Dignus Healthcare Limited

39 School Lane

Inspection report

39 School Lane
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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

About the service
39 School Lane is a residential care home providing personal care to up to 8 people. The service provides support to people with a learning disability and autistic people. At the time of our inspection there were 8 people using the service.

Not everyone who used the service received personal care. In this service, the Care Quality Commission can only inspect the service received by people who get support with personal care. This includes help with tasks related to personal hygiene and eating. Where people receive such support, we also consider any wider social care provided.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

People's experience of using this service and what we found
Based on our review of Safe and Well-Led the service was not able to demonstrate how they were meeting some of underpinning principles of "Right Support, Right Care, Right Culture.

Right support: People were not always supported in a way which promoted their safety and well-being. Staff did not always identify when people were at risk of abuse. People were supported by staff who knew them well and who they felt comfortable with.

Right care: People were supported to make choices about their care however care records did not always clearly document if a person had capacity to make a decision. People were not supported to have maximum choice and control of their lives and 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.
We found records relating to medicines were not always completed in line with guidance which meant there was a risk of people being over medicated or receiving medicines that were ineffective.

Right culture: The service was not always well-led. The quality assurance systems to assess and monitor the service were not always in place, and where they were, they were not effective. We found the provider did not have enough oversight of the service to ensure it was being managed safely and quality maintained. Quality assurance processes had not identified all of the concerns in the service. This meant people did not always receive high quality care. The provider took action after concerns were raised to them to improve the oversight of the service and the safety of people who used it.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection:
The last rating for this service was good (published 26 October 2021.

Why we inspected
The inspection was prompted in part by information of an incident following which a person using the service was placed at risk of avoidable harm. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. The information shared with CQC about the incident indicated potential concerns about the management of risk of people not being protected from the risk of abuse.

As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 39 School Lane on our website at www.cqc.org.uk

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 COVID-19 and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified breaches in relation to safe care and treatment, safeguarding people from abuse, how the provider assessed people's capacity to make decisions, staffing and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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.

We will continue to monitor the service and will take further action if needed.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 safe.
Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.
Details are in our well-led findings below.

39 School Lane

Detailed findings

Background to this inspection

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.

Inspection team
The inspection was carried out by 3 inspectors. 2 inspectors visited the service on the first day of the inspection. On the second day a third inspector accompanied one of the inspectors who visited on the first day.

Service and service type
39 School Lane is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and we looked at both during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This first day of the inspection was unannounced. The provider was informed we would return for a second day of inspection.

What we did before the inspection
We gained feedback from the local authority prior to our inspection visit and reviewed information received about the service since our last inspection. We used the information the provider sent us in the provider information return. 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 of this information to plan our inspection.

During the inspection
Inspection activity started on 28 November 2022 and ended on 07 December 2022. We visited the service location on 28 November 2022 and 01 December 2022.

We spoke with the nominated individual, the regional manager, and interim manager. We spoke with 7 staff members and 2 people living at the service. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 3 people's care records. We checked 4 people's medicines records and looked at arrangements for administering, storing and managing medicines. We looked at records in relation to staff recruitment and a variety of records relating to the management of the service, including audits, policies and procedures.

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 our last inspection we rated this key question good. At this inspection we have rated this key question requires improvement. 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.

Systems and processes to safeguard people from the risk from abuse

- People were not protected from the risk of abuse.
- Staff had received training about how to recognise signs of abuse and how to report these, however staff did not use this knowledge to report actions which endangered the well-being of people living at the service.
- Staff did not recognise these actions as a risk of abuse. One staff member who had undertaken these activities told us "If I felt something was wrong or out of order, I would definitely report it to the manager but so far, I haven't been worried."

The provider did not have systems and processes in place to effectively prevent people being at risk of abuse and investigate evidence of abuse. This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Once we informed the provider of the concerns, we had received they took prompt action to remove the members of staff from the service who were alleged to have taken part in the alleged abuse. The provider investigated the concerns in accordance with their disciplinary policy and removed the instructions in the person's care records which instructed staff to act in a potentially abusive manner. The provider also informed staff of this change.
- People told us they knew staff well and felt comfortable with them. People told us staff knew how they liked to be supported.

