Leonard Cheshire Disability

Dorandene - Care Home Learning Disabilities

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Dorandene is a residential care home providing personal care and accommodation to up to 9 people. The service provides support to who have a learning disability and/or autistic people. At the time of our inspection there were 9 people using the service.

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

Right Support:
People were not living in a service that promoted choice, control and independence. Staff lacked time to support many people to go out into the community or participate in meaningful activities in the home. Some people were sitting with minimal interaction from staff for long periods of time. Others with more mobility could choose to move themselves around the home. People were not always supported to take their medicines safely.

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.

Right Care:
People did not receive care that was person centred or met their individual needs. Poor risk management meant people were not always safe. Guidance from health professionals had not always been followed. People were not always treated with dignity and respect and there was often not enough staff on duty to meet people's needs. Staff understood they had a responsibility to protect people from abuse but were not clear on how to report concerns should they need to.

Right Culture:
Governance at the service was not effective which placed people at risk of receiving poor care. The culture of the service was not empowering for autistic people or people with a learning disability. People and their families did not have the opportunity to contribute to planning their support. Relatives told us that communication from the service was often poor and complaints were not always dealt with appropriately. People were not supported to develop skills or to be as independent as possible.

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

Rating at last inspection
The last rating for this service was good (published 17 January 2019).

Why we inspected
The inspection was prompted in part due to concerns received about staffing and infection control. A decision was made for us to inspect and examine those risks. We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to safe care and treatment, person centred care, consent to care, complaint management and governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Dorandene - Care Home Learning Disabilities

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can 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
This inspection was carried out by 2 inspectors.

Service and service type
Dorandene is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Dorandene is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been in post

for 2 weeks and told us they plan to submit an application to register.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 3 people who used the service and 2 relatives about their experience of the care provided. We spent time observing people receive care and support. We spoke with 6 members of staff including the manager, regional manager and support workers. We reviewed a range of records. This included 3 people's care records and multiple medication records. We looked at 2 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.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely

- Risks associated with people's care were not managed in a safe way. Guidance from a speech and language therapist stated that 1 person needed one to one support when eating due to their risk of choking. We observed during the inspection this level of support was not provided. We discussed this with the manager who put a plan in place to ensure this guidance was followed immediately after the inspection.
- One person had diabetes and there was guidance in place for staff to seek medical advice when the person's blood sugar dropped below a certain level. Records showed this had happened 18 times this year however no advice had been sought by medical professionals. This increased the person at risk of becoming unwell due to hypoglycaemia. Following the inspection the manager reviewed the procedure for blood sugar monitoring to ensure this person's care plan was followed by staff.
- The front door to the service was not locked effectively. People had been assessed by the local authority as not being safe to be in the community without support however the front door was not secure meaning that some people were able to open and leave the building it if they wished to. The manager told us they planned to install a suitable front door lock shortly after the inspection.
- One person had gone missing last year and been found in a local café. Their missing person information had not been updated in relation to this. This meant if the person was to go missing again there was no information about where they had been found previously.
- Some people had charts in place to record their fluid intake due to a risk of dehydration. Several of these charts were not being completed correctly meaning that staff could not accurately account for whether people at risk of dehydration were drinking enough.
- Medicines were not managed safely. Some medicines were being stored in an unlocked fridge and an unlocked cupboard in the kitchen which meant they could be accessed by anyone at the service.
- Medicine stock checks were incorrect. One person had run out of two prescribed PRN medicines which are medicines people take as and when needed. This meant that should the person need these medicines they were not available for them. Stock checks showed that both medicines were still in stock for the person.
- There was no evidence of the service following the principles of STOMP (stopping over-medication of people with a learning disability, autism or both). Records showed one person who was prescribed anti-psychotic medicines had not had these reviewed for 2 years. This meant people were at an increased risk of having their behaviours controlled by excessive and inappropriate use of medicines.

The failure to manage risks associated with people's care in a safe way and the unsafe management of medicines is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Preventing and controlling infection

● People were not always kept safe from the risk of abuse or neglect. Accidents and incidents were not being recorded at the service or reported to the local authority when appropriate to do so. A member of staff told us, "We used to have an accidents and incidents book, but we don't really record them in writing at the moment."
● Staff told us the low staffing numbers were affecting their ability to keep people safe. One member of staff said, "We try our hardest to keep people safe, but I do worry as we need more staff."
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. There was a strong malodour downstairs in the service and some flooring and handrails were not clean and felt tacky to touch.

