told us "We close the door and curtains if we are providing personal care, we put a towel over them when positioning people on the bed and talk to them and tell them what we are doing. We always knock if the door is closed." Another care worker said "We provide support in people's bedrooms behind closed doors, or ask other tenants to leave the room if assisting with personal care"

However, relatives of people using the service told us that staff did not always support people to maintain their privacy and dignity. For example, one relative we spoke

Requires improvement

Is the service caring?

with said they had visited a number of times and found the person using the service wearing incontinence pads only with no underwear or pyjama bottoms on. They told us that this did not promote their privacy or dignity.

This was a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service responsive?

Our findings

Each person using the service had a care plan, which contained information about their needs and what support was required from care workers to meet those needs. We looked at care plans of people using the service and found that these contained person centred information about the person including information about their likes, dislikes and personal preferences. We could see from this that, where possible, people using the service or their carers or relatives had contributed to the information in their care plans. A relative of someone using the service told us "I was involved with the care plans to start with, they are due to be reviewed, and we will have a meeting to discuss them." Another relative told us they had been involved in writing the care plans to ensure they contained detailed person centred information for the care workers to use. Service managers we spoke with told us they encouraged people or their families and carers to be involved in writing care plans as this helped them to provide person centred care.

A visiting health and social care professional told us "They're pretty good care plans here in my experience, though sometimes they are lacking a bit of detail." We asked care workers if the care plans enabled them to provide person centred care; comments included "The care plans are useful, very repetitive" and "The care plans are really in depth, helps gain a real in depth knowledge. The care plans are pretty much spot on and updated regularly if anything changes."

Care workers told us that they were encouraged to read the care plans as part of their induction to get to know people using the service. One care worker said "I have read all the care plans, I read back to make sure I'm doing things properly and to check they haven't changed." Other care workers told us that they used care plans to find out basic information, but learnt what people liked and more information about their personal preferences by working with them on a regular basis.

We saw that care plans contained a 'Disability Distress Assessment Tool' which documented information about people's non-verbal communication including how that person showed that they agreed with something or how they might act if they were happy or unhappy. This also contained information about what a person may be trying to communicate through certain behaviours. We found that this was an effective tool to ensure that care workers could identify non-verbal communication to provide responsive care.

We noted that care plans were reviewed and updated. We could see that some supported living schemes had established keyworkers responsible for reviewing and updating care plans, however, in other schemes this was less well established. Care workers we spoke with said "Some [care plans] are outdated and need updating; as I've got to know people I've noticed they need changing a little bit." Other care workers identified specific examples where they had found care plans to be out-of-date or they had learnt additional information about people's preferences during the course of providing care and support. Care workers we spoke with were not consistently clear about who was responsible or how the care plans were updated and we found that this information had not always been handed over to the keyworker or the service manager meaning that opportunities to update care plans with personalised information were being missed.

Care workers we spoke with understood the principles of person centred care commenting "What we do is for the tenants, everything is centred on that person, their choices and wishes, this is their home" and "The tenants definitely come first." However, we found that one person who needed support during the night did not have any telecare equipment or means to call for assistance; we spoke with the service manager who told us that this person would be able to use a call bell or pendant system to alert care workers, but this had not been considered. This was not person centred care as staff were not supporting this person to access support which was responsive to their needs.

We recommend that the registered provider seeks advice and guidance from a reputable source about person centred care.

We reviewed care plans and made observations throughout our inspection. We saw that people were supported to attend a range of activities including trips to the shops, day centres, hydrotherapy sessions or work placements. Relatives of people using the service told us "They do all sorts with [Name] they take them to Leeds shopping, to town, they took them to the seaside, and they take them out on a night. They always seem to be doing something" and "Activities are well organised, but I would

Requires improvement

Is the service responsive?

like there to be more." Another relative told us "They used to do a lot of things, now they just go to the hydro. Sometimes they do not want to go, but they have stopped trying. The activities schedule has gone by the wayside; they do nothing now and have nothing else in their life." These and other comments reflected concerns raised by care workers we spoke with - that low staffing levels meant that support was not always available to take people out or for one to one time. During the course of the inspection seven people we spoke with made comments about the lack of activities or told us that staffing levels impacted on the support provided to engage in activities. We noted that rotas and care records did not always clearly evidence people's allocated one to one time and how this had been spent. Other relatives raised concerns that the high turnover of care workers meant that care workers did not have the confidence or knowledge of the people they were supporting to take them out or encourage activities. One person told us "There are three stand out members of staff…the replacements are not of the same calibre", whilst another said "They have a high turnover of staff so they do not know what [Name] can and can't do. They have to push [Name] a little bit…they are not proactive."

