Care Quality Commission

Royal Mencap Society

Dolphin Court

Inspection report

9 Bulbeck Road
Havant
Hampshire
PO9 1HN
Tel: Tel: 023 9245 1093
Website: www.mencap.org.uk

Date of inspection visit: 3 & 8 December 2014
Date of publication: 10/07/2015

Ratings

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

Overall summary

This inspection took place on 3 and 8 December 2014. Dolphin Court is a service which is registered to provide accommodation for 13 people with a learning disability who require personal care. On the days of our visit 12 people lived at the home. Care was provided in three adjoining houses and three separate flats above the houses. The flats are for single occupancy and had their own entrances. Two flats were occupied and 10 people lived in the three houses.

The service is run by Royal Mencap Society. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered manager was not present for the inspection and does not attend the service every day. There was a manager with overall responsibility for Dolphin Court, a house manager for each of the three houses and another manager for the flats.

Summary of findings

There were not always enough staff to ensure the needs of people could be met at all times. Where unplanned staff absences occurred due to staff sickness for example, the provider used agency staff to cover all shifts and told us that all planned hours were covered. Some staff said they felt unsafe at times due to their feeling that the staffing levels were low. Staffing recruitment procedures were being followed

The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The manager and provider understood when an application should be made and how to submit one. Staff had a good understanding of mental capacity and consent and how this affected people who lived there.

People said that the staff were caring and we observed staff being caring and compassionate in their approach. Staff knew the people they supported well and had a positive rapport with them.

Risk assessments did not always identify the risk and the support that people required and some care plans had not been updated to reflect changes in people's needs.

People were supported to take their medicines as directed by their GP. Records showed that medicines were obtained, stored, administered and disposed of safely.

The service was not always well led; staff did not always know who was in charge. The provider clarified that the management structure had been changed in summer of 2014. Changes in managers and a lack of clarity of roles meant the quality of the service was not being monitored and this put people at risk of receiving unsafe care.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond with breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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. There were not always enough staff deployed to ensure the needs of people could be met at all times though the provider used full agency cover to meet planned support hours. Safe staffing recruitment procedures were being followed .

Risk assessments were not always in place to ensure people were protected from the risks of injury.

Staff were not consistently aware of safeguarding procedures, and not all incidents had been reported appropriately.

Appropriate arrangements were in place for obtaining medicines and ensuring people received their medicines.

Is the service effective?

Requires Improvement

The service was not always effective. Care planning and delivery was inconsistent and staff had different views on the support some people required.

Staffing levels and how they were deployed meant staff could not always deliver the effective support people needed.

People had care plans to meet their needs, however these were not always up to date.

People were supported to eat and drink and their choices were respected.

The provider and staff understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

People said the staff were kind and our observations confirmed that they were caring and compassionate.

Staff knew people well and showed a caring and natural rapport with them.

People's views were incorporated into their care plans and staff worked hard to ensure these were respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not receive care that was always responsive to their changing needs.

Summary of findings

There were limited activity plans in place and some people were not able to go out due to staff shortages and deployment issues.

Relatives had regular meetings and were able to raise concerns or complaints if they needed to.

Is the service well-led?

Requires Improvement 

The service was not always well led because staff didn't always know who was in charge.

Changes in managers and a lack of clarity of roles meant the quality of the service was not being monitored and this put people at risk of receiving unsafe care.

There was a lack of meaningful auditing to ensure the quality of the service met people's needs. Accidents and incidents were recorded but there was no clear analysis to ensure lessons were learnt to prevent further incidents or accidents.

Dolphin Court

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 3 and 8 December 2014 and was unannounced.

The inspection team consisted of one inspector on the first day and two inspectors on the second day.

Before the inspection we reviewed information we held about the service including notifications. A notification is information about important events which the service is required to send us by law. We also received and reviewed a Provider Information Return on the 10 December 2014. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

It was not always possible to establish people's views due to their individual communication skills and needs. We spoke with one person and two relatives. To help us understand the experience of people who could not talk with us we spent time observing interactions between staff and people who lived in the home.