The failure to review incidents or to ensure adequate infection prevention and control measures are in place is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were not clear on what the safeguarding process at the service was. Staff told us they would tell their manager if they were concerned someone was being abused but they were not clear on any further action they may need to take such as informing senior management or the local authority if their manager took no action to safeguard people. The manager told us they would ensure there were clear guideline put in place for staff regarding this.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● Visits for people living at the home were facilitated in line with the current guidance.

Staffing and recruitment
● There was regularly a shortage of staff on duty which placed people at risk of harm. Several people had complex care needs and there were not enough staff available to meet these. A relative told us, "I visited and was in a meeting with a member of staff and that left only one member of staff looking after 9 people downstairs."
● We observed that staffing levels were too low, and records also supported this. Some people were being funded to receive significant amounts of one-to-one support in order to meet their care needs however very few of these hours were being provided as there were not enough staff on duty to do this. This meant risks associated with people's care could not always be mitigated effectively.
● Staffing vacancies meant that people did not always receive the support they needed to fulfil social needs as reported on in the Responsive section below. When asked if there were enough staff one person told us, "No not really... I like to go on the trains and buses, but I don't really get to do that.
● Staff fed back there were not sufficient staff on shift each day. One member of staff said, "To be honest there is not enough staff at all. Another member of staff said, "There isn't enough staff here. We need a lot more."
● There was no plan in place to ensure people received the support hours they were funded for, and the management team were not clear on how many care hours people needed. Recruitment was ongoing but other solutions such as agency staff were not being utilised sufficiently to ensure there were enough staff on

duty to meet people's care needs.

Failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● New staff were recruited safely and pre-employment checks were in place, which included verification of identity, references from previous employers and the Disclosure and Barring Service (DBS) check. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● People's care was not provided in line with the principles of the MCA. Mental capacity assessments lacked detail and there was no evidence of these being reviewed. For example, one person had been assessed in 2020 as lacking capacity to manage their finances. This decision had not been reviewed for over a year and the assessment contained no supporting evidence for how a judgement of the person's capacity was made.
● The information on people's DoLS applications was not always accurate. One person's DoLS application stated that codes were needed to unlock all external doors. As reported in safe, this was not the case. There were no coded locks on external doors and some people were able to unlock the front door if they wished to.
● Staff had received training in the past around MCA and DoLS however there was a lack of understanding of the principals involved.

Failure to meet requirements of MCA was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● One person had moved into the service 2 years previously however there was no evidence of a pre-admission assessment taking place. This meant the provider was not taking sufficient steps to ensure they could meet people's care needs.

● People with learning disabilities and autistic people were not having their care assessed or delivered considering the guidance 'Right support, right care, right culture.' This meant care was not being provided in line with current national guidance. The new management team were aware of Right support, right care, right culture and told us they would be embedding its principles into people's care.

Staff support: induction, training, skills and experience

● Staff did not always have the support they needed to fulfil their roles effectively. All of the staff we spoke to told us they were not receiving regular supervision and there was no record of any supervisions taking place for staff. This meant staff had not had this opportunity to discuss training and practice and reflect on difficult or challenging situations.

The failure to provide staff with ongoing or periodic supervision as necessary to enable them to carry out their duties was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager told us they planned to arrange supervision sessions for all staff shortly after the inspection.

● Training records showed that staff received the training they needed for their job roles and staff we spoke to confirmed this. This included specific training for supporting people living at the service with conditions such as epilepsy and autism.

● New staff received an induction from the provider which included The Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

Supporting people to eat and drink enough to maintain a balanced diet

● There was a lack of variety for what people could eat and drink. Menus showed that people did not have many choices of what they would like to eat at mealtimes and our observations supported this. We saw that the fridge and food cupboards were not well stocked meaning people were limited in what they could have to eat.

● Staff told us this was in part due to the amount of money available for food being insufficient. A member of the management team told us, "The [service bank] card declines if it goes over £250. Last week they didn't have enough in their budget to buy butter." The provider had identified this as an area in need of improvement and the management team said they were increasing the budget for food to enable a wider variety of items to be purchased.

● Some people needed their food and drink to be prepared to a certain consistency. This was recorded in their care plans and staff were aware of how to prepare people's food correctly.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Guidance from health care professionals was not always followed. A healthcare professional told us they had recommended the provider purchase equipment to enable one person to eat more independently however the provider did not do this until they were prompted at a follow up appointment sometime later. We saw that the provider had purchased this equipment at the time of inspection.