Using medicines safely

- We could not be assured medicines were managed safely
- Medication administration records (MARs) did not always provide clear instruction for how often people needed to take their medicines. One person was prescribed a medicine which the instructions stated, "To be given three times a day and once as needed." This should have been recorded as two separate medicines, as a regularly given medicine and as an "as required" medicine.
- People were prescribed "as required" medicines to alter their mood (psychotropic medicines), for example to reduce feelings of anxiety. To prevent over medication of people who were using mood altering medicines it is good practice that people's behaviour prior to taking the medicine be recorded, including details of other techniques used prior to the use of medicine. The result of using the medicine should also be recorded, this allows the prescriber to review the effectiveness of the treatment. The behaviours prior to and result of using the medicine were not recorded. This meant the provider could not be assured people were receiving their medicine appropriately.
- One person had a handwritten MAR, it is good practice that medicines administered on a handwritten

MAR are signed by two members of trained staff to reduce transcribing errors however it was signed by one member of staff.

Systems and processes were either not in place or not robust enough to demonstrate safe medicines management. The failure to ensure safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our findings, the interim manager instructed staff to complete behaviour records for people receiving mood altering medicines and arranged medication reviews for each person living at the home. The interim manager also told us they would ensure two staff completed all handwritten MARs.

● Staff who administered medicines had received training and had their competence to administer them safely checked.
● Medicines were stored securely.

Staffing and recruitment
● There were enough staff to support people at the times they needed. However, there was a high turnover of staff which had resulted in some staff working excessive hours. We saw rotas which demonstrated some staff members were working 15 hour shifts on multiple days in a row. Several staff were working in excess of 60 hours per week on a regular basis. These staff members were regularly supporting people with very complex needs who required supervision. This placed people and staff at increased risk of harm.

The provider failed to ensure enough staff were deployed to meet the needs of people using the service. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited safely. We saw Disclosure and Barring Service (DBS) checks were carried out when appointing staff members to ensure they were suitable to work with vulnerable people. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Staff were allocated to people so people knew who they would be working with, and they developed good relationships. We saw one person react positively when they found out who would be working with them on the day of inspection.

Assessing risk, safety monitoring and management
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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We found the service was not working within the principles of the MCA. Mental capacity assessments were completed when it was thought a person lacked capacity to make a decision. However, the assessments did not contain sufficient detail to explain why a person did not have capacity. The assessments used

generalisations based on a person's diagnosis of a learning disability or autism and were not time or decision specific.
● The lack of information in the mental capacity assessments meant staff did not have the information necessary to make decisions in a person's best interest in regard to their medicines and their finances. The lack of information meant people could be deprived of making decisions they had capacity to, or decisions were made which would mean they were not receiving care and support in the way they would want.
● Staff did not have a thorough understanding of the MCA or their responsibilities to support people in line with this. We asked a staff member about the MCA and they were not aware of the act. Following further explanation of what the MCA was one staff member told us "I think I've had training, I'm not sure about it, I don't know how to do the assessments." This meant staff could not be relied on to identify if a person was being restricted of liberties.

The provider failed to ensure they assessed people's capacity to make decisions. This was a breach of regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Most potential risks to people's health and welfare had been assessed and there was guidance in place for staff to reduce the risk to people. There was information for staff about what was a good day for people and what was a bad day. There was guidance about how people reacted to these feelings and how this was expressed.
● People had positive behaviour support plans in place, which had been developed once staff knew people. These included the triggers for people and how they expressed themselves was categorised as red, amber and green. There was guidance for staff about how to manage these expressions. Staff told us they knew where to find the guidance and had followed the guidance when needed. Records showed the guidance had been effective.
● Checks had been completed on the environment and equipment used to keep people safe.