We also spoke with the manager, eight care staff, a deputy manager and two social care professionals. We looked at care plans and associated records for six people, staff training records, four staff recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

The last inspection of this home was in November 2013 and there were no concerns at that time.

Requires Improvement

Is the service safe?

Our findings

People were not always safe because staff understanding of what constituted abuse varied . Not all incidents were recorded according to the provider's safeguarding policy. For example one member of staff said they thought the term safeguarding related mainly to finances. Others were clear about what safeguarding meant and their roles and responsibilities, however, we were made aware of two incidents that put people at risk of harm or abuse that had not been reported under the provider's safeguarding policy. One relative told us, "They are hot on bruises, they keep me informed and let safeguarding know." Training records showed that out of nine care staff, one had not been trained in safeguarding adults and six had received training that was recorded as "expired" and no update had been provided. Two of these had expired in 2013. Staff were aware of the whistleblowing policy and said they would use it if necessary.

One person told us they felt safe and would raise concerns to staff if they needed to. Other people were not able to verbally raise concerns and this could put them at added risk. Staff told us they knew people well and were able to describe how someone would behave if they were unhappy. Staff said things like "Oh, you'd know" and "By body language and behaviour".

The lack of up to date staff training and robust practical application of safeguarding procedures was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk management policies and procedures did not always uphold people's freedom, choice and control. One person had displayed behaviour which might place them at risk when in the community. A risk assessment was in place which identified these behaviours but did not provide any indication as to the risk it presented and how to support the person when the situation arose. The risk assessment stated to refer to behaviour support plans, however these did not give any guidance for staff on how to minimise the risk to the person or others when in the community.

For a second person we saw their flat door was locked at night and the keys were held elsewhere in the building. There was a protocol in place that noted that the person's front door was shut but not locked from their side and that they were able to exit but that staff would need the keys in order to gain entry. However the Personal Emergency Evacuation Plan had not been completed and the risk assessment for fire evacuation did not make reference to the fact this person was locked in their flat at night. There was no further information within the care records about the risk locking the door presented and how these risks would be managed. There was no record of the person's preferences regarding this arrangement. This meant that in the event of an emergency the person may be at risk.

The manager showed us how staffing levels had been determined and provided us with a document which outlined the shifts required to meet people's needs throughout the day. We reviewed this for one house where staff had told us staffing levels were regularly too low. We found the dependency tool (a standard assessment of required staffing levels) showed four staff were required between 7am and 10am, however on the week prior to our visit we found two occasions when only two staff were supplied. This meant people were not always receiving their planned care.

In a second house we saw a planned activity for one person was to attend a coffee morning and go out for a walk or drive. This activity did not happen and staff had recorded this was due to "No staff". Staff told us this person wants to go out and when they get bored they can display behaviours which may place them at risk. We observed that the person displayed some of the behaviours described to us by staff indicating they may be bored and wanted to go out.

The manager told us that shifts could be difficult to cover so the staff working across the whole service would support if needed. We observed this happened on one occasion. A staff member was required to provide support to a person who wanted to go out. This meant another person who was allocated a member of staff for that period did not receive any support for approximately 30 minutes as their allocated staff member was not in the building. Staff told us they felt unsafe at times due to the staffing levels. The provider told us that they used agency staff to ensure that all planned staffing hours on the rota were covered, for example through the deployment of agency staff. However, staffing levels that we observed on the days of our inspection were not sufficiently adequate to ensure all people received the care they needed

Requires Improvement

Is the service safe?