● People were not always supported to access regular healthcare services. One person's care plan showed they had not been supported to see a dentist for over 3 years and care records did not include whether people had been supported to maintain oral hygiene. This increased the risk of the person having poor oral health. The management team told us they would be addressing this after the inspection to ensure people received the support they needed to maintain good oral health.

● Detailed and up to date health action plans were in place which recorded important information such as how to tell if someone was feeling unwell and records of previous appointments with healthcare professionals.
● People had a hospital passport that would be used if they needed to go into hospital. This included important information hospital staff would need to be aware of to provide care in a person-centred way that suited the individual.

Adapting service, design, decoration to meet people's needs
● There was a lack of personalisation at the service. People had not had the opportunity to personalise their bedrooms or chose the decoration. One person's bedroom wardrobe had a 3-year-old record of their body temperature hanging on it. We raised this with the manager who said they would remove it.
● There had been a lack of maintenance work and repairs happening at the service. There were several broken or loose door handles around the service which made it more difficult for people to open doors and communal furniture looked worn and tired. A member of staff told us, "Refurbishment will hopefully [happen] soon as the home needs a lot of improving. It isn't really fit for purpose at the moment."
● We raised the need for refurbishment with the management team. They told us a budget had been set aside to replace items of furniture and they planned to start this shortly after the inspection.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- People were not always treated with respect. We observed one person being asked to leave the dining room table just after they had finished eating lunch so that another person could come into have their meal. A staff member said to the person, "Would you like to go and read your paper in the sensory room because I am going to bring someone else in now." Staff said this was because they did not want the two people to be in the dining room together but care plans did not reflect that there was any risk involved with this.
- Due to staffing pressures staff universally told us they did not have enough time to spend with people. When asked if they had time to listen to people, comments from staff included, "Not always, as we are very busy" "No, it makes me sad" and "I'm afraid not, no."
- People and relatives told us they were not regularly involved in making decisions about their care. A person told us, "At my last place I was asked a lot and there were meetings but there haven't been any here." A relative told us, "I wouldn't say [person] makes many decisions about their care."
- People spoke positively about the staff supporting them. People told us that staff were kind and caring towards them.
- We observed kind interactions between staff and people. Staff members when spoken with appeared to be genuinely upset that they could not provide a better level of care to people at the time.

Respecting and promoting people's privacy, dignity and independence

- People's independence was not always promoted. People were not being supported to gain independence with household tasks such as preparing meals for themselves or doing their own shopping.
- People had not been supported to build on skills and independence they had learnt before moving to Dorandene. A person told us, "I would like more independence. When I was a chairperson of a group for our community [at a previous service] I went to the house of commons and I felt I could speak up. I haven't really got to do anything like that since I moved here."
- People were not always treated with dignity. We saw that everyone was served their meals on plastic plates at lunchtime without staff checking if they wanted or needed these. People were not offered ceramic alternatives.
- One person's care plan for supporting them to eat and drink was displayed on a kitchen cupboard door meaning that anyone visiting could read personal information about the person.
- Staff were respectful of people's privacy when providing support. We saw that staff knocked on people's doors before entering.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them; End of life care and support

- People were not supported to engage in meaningful activities. People told us they were bored and had little to do. One person told us, "I like to go on the trains and buses but I don't really get to do that... I would like to do a lot of things like cook, like I used to but they don't really want me to I don't think, that's a shame."
- Relatives also told us there was a lack of engagement at the service. A relative told us, "There used to be someone to help them with baking and doing crafts but they don't seem to be doing that now which is a shame." Another relative said, "[Person] used to go shopping every week and work in a charity shop before he moved to Dorandene. Since he has been there he has done very little."
- We observed that there was a lack of structure to the support some people received. We saw that some people were walking around the service appearing to be bored with little to do, other people were just sitting in front of a television with very little interaction with staff.
- Staff told us that they were often not able to support people to follow their interests due to there not being enough care staff on duty. A member of staff told us, "We don't give people enough regarding activities, they deserve more."
- People did not have the opportunity to discuss any goals and wishes they had or to review progress achieving these. There was not a staff structure in place such as keyworking to allocate responsibility for this. A keyworker is a member of staff with delegated specific responsibilities for an individual.
- We saw people appearing withdrawn and anxious. Records showed that people did not receive all of the support hours they had funding for to carry out areas of personalised care such as preparing their own meals and accessing the community which could have been beneficial to their mental wellbeing.
- Care plans included some information about people which was not accurate. People had activity planners in place which showed what they would like to be doing each day however these had not been reviewed and were not being followed by staff.
- At the time of the inspection, nobody living at the service was receiving end of life care and support. There was no information in people's care records about their end of life preferences however there were resources in place to record this information.