Preventing and controlling infection including the cleanliness of premises
● The service was clean and free from malodours. Environmental checks were being completed. Staff wore appropriate Personal Protective Equipment (PPE) and had received training on how to wear this and dispose of it safely.
●We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● 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 accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises .

Visiting in Care Homes
● The provider was facilitating visits for people living at the home to maintain contact with family and friends.

Learning lessons when things go wrong
● The risk of harm to people due to staff working excessive hours had been identified at another service operated by the provider in September 2022. We were told by the nominated individual that all managers of services operated by the provider had been instructed not to schedule staff for 15 hour shifts and was not aware that these had continued at 39 School Lane.
● Systems in place to drive improvements within the service were not in place or were not effective.

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 our last inspection we rated this key question good. At this inspection we have rated this key question requires improvement.

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; Continuous learning and improving care

- The provider's oversight and governance of the service was ineffective in identifying the serious concerns and failings in relation to the safety, quality and standard of the service as detailed in the safe section of this report.
- Systems and processes to monitor the service were not robust. This meant they were not always effective, did not drive improvement and did not identify all of the issues we found at this inspection. The provider had some audits and checklists in place but where actions were identified these were not always completed or reviewed. An audit had been completed by a regional manager in August 2022 which identified the mental capacity assessments were not completed with sufficient detail and an action was for the registered manager to review these. At the time of our inspection the assessments had not been reviewed.
- The provider had failed to recognise or investigate incidents to prevent reoccurrences. An activity care plan had been created by the deputy manager instructing staff to hold a plastic bag over a person's head when they requested it. This had been reviewed on 17 November 2022 by the deputy manager, but it was not identified that this was inappropriate, and the providers audits had not identified or responded to the risk that this presented to the person.
- We identified concerns in relation to poor record keeping. For example, in relation to the administration of mood-altering medicines. We could see no evidence these concerns had been identified by the registered manager and action taken to address them.
- Although the provider had issued guidance to registered managers about length of staff shifts this had not been followed and the provider had not identified this.

The failure to operate effective systems to assess, monitor and improve the service, monitor and mitigate risks and maintain accurate and complete records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- After CQC raised concerns with the provider, the provider was prompt to take action to address these which included employing an external organisation to complete an audit of the service and who was on site on the first day of our inspection. During our inspection and in communication after, the provider continued to take action to improve the safety of people using service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good

outcomes for people
● The culture of the service did not reflect our Right Support, Right Care, Right Culture guidance. People were not always supported in a way which reduced risk of harm.
● Staff told us they were aware of how to raise concerns, but they were not confident these would be acted on. A member of staff contacted CQC prior to our inspection to raise concerns and we were told during the inspection by the interim manager that these concerns had been raised by the member of staff to the registered manager and the deputy manager but had not been acted on.
● The nominated individual told us they had arranged new interim management of the service which included an interim manager and a new regional manager, to address the concerns found during our inspection and were reviewing their quality assurance processes.

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 provider had a duty of candour policy that required staff to act in an open and transparent way when accidents and incidents occurred. Relatives were informed of accidents and incidents as well as any actions taken.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were consulted daily around how they wanted their care to be delivered. People's equality characteristics were considered, and care plans contained a good level of detail in relation to things such as people's religion, sexuality, gender identity and cultural beliefs. People were supported to meet needs related to their protected characteristics.
● Staff held regular key-worker meetings with people which gave them the opportunity to provide feedback about their care and if they wanted to make any changes.
● Regular staff meetings and supervisions demonstrated the registered manager sought feedback and encouraged staff to identify potential improvements to the service.
● Staff told us they had received regular supervisions and had been given the opportunity to attend staff meetings. Staff told us positive changes were made as a result of supervisions and staff meetings.

Working in partnership with others
● The provider worked in close collaboration with health and social care professionals involved in people's care and were receptive to advice provided. Where professionals identified concerns with people's care the provider responded appropriately, and we received positive feedback around the changes made.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment (1) People were not protected from the risk of abuse and staff did not understand how to recognise and report potential abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing (1) The provider did not ensure there were sufficient staff employed which meant staff were required to work excessive hours.