There was a complaints policy and procedure in place at the time or our inspection. The registered manager told us that complaints were dealt with by the service managers of the supported living schemes or escalated to the area operations managers where necessary. We saw that the complaints policy and procedure contained a triaging tool to guide service managers in identifying when complaints needed to be escalated. The registered manager told us that all complains escalated to them were logged with the Human Resources Department so that they could monitor and ensure a timely response. We saw that there was a clear audit trail for complaints escalated to the registered manager. We saw that complaints escalated had been investigated, written responses provided and meetings held or mediation services used to try and resolve on-going concerns.

The registered manager told us that people using the service and their relatives or carers were given information about how to complain when they moved into a supported living scheme. However, as some people using the service had been using the service for a significant length of time this information could be out of date. The registered provider told us that visible information about making compliments, complaints, comments or raising concerns was not displayed in the supported living schemes as these were people's homes. Although there is no requirement to display this information, this decision made it more difficult for people using the service and visitors to obtain information about how to raise a complaint. Some relatives we spoke with were unsure of who the registered manager was and unaware who they could contact if they wished to escalate their concerns. However, other people we spoke with said "If I've got any complaints I can talk to the management [service manager] and we sort it out" and "The managers have always been quite open, I've said to managers if I've had problems and they've been dealt with." Another person said "They would listen to me if I had concerns. I get in touch with the manager or send it higher. I am really happy with the service."

Other relatives we spoke with raised concerns about communication and about on-going low level concerns and complaints that they did not feel had been dealt with. One person told us "I'm banging my head against a brick wall...I'm worried about being a tittle-tattler, it's the manager's domain, I'm not made to feel welcome…They think of me as overbearing and interfering, all I want is the best for my relative." Other relatives told us "I give up complaining", "It's an on-going battle…communication isn't as good as it should be" and "I've mentioned concerns on numerous occasions and put it in writing, but nothing seems to change."

We recommend that the registered manager seeks advice and guidance from a reputable source about the management and recording of low level concerns to ensure that these are effectively dealt with.

Requires improvement

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of registration for this location. On the day of our inspection there was a registered manager in post and, as such, the registered provider was meeting the conditions of their registration. The registered manager was known within Mencap York Domiciliary Care as an area operations manager and, at the time of our inspection, shared management responsibility with another area operations manager. Reporting to the area operations managers were service managers, responsible for managing individual or a small group of supported living schemes. Some supported living schemes also had an assistant service manager or support workers with additional responsibilities; however, this depended on the size of the scheme and the needs of people using that service.

People using the service said "I'm happy here" and "I think it's all right I enjoy it here." A visiting health and social care professional told us "Mencap is very good; the standard across York is very good." Other comments from health and social care professionals included "The service is well organised and responsive to requests" and "I've been particularly impressed with the support and input Mencap have provided to one particular family…It's difficult to find a negative of the service they provide."

We asked care workers if they thought the service was well-led and comments included "I think it is well-led, there are some things I'd do differently, but it's brick wall syndrome trying to change it" and "It is well led, [the service manager] is doing a brilliant job. They could do with more support and back-up" and "[The service manager] is really good, if I need anything they are there, if it needs looking into they'll do it." A service manager said "The [registered manager's] door is always open. There are always other service managers about you can talk things over with, we are very supportive." Another service manager told us "We have two very good assistant area managers…they are incredibly supportive."

However, feedback was not consistently positive and other care workers responded to questions about whether the service was well-led by saying "I don't think so, things don't get done. Shift patterns do not support staff, changes are not discussed." Other staff we spoke with said "There's a negative atmosphere in the service, there's been a high turnover of staff…It's quite chaotic, communication is not the best between staff and management" and "Not a lot of people particularly enjoy it [working here]; I know a lot of people have left."

We found a number of relatives felt that they were working against staff and seen to be interfering when they raised concerns. A relative of someone using the service told us "I have a problem with communication; I still want to be involved with [Name's] care" another relative said "I cannot cope with the upset of visiting the house…I do not have a good relationship with the manager, not great communication. There is an attitude of 'I know best' but they do not know [Name]." Other people commented "Overall I think this service is working really well, but Mencap seem to stretch the managers, as they are involved in providing care and therefore they are not managing, meaning there is less supervision."