People were at risk of receiving unsafe and inappropriate care because of insufficient staffing levels and unclear arrangements for individual safety. This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

Storage arrangements for medicines were secure. The home did not hold any controlled drugs; however storage arrangements were in accordance with the misuse of drugs safe custody regulations and in line with appropriate guidelines. The home had a policy and procedure for the receipt, storage and administration of medicines. Staff supported people to take their medicines and these had been administered as prescribed. Two members of staff were involved in the administration of medicines. One person acted as an observer to help ensure safe practice. Medicines Administration Records (MAR) were up to date with no unexplained gaps or errors. People were prescribed when required (PRN) medicines and there were protocols for their use. MAR's showed these were not used excessively and the dosage given and time they were administered were clearly recorded. Protocols for the use of PRN medicines were in place to guide staff on when these medicines may be required. In addition for one person who was prescribed PRN medicines to help with their anxieties there was a clear flow chart in place about when to consider administering medicines.

All staff said they had completed training in the safe administration of medicines and said they were not able to administer medicines until this had been completed and they had been confirmed as competent. They said this training was updated annually. Staff were able to describe what they would do in the event of a medicines error and told us these were always investigated and action taken by the provider.

Recruitment records for staff contained all of the required information including two references, proof of identity, application form and Criminal Record Bureau (CRB) checks and Disclosure and Barring Service (DBS) checks. These checks identify if prospective staff have a criminal record or are barred from working with children or vulnerable people. The procedures in place protected the people who lived at the home from receiving support from unsuitable staff.

Requires Improvement

Is the service effective?

Our findings

The service was not always effective because care planning and delivery was inconsistent and staff had different views on the support some people required. For example, staff had different opinions about whether or not one person was locked in their flat during the day. Some staff said the door was wedged open and the person could walk across the courtyard to ask for support if they needed it. Other staff said the door was shut, not locked, but the person could not open the door and would "Bang and scream" if they needed support. The manager told us that the registered manager had told her on the telephone the person could open the door when it was shut but not locked. There was no care plan or risk assessment in place for this to identify the risks to the person and how staff should support them. We reported this to the local safeguarding authority in case there was an unlawful deprivation to this person's liberty. The local authority told us they were satisfied the arrangements were not a deprivation of liberty. The provider subsequently clarified the arrangements and told us that the issue was linked to staff gaining access and not about the person being unable to get out. However, staff were not consistent in their support or understanding of this person's support requirements and this needed to be reviewed.

People had care plans in place to meet their health needs; however these were not always dated, up to date or accurate. For example, one person's mental health care plan was dated 9 September 2013, a hand written note was attached stating 'assess mood after PRN meds and before accessing the community'. There was no record of this assessment or whether this was still applicable. Another person's Epilepsy care plan was dated 12 December 2012 had not been reviewed or updated. This meant that people could be at risk of receiving unsafe or inappropriate care.

Staff knew people well and demonstrated good communication skills and understanding of their role. However they said they could not be effective because they felt there were not always enough staff on duty to support people with their planned care and activities. One relative told us they "Need more staff." They gave an example of a missed medical appointment due to staff shortages. They added about the staff, "They work so hard, they are trying their best." Staff told us people could not always go out on activities due to staff shortages. They were frustrated that they could not support people properly. We looked at the rotas but it was not possible to establish the staffing levels as staff did not always work in the house or flat that they were allocated to on the rotas. Staff told us they came into work expecting to be working in a flat but would be asked to work in a house when they arrived. One person did not get their planned and funded one to one time because the allotted member of staff was asked to support someone else to go out. Staff told us there were no planned day time activities for people and daily records confirmed that those who needed support to access the community often stayed in for several days at a time. People lacked stimulation and support to access the community.

On the second day of our inspection one person's care plan was not available. Staff thought this had been taken off site but no one could tell us where this was. The manager was unable to find it. Staff thought it had been taken by a service manager who was not based at Dolphin Court but had "been doing some work on care plans." When this person later visited the home they said they had been working on this person's care plan on Friday but could not remember where they had left it. The manager later found it under a pile of papers on the finance officer's desk where it had been all weekend. When we asked if the person had been without a care plan all weekend the manager said, "Luckily we didn't have any agency staff on duty." This put the person at risk of not receiving safe care appropriate to their individual needs.

