Cephas Care Limited

Dunsland

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Dunsland is a residential care home providing personal care and support for up to 14 people aged 18 years and over living with learning disabilities, autism, physical and mental healthcare needs. At the time of the inspection, 11 people were living at the service and one person was in hospital.

The service has not been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. The service was a large home, bigger than most domestic style properties, and larger than current best practice guidance for people with learning disabilities and autism. The size of the service was having a negative impact on some of the people due to building design and layout, and the number of people sharing communal areas of the service.

Not all of the principles had been applied to the service provided, to ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that includes having control, choice, and independence. People using the service should also receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

People's experience of using this service and what we found
People were not always supported by enough suitably trained staff. This was confirmed by our observations of care, reviews of incidents and feedback we received.

We identified environmental risks and concerns impacting on the standards of safe care being provided. The care environment continued not to be clean throughout, and concerns identified during the inspection had not been found by the management team as part of their audits and quality checking processes. Leadership and governance arrangements within the service remained a concern since the last inspection. The remained concerns in relation to the safe management of people's medicines.

We identified breaches of regulation and the provider, in the absence of a registered manager, was not meeting their legal, regulatory responsibilities to ensure people received good standards of care.

People were not always supported to have maximum choice and control of their lives. Staff did not always support them in the least restrictive way possible; policies and systems in the service were not followed to support good practice or reflecting the principles and values of Registering the Right Support.

People's care records were not person-centred, and did not reflect changes in ability, risk or behavioural presentation. The manager had not completed reviews and made the necessary changes to each person's care records or aspects of their medicine management plans since the last inspection.

Rating at last inspection:

Dunsland was previously inspected 09 May 2019 and rated as Inadequate overall and the service was placed into special measures. The report was published 27 August 2019.

Why we inspected:
We received concerns in relation to the management of medicines, the condition of the care environment, the standards of care being provided and the overall safe running of the service. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only.

The overall rating for the service remains the same, and the service continues to remain in special measures. This is based on the findings at this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Dunsland on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation keeping people safe from harm and risks of abuse, and repeated breaches of safe care and treatment and good governance procedures at this inspection.

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

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 and as part of this process we will ask for the service to provide a detailed improvement plan. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service remains 'Inadequate' and the service remains 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 well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Dunsland

Detailed findings

Background to this inspection

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

Inspection team
Two inspectors and one medicine inspector.

Service and service type
Dunsland is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection completed on 09 May 2019. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with two people, and observed care and support provided in communal areas. We spoke with the manager, the associate operations manager and quality assurance manager and one member of the care staff. We looked at five people's care and support records and nine people's medicine records. We also

reviewed staff files as well as records relating to the management of the service, recruitment, policies, training and systems for monitoring quality.

After the inspection
Due to risks identified during the inspection, we asked the service to send us additional information and updates on actions taken as an outcome, this information was provided within agreed timescales. We spoke with two staff, and one relative by telephone.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained rated Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

●One person's care record stipulated that they required food of a liquidised consistency. We observed staff to give the person non-liquidised foods. We also observed staff and the manager to approach a member of staff and question the consistency of the food served but allowed for the person to continue to eat non-liquidised food, leaving them at increased risk of choking. Not all staff had completed nutrition and hydration training.

●We observed a person to be seated in their wheelchair for the duration of our visit. Sufficient measures were not in place to protect this person's skin condition and ensure they adjusted their position regularly to prevent development of pressure ulcers. Only one staff member had completed pressure care training.

●Care records continued not to consistently contain up to date, detailed risk assessments and management plans.

●Care records did not include consideration of environmental risks linked to people's individual risk histories. For example, risks around climbing stairs, stepping in and out of shower cubicles for people with limited mobility and known falls risks. Where equipment had been put in place to assist people, the impact of this on other people accessing shared facilities had not been considered. For example, we found equipment placed over toilets prevented the toilet door from closing, impacting on people's privacy and dignity and posing a tripping hazard.

● Risks to people had not been fully assessed or considered. We identified environmental risks such as steep stairs and external steps and an unlocked laundry room with access to cleaning chemicals. People living at the service also had access to an empty, unlocked bedroom full of disused items of equipment and items of maintenance equipment, including ladders. Not all staff had completed health and safety training.

●Personal Emergency Evacuation Plans (PEEPS) were in place, however, not all staff had completed fire safety training. We identified that when the service was completing evacuation drills, they were experiencing difficulties encouraging certain people to leave the service. Whist concerns regarding this were recorded on the evacuation drill records, there was no further details recorded to reflect actions taken to address this risk.

●We identified gaps and a lack of consistency in completion of records relating to people's fluid intake, body maps to record areas of sore skin and bowel care charts. Where risks had been identified, people relied on staff to ensure these areas of their care were monitored closely and action taken when required. Incomplete records did not ensure staff had sufficient oversight of each person's needs and changing risks.

●There was a written log of accidents and incidents. However, managerial oversight of these was poor. Written information was not consistently stored in the corresponding folder, with some information in people's own care folders making it difficult to review all information relating to one incident. The manager was not completing thematic reviews of this information or reviewing incident forms alongside behavioural monitoring forms.

Risks to people and the care environment continued to not be well managed. This placed people at risk of harm. This was a repeated breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our request, further work was completed by the management team to address shortfalls in relation to the management of people's choking risks and pressure care needs.

●Equipment for fire safety and water quality checks were regularly completed to ensure that they worked correctly. However, staff were not recording the actual temperature of the water when checked, to enable changes or concerns to be identified.

