FitzRoy Support

Dalvington/The Oaks

Inspection report

Dalvington
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Dalvington/ The Oaks is a care home that provides accommodation with support for up to 13 people with a learning disability or autistic spectrum disorder. On the days of our visit there were 12 people living there. The accommodation is split over two homes, with six people living in each house.

The home had been developed and designed before the principles and values that underpin Registering the Right Support had been published. This guidance aims to ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People's experience of using this service and what we found

There were not always enough staff to ensure people's safety at all times.

The service was not always well led. Ineffective quality monitoring systems meant there was no oversight of the risks associated with people's health safety and welfare. The provider's quality checks had not identified the improvements required to make sure the Mental Capacity Act had consistently been followed. Opportunities to learn lessons and drive improvements when concerns were raised had been missed

Risks associated with people's care and support arising from needs were not managed safely.

People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 06 August 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found some improvements had been made however the provider was still in a continued breach of regulation 17 Good Governance.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We

had also received concerns from a whistle-blower and a health and social care professional.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Dalvington/The Oaks on our website at www.cqc.org.uk.

Follow up
We have arranged to meet with the provider to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not well-led.

Details are in our well-Led findings below.

Dalvington/The Oaks

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted to understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of two inspectors.

Service and service type
Dalvington/ The Oaks is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.
The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.
Before and after the inspection we contacted the Local Authorities to see if they had any information to share with us to inform our inspection planning.

During the inspection
We spoke with 13 members of staff including the provider, registered manager, two deputy managers, senior support worker and support workers. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included two people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We spoke with eight relatives about their experience of the care provided and one staff member. We spoke with health and social care professionals who regularly visit the service. We continued to seek clarification from the registered manager to validate evidence found. This included, staff rotas, care documentation and staff training data. Additionally, we spoke with the nominated individual who is responsible for supervising the management of the service on behalf of the provider. We requested the nominated individual send us information to enable us to complete the inspection. This included mental capacity assessments, best interest documentation and further information about staff rotas. We reviewed this information and took it into account when reaching our judgements. A provider meeting was held with CQC and the Local Authority to gain assurances that concerns identified at the inspection would be addressed. The Nominated Individual forwarded an action plan to address these concerns.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice [against a breach of regulation 17 Good governance], we served following our previous inspection. We are also responding to specific concerns raised by a whistle-blower and a health and social care professional. We will assess all of the key question at the next comprehensive inspection of the service.

Systems and processes to safeguard people from the risk of abuse ; Learning lessons when things go wrong

● Although staff had received training in safeguarding and reporting, we saw from the communications book and from a provider's internal investigation findings, staff were not always reporting incidents on the occurrence forms as required by the provider's policy guidance.

Assessing risk, safety monitoring and management

● Risks assessments were in place and reviewed monthly, however we found they did not cover all aspects of people's needs to help keep them safe. For example, one person had specialist equipment, we could not find any guidance for staff to follow, to ensure it was used safely. Best interest decision meetings had not taken place; however, we were told the equipment had been reviewed by a physiotherapist to ensure this was safe and met the person's requirements. We found a part of another person's specialist equipment had "Been lost." After the visit we requested assurances from the registered manager a replacement had been ordered and noted alternative temproary measures to reduce the risk were in place.

● Relatives we spoke with were confident their family members safety was promoted by staff who knew them well. One relative said, "I feel my [family member] is safe here."

Staffing and recruitment

● Staff did not feel there were always enough of them on shift to support the people who lived at the home, particularly at weekends. Staff described how there were often only two staff members per house on duty at times. One staff member said, "We are worried because if an emergency arises with one person, who would look after the rest. This is when we make mistakes like medication has been missed. If we are bathing people one person has to remain sat in their wheelchair until we've finished."

● The staff member told us, they had raised these concerns with the registered manager, but the solution has been to put an extra staff member on a 10.30am to 5pm shift at weekends. The staff member told us, "This does not really help us with people's personal care in the mornings or assisting people with their evening meal."

● Following our inspection, we received assurances from the nominated individual staff rotas were being reviewed to ensure adequate staff were on duty to meet people's needs.