The lack of proper co-ordinated care and welfare of people was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 (3) (a) (b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received training on the Mental Capacity 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for themselves. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person

Requires Improvement

Is the service effective?

from harm. For people that lacked mental capacity to make certain decisions we saw that Best Interest meetings were held. Relatives confirmed they were involved in these and had no concerns in this area.

People were supported to eat and drink and where they chose to, they were involved in the shopping and cooking of food. People's dietary needs and preferences were recorded and known to staff. In one house people had their favourite places to sit and staff ensured this was respected.

Good

Is the service caring?

Our findings

Staff knew people well and showed a caring and natural rapport with them. One person told us about how staff had gone to great lengths to surprise them with an outing. This person said they liked the staff saying they were kind and when they felt upset they could, “Talk to anyone, they listen.” We observed people showing affection to staff and staff responding appropriately. Relatives said staff were “Very caring,” and, “Her keyworker has a lovely relationship with her.”

In one house people were being supported to shop for and wrap up Christmas presents for their relatives. Staff also knew when relatives’ birthdays were and supported people to send cards.

Staff told us that they preferred working mainly in one house which meant they built up good relationships with people. Staff promoted privacy and dignity when people appeared unaware of their actions. For example, not being dressed in a way that protected their dignity. Staff gently encouraged one person to dress appropriately and recognised the cause of this behaviour. When they recognised the cause was wanting to go out they made arrangements so this could happen for the person.

Staff had a good understanding of people and the support they needed. Staff described how they supported a person with their medicines, which we also observed. This was done in a respectful way, giving them information and encouragement throughout. Staff knew people’s preferences and routines and these were respected. When one person who was unwell chose to stay in bed staff regularly checked on them and encouraged them to eat and drink. We heard staff talking to each other about different things to try. They showed concern and compassion. People’s known preferences were recorded in their care plans, and people and their families were involved in this process. In one house staff were working with a family to develop a care plan system on a touch screen computer tablet. This would enable the person to be more fully and actively involved in their care planning and decision making.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care that was responsive to their needs. Care plan files had a "grab and run" sheet at the front of them. These sheets were to be taken out of the service in the event of an emergency such as evacuation or admission to hospital. One was dated 12 December 2014, others had no date on them. They contained information that was out of date, such as the name and telephone number of a manager who no longer worked at the home. Medicine records for people had not been updated as and when these had changed and some medical conditions were omitted. This meant people were at risk of not receiving appropriate care in relation to medical conditions.

Care plan files contained care plans with various titles. For example, mobility, toileting, food, drink, communication, bathing and general health. One we looked at contained care plans dated 12 December 2012. Some had hand written notes and crossing's out and were signed by a service manager who had written "needs updating" on them. Some were dated July 2014 and others September 2014. One hand written note on a "toileting" care plan stated, "Hands. 2nd person holds [person's initials] hands. Pre warning." On their "bathing" care plan a note was written, "Not having shower hair in bath lean head back." There were no detailed guidelines for staff to ensure this person was supported safely. Their changing needs had not been responded to and left them at risk of not receiving appropriate and consistent care.

Staff spoke to us about one person's behaviour which put them at risk. The service had developed a document for all staff about how to support the person when this behaviour was displayed in communal areas of the home. This was dated 17 October 2014 and was held in a separate folder that we were told was for staff to sign to say they had read. This detailed the behaviour and steps staff should take to support the person. This involved staff ignoring the behaviour and using distraction and redirection with limited or no interaction. The document stated these behaviours could be as a result of boredom. There was no plan for how staff would support the person if they displayed the behaviour in public which we were told they did. The person displayed this behaviour during our inspection and although staff were kind, patient and supported the person they did not follow the document that was in place.

Activity plans were not in place for everybody and some people were not able to go out due to staff shortages. The limited number of staff available and qualified to drive the home's mini bus also impacted on people's choices and opportunities for going out. This meant people's care was not individualised as they needed to fit in with the needs of others and the availability of suitable staff. A relative told us their loved one did not always receive the one to one staff hours that they were funded for so this meant they did not go out as much as they should.