We found that these comments reflected our observations regarding the inconsistencies in the quality of care and support provided across the supported living schemes we visited. During the inspection we identified concerns around risk management and risk assessments, training, communication and management of low level issues. We identified that the safe storage of medication was not always properly risk assessed and identified concerns that the systems used to monitor and ensure adequate staffing levels were not robust enough. Underlying this, were concerns about quality assurance and the systems used by the registered manager to monitor the quality of care and support provided at each of the supported living schemes.

The registered provider had a national quality team who completed internal quality assurance audits, where concerns had been identified, and also undertook spot checks annually across the region. The registered manager told us that because of the size of the region and the number of spot checks completed, it could be more than a year between quality assurance visits by the national quality assurance team. There is no regulatory requirement regarding the frequency of quality assurance visits and the registered provider told us that the local authority completed annual quality assurance visits.

Service managers completed a monthly 'Continuous Compliance Tool' which was submitted electronically for the registered manager to review. This asked the service managers to confirm, for example, that support plans and risk assessments had been updated, that reviews due had

Is the service well-led?

been completed, that Medication Administration Records were up-to-date and that team meetings had been held. Where a review had been held and a care plan updated this was recorded and the registered manager then told us they remotely accessed the care plan and risk assessments to check the quality of the records and signed them off. Alongside this the registered manager told us that they visited each supported living scheme at least once every three months to look at a particular area of the care and support provided, for example, finance, medication management or care plans. The registered provider told us that the registered manager had visited the five supported living schemes we visited 26 times in the six months before our inspection.

Each supported living scheme had an electronic continuous improvement plan accessible to the registered manager and service manager. Outcomes from quality assurance visits were recorded here as well as any actions the registered manager had identified from reviewing the continuous compliance tools. The service managers then recorded what actions they had taken in response and the date this was achieved. For example, one quality assurance visit identified that guttering needed to be repaired in one of the schemes. This had been recorded on the continuous improvement plan and the date it had been reported for repair was also recorded by the service manager. Although this system provided a mechanism for recording and communicating actions and improvements required, the scope and breadth of quality assurance completed was not robust enough and we found that there was insufficient monitoring and detailed quality assurance taking place. This meant that issues and concerns we identified during the course of our inspection and documented throughout this inspection report had not been identified and addressed and this had led to overall variation and inconsistencies in the quality of care and support provided in the schemes we visited.

This was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Alongside this, we identified that records were not always well maintained and there were inconsistencies in the quality of records kept across the supported living schemes we visited. One care worker told us "The care plans were quite old and not relevant; they're getting better and more up-to-date." We found that some care plans were out of date or contained out of date information. Other care plans contained duplicate copies of records where old information had not been removed. This meant care plans were not always accessible as information was not stored in a clear and coherent way. We noted one person's medication folder contained out of date information about their medications and their 'only when required' medication protocol had last been updated in November 2013. Another medication folder contained out-of-date information dating back to 2011 about a percutaneous endoscopic gastrostomy (PEG) feeding regime. Whilst this file also contained an up-to-date PEG feeding regime we were concerned that out of date information could cause confusion and result in errors.

We were told team meetings were held in each of the supported living schemes on a monthly basis. We saw examples of team meeting minutes from two supported living scheme we visited and observed that the needs of people using the service were discussed; information was shared about changes within the service and concerns around best practice addressed. Service managers told us that they had to send the date of their team meeting to the registered manager so that they could monitor and ensure that regular team meetings were held in each of the services.

The registered manager told us that they completed an annual staff survey, customer survey and stakeholder, family and professional survey. At the time of our inspection we were told the survey was on-going, questionnaires were still being returned and the results had not yet been collated. However, we noted that completed questionnaires were returned to service managers and the registered manager told us that the service manager reviewed and took action where necessary before these were collated centrally. This meant that there was little anonymity for people completing the surveys and this could undermine how effective these surveys were in collecting people's views and opinions about the care and support they received.

The registered manager told us that they kept up-to-date with changes in legislation, policies and guidance on best practice through monthly internal bulletins sent by the registered provider. The registered manager told us they also received updates from the Care Quality Commission and updates were cascaded to them through team meetings with their line manager.

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
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered manager had not fully assessed the risks to the health and safety of people using the service and had not done all that is reasonably practicable to mitigate any such risks. Regulation 12 (2) (a) (b).

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered manager did not ensure that sufficient numbers staff were deployed. Regulation 18 (1).

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered manager did not ensure that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely. Regulation 12 (2) (c).

Regulated activity	Regulation
Personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered manager did not ensure that all people using the service were treated with dignity and respect.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered manager did not establish and operate systems or processes to effectively: assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated. Regulation 17 (2) (a).