● Relatives, we spoke with were satisfied with staffing arrangements at the home. One relative said, "There

seems to be enough of them [staff] about."

Using medicines safely

● Medicines were received, stored, administered and disposed of safely. Staff had received training around safe administration of medicines and their competencies checked. However, on the second day of our inspection, a staff member carried a tray of people's medicines whilst pushing someone in their wheelchair. We reported the incident to the deputy manager who told us, they would speak to the staff member concerned to ensure this practice was not repeated.

Preventing and controlling infection

● This inspection took place during the Covid-19 pandemic. There were systems in place to prevent and control infection for staff to follow good practice guidelines. Guidelines were displayed at the entrance of the home for visitors to follow and anti-bacterial hand wash was available throughout the home.

● Staff were seen wearing Personal Protective Equipment (PPE) such as masks, however, we saw a staff member serving people's food not wearing gloves and aprons. We brought this to the attention of the registered manager, and they told us they would remind staff about PPE guidelines and practices.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider's quality checking systems and processes were ineffective. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found not enough improvement had been made and the provider was still in breach of Regulation 17, as the provider's quality checking systems and practices required further improvement. The nominated individual had arranged for the provider's quality team to support and provide extra training for the management team and to have greater oversight.

● The management team had sought to implement and strengthen their quality checking systems. These involved checks on the standards of care documentation and the home environment where improvements had been made since our last inspection. However, we found there was still scope for the provider to further develop and reinforce their quality checking processes. For example, the leadership team told us staff were not following the providers procedures, so that all incidents were consistently reported, followed through with lessons learnt. Although incidents were reported to us retrospectively, the provider's quality assurance and governance practices had not consistently identified staff were not following the providers policies. The leadership team gave assurances immediate action would be taken.
● The provider did not have a system to assess the dependency needs of people living at the home and therefore to establish the staffing levels to be able to meet these needs. The registered manager and provider audits failed to identify that people were not always receiving their funded one to one care.
● The registered manager's audits had failed to identify the homes fire and safety risk assessment should have been reviewed in June 2020. Following our inspection this was identified by the provider's quality assurance team audit.
● The registered manager's audits failed to identify 32% of staff were non complaint with their training requirements.

At our last inspection the provider had not notified us of incidents. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.
● At this inspection, this had been addressed [although some notifications were sent in retrospect – this was

addressed with the nominated individual and assurances sought the changes would be embedded]. This meant the provider was no longer in breach of Regulation 18.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Prior to the inspection the Care Quality Commission (CQC) conducted an Emergency Support Framework call to assess how the service was coping during the Covid -19 pandemic. The inspector was given assurances the testing for Covid -19 for people was being arranged as the registered manager confirmed this was "in hand." After several requests [including from the local authority] for copies of mental capacity assessments and best interest decisions this documentation was not provided. We requested this documentation from the nominated individual, and this was sent to us. However, the mental capacity assessments and best interest decisions were not completed to confirm the Mental Capacity Act had been followed and correct decisions had been made. The nominated individual told us, they would ensure this documentation was completed again and training would be provided to all staff. The nominated individual sent us an action plan stating this would be completed by 22nd September 2020.

●The rating from our last inspection was displayed in the home for people and visitors to see.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people: Continuous learning and improving care: Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Relatives were positive about how their family members were cared for.

● We received mixed responses from staff when we asked about the management of the home. Some staff felt they were supported by the registered manager, but others stated they felt they could not raise concerns for fear of being penalised. One staff member said, "Staff don't raise concerns because if they do, they are penalised, for example, by not getting sleep-ins". Another staff member told us whistle-blowers were poorly treated by the management of the home, once they raised concerns, so staff were fearful for their jobs. We raised these comments with the nominated individual for their investigation.

● Not all staff we spoke with told us they received regular supervisions with their line managers. One staff member told us, "I can't remember the last time I had a supervision – it was one this year."

Working in partnership with others

● The registered manager continued to use satisfaction surveys to obtain the views of relatives in order to support engagement arrangements.

● People met with their key workers to review their care and activities choices.

● The registered manager worked with other health and social care professionals such as speech and language therapists and community learning disability nurses to support people's needs.