The failure to provide care which meets people's individual needs is a breach of Regulation 9 Person Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● People and relatives told us that when they had raised concerns these were not always addressed or responded to. A relative told us they had raised a concern with the provider about the staffing levels at the service but had never had a response.
● There was no information displayed at the service explaining how people could make a complaint, or what the provider's procedure was for dealing with these. This meant people did not know how to complain about their care or what to expect in response from the provider.
● We could not find a complaints/concerns file or system to log complaints at the service. The provider told us they did not know if the previous registered manager had kept complaints records.

The service did not have a system to identify, receive, record, and respond to complaints. This was a breach of regulation 16 of the health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● People told us they felt comfortable raising any concerns they had with staff. One person told us, "I talk to staff, they [help me]."

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
● People's communication needs were met. Where people's communication abilities were limited, they had information in their care plans to support staff to know how best to interact with them.
● We observed good communication between staff and the people they were supporting. Staff knew people well and were able to communicate effectively with them using speech and gestures.

Inadequate

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The provider failed to ensure a culture which promoted person centred care. Outcomes for people did not reflect the principles and values of Right Support, Right Care, Right Culture. For example, people were not encouraged to have maximum choice and control over their support, and people did not receive planned and coordinated person-centred support that was appropriate and inclusive for them.
- There had not been sufficient planning with some people to identify goals and outcomes which meant that their support hours were unstructured and not spent in a meaningful way.
- The physical environment was poorly maintained, and there was little attempt to meet people's individual needs. The service appeared dull and dingy with very little to stimulate or interest people.
- People and staff were not engaged in how the service was run. There was no record of residents' meetings or staff meetings taking place to gather feedback and discuss plans for the service. The new manager told us they planned to implement these soon.
- Relatives told us they had not been asked for feedback or kept up to date with changes at the service. A relative said, "I am never asked for feedback… no one told me [registered manager] was leaving and that a member of staff had left."
- Records did not record reflective practice taking place. This meant the provider could not evidence that they learnt from incidents to improve care.

The provider had failed to implement governance systems to effectively monitor, evaluate or improve the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and staff spoke positively about the manager who was new in post. A person told us, "[Manager] is nice, he is a lovely man and very friendly." A member of staff said, "[Manager] is new but he seems good."
- Although there was little evidence of continuous learning happening at the service there was a new management team in place who had identified the need for improvements at the service and had started to implement these.

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

- The provider failed to establish robust governance systems to oversee the quality and safety of the service.

Current systems and processes did not ensure the provider was able to identify where quality and safety was being compromised and respond to it appropriately. For example, medicines were not being managed safely and risks to people were not being mitigated effectively. This placed people at risk of receiving inappropriate or unsafe care.

● The provider failed to ensure audit and governance systems were effective. For example, we identified very few audits were being completed. Those that were completed were ineffective as they had failed to identify issues we raised during the inspection. This was raised with the manager who advised there would be improvement to quality monitoring and they would be conducting a range of regular audits going forward in order to identify where improvements needed to be made.

●The provider did not have effective systems in place to ensure always meet their regulatory requirements. There were several open safeguarding enquiries at the service relating to allegations of abuse. There is a regulatory requirement to notify CQC of these however systems in place had not ensured that this was always done.

The provider had failed to implement effective systems and processes to assess and monitor the service. This was a breach of regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Working in partnership with others

● The provider did not always work in partnership with others. Several people at Dorandene accessed day services. One person had a regular placement at a day service however they had not been for some time and the provider had not worked with the day service to ensure the person was able to attend. This significantly restricted the person's ability to socialise with others.

● There had been some improvements in partnership working since the manager had been in post. The management team had shown a willingness to work with other agencies such as the local authority and health professionals to help make the improvements needed.

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

● The manager understood their responsibilities regarding the duty of candour. Although communication needed to improve, relatives were informed if their family member was involved in an incident or accident and what actions would be taken to mitigate further risk.

● Staff and people living at the service told us they felt comfortable raising any queries with the manager, and that the culture was improving.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to meet the requirements of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to implement an effective system to receive and manage complaints.