The lack of proper assessment, planning and delivery of care and support, including a lack of activities was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 (3) a (b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home hosted regular meetings for relatives where they were able to discuss matters relating to the running of the home and the care of their loved ones in private. Representatives of the management team then joined the meetings so feedback and updates could be given.

There was a complaints policy and a record of complaints was kept, this included the provider's response and any follow up action. Relatives told us they could raise concerns, one said, "nine times out of 10 I get a response." However, staff felt that concerns they raised were not always listened to. We saw records of staff meetings from September and October 2014 where staff had raised concerns about staffing levels. Staff stated they were 'breaking care plans and risk assessments' when there was only one member of staff on duty in a house where two people need two staff to support them with personal care. Staff we spoke to said the 'management' had not responded to their concerns and therefore we could not be assured that all concerns were investigated or that appropriate action was taken to resolve them.

Requires Improvement

Is the service well-led?

Our findings

The service was not well led because staff didn't always know who was in day to day charge. The management structure consisted of a registered manager who attended the home two days a week, the manager (Service Operations Manager) who told us they had overall responsibility for the three houses, and a manager who had overall responsibility for the flats. In addition there were three 'house managers' (assistant service managers) for each of the houses. Two of these were in post and one post was vacant. Both the manager and one of the house managers were newly in post. Staff were not clear about the management structure and who had overall responsibility for the running of the home. Another, recently appointed manager told us they were in charge of the day to day management of the home. Some staff said they felt supported and had a good relationship with their line manager. Others said they did not feel supported. One person was unsure who their line manager was and said they had three line managers. The provider clarified the management was changed in the summer of 2014, with a Service Operations Manager taking the lead with three assistant service managers linked to each bungalows.

Views on the management of the service were mixed. One relative told us, "It's improving". One staff said "We have only had a house manager for three weeks; they have started to look at the care plans. [The manager] never visits the house, today was very unusual. I don't think they have ever looked at the care plans". Another said they did not feel supported. They said "The staff team work together and support each other, but it is very much them and us. They [the managers] sit in the office. [The manager] rarely visits the house. Today was unusual".

There was a process in place for the reporting of accidents and incidents. When we asked the manager for any analysis of these they said, "We are monitoring [service user's name] behaviour at the moment and monitoring everything". When we asked to see this they said, "We are not actually recording it, it's more a conversation and in team meetings." The lack of systematic analysis of accidents and incidents may put people at risk of lessons not being learned and preventative measures being put in place.

The provider's systems for monitoring the quality of the service were not being followed and this meant people may be at risk. For example, care plans and risk assessments were not being adequately completed, audited and updated and so people were at risk of receiving unsafe or inappropriate care. The staff team's training and practical understanding of safeguarding was not fully updated nor assessed. Two safeguarding incidents had not been reported in line with the provider's policy.

Although the manager told us a staffing levels analysis had been completed, they were still short of 401.5 care hours a week. The provider told us such shortfalls in staffing levels were being fully covered by agency staff so that planned levels of staffing were being met. However, our own observations showed that on some occasions, staff could not deliver high quality care nor provide agreed activities and at times felt they and people using the service were unsafe.

The lack of a robust quality assurance process and the failure to identify, assess and manage risks was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People did not have up to date and accurate risk assessment or care plans. This was a breach of Regulation 9 (1) (a) (b)(i) (ii) which corresponds with Regulation 9 (3) (a) and (b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The provider did not have adequate quality assurances in place to assess and monitor the quality of the service provided. The provider did not have systems in place to ensure there could be learning from incidents in the home. This was a breach of Regulation 10 (1) (a) (b) (2) (c) (i) which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse People did not have relevant risk assessments to ensure they were protected from harm and not all safeguarding incidents were reported. This was a breach of Regulation 11 (1) (a) (b) (3) (d) which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Sufficient numbers of suitably, qualified, skilled and experienced staff were not employed at all times. Staffing was not provided as assessed as being needed to meet service users' needs. This was a breach of Regulation 22 which corresponds to Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014