We recommend that the service ensures best practice guidelines are followed regarding the regular monitoring and recording of water safety.

Preventing and controlling infection

●We identified poor standards of cleanliness in people's bedrooms, ensuite bathrooms and shared bathroom facilities. These concerns had not been picked up by the manager as part of their infection, prevention and control audits. Staff were responsible for completing cleaning tasks during each shift in addition to their caring roles. Not all staff had completed infection prevention and control training or training around the safe handling of hazardous substances such as cleaning products.

●We found domestic bins in people's bedrooms containing soiled continence pads, therefore continence pads were not being appropriately disposed of to prevent the spread of infection.

●We identified communal bathrooms and toilets, as well as people's own ensuite facilities without access to hand soap, or other personal care products, including tooth brushes. This did not ensure people's basic standards of personal care were being maintained, to prevent the spread of infection. Some people living at the service required prompting from staff and environmental cues to maintain good standards of personal hygiene.

●Equipment for giving people medicine via a tube through their skin (PEG) and medicine pots were being washed up in one of the kitchen sinks. The kitchen was accessed by staff and people living at the service, and people living at the service helped with food preparation and washing up. The service was not working in line with the guidelines they had in place on how to safely clean equipment for use with a PEG to prevent the risk of infection.

●The service did not have effective systems in place for the management of soiled laundry, with colour coded bags placed on the floor in the laundry room next to people's bedroom laundry baskets which were moved around the service. We also found some people's bedding to be stained and appeared unclean.

●The service had been awarded a one star food hygiene rating.

Risks to people and the care environment in relation to cleanliness and preventing the spread of infection continued to not be well managed. This placed people at risk of harm. This was a repeated breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection visit, we were told by the management team that hand soap dispensers were being installed.

Using medicines safely

●There were gaps in daily refrigerator and room temperature records used to assure that medicines were always stored at appropriate temperatures.

●Regular checks of medicines and their records were not always being conducted. This created a risk that any administration or recording errors would not be promptly identified. Some records of people's currently prescribed medicines were inaccurate and potentially misleading which could lead to errors.
●Staff had access to guidance about how people preferred to take their medicines. There was some guidance in place for medicines given on a when required basis but not for all medicine given in this way. We identified that guidance was not in place for a person who had medicines prescribed to manage seizures. There was no guidance in place around how and when this medicine should be used to manage the person's condition and associated risks.
●Medicines prescribed for external application such as creams and emollients were not always handled in a way that ensured they would not be used after their shortened shelf-life. We noted there were containers of creams in people's rooms that had expired, and some creams were not stored securely in people's bedrooms and communal bathrooms. There were body maps in place showing staff where on people's bodies these medicines should be applied, however, at the time of inspection there was a lack of records showing that creams had been applied.
●From training records provided by the service, not all staff were trained and assessed for their competency to handle and give people their medicines safely. This included training on the administration of medicines by a specialist technique via a tube through the skin (PEG). Not all staff undertaking this technique had recently been assessed for their competence in giving people their medicines in this way.

Risks to people in relation to the safe handling and administration of medicines continued to not be well managed. This was a repeated 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
●Not all people living at the service were able to tell us if they felt safe. We observed episodes of people showing signs of frustration or distress, and one episode of a person becoming frustrated towards a staff member and telling them to go away. We did not observe staff routinely offering people reassurance or implementing de-escalation techniques. Not all staff had completed specialist training to support people with behaviours which challenge.
●We reviewed information on incidents, accidents and responded to feedback given to us by people using the service, as well as information we had gathered prior to the inspection. We identified five safeguarding incidents between August and October 2019 that had not been sent to CQC in line with the service's regulatory responsibility. These incidents were not recorded on the service's safeguarding log.
●Staff had completed safeguarding training; however, they did not demonstrate that they were consistently following the service's policies and procedures in relation to keeping people and themselves safe.

People were not consistently being kept safe and protected from harm. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
●The service used agency staff. The manager told us they had a pen profile folder, with an overview of each person's needs and bedroom numbers to assist staff in an unfamiliar environment. We reviewed the pen profiles folder and found the content to be out of date.
●We spoke to new staff member who told us they had not received a full induction on arrival at the service, and had been assigned people to work with, without being briefed on their needs and risks.
●The manager told us there had been recent changes made to staffing levels and shift patterns. Some shifts lasted up to 14-hours, and we identified staff did not have access to regular breaks during their shifts. From reviewing information held by the service, there had been a recent episode of a member of staff found

asleep during a night shift and not responding to a hand-held monitor to alert them that a person was out of bed. Following the inspection, we received written confirmation from the provider that this incident had been investigated.

●There were two staff on shift at night time, if one staff member took a break, this left one staff member responsible for the whole service. From speaking with staff, we were told they did not take breaks when working at night. Following the inspection, we received written confirmation from the provider that this incident had been investigated.

●Due to the layout of the service, with rooms across multiple floors and across two, interconnected houses this did not enable staff to regularly monitor people's needs. Staff were expected to complete observation sheets during the day and overnight for each person. From those reviewed, we identified variable levels of detail and gaps in recording. We also identified that there was a lack of consistency in how frequently people were being checked overnight, in line with the guidance set out in their care records.

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 the last inspection this key question was rated as Inadequate. At this inspection this key question has remained rated 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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

- We identified multiple incidents and safeguarding concerns which had not been reported to CQC. The safeguarding and incident logs kept by the service were not up to date. The manager was therefore not clear of their regulatory responsibility in relation to completing notifications to CQC and in monitoring performance and risk. This did not provide us with assurances that people were consistently being kept safe.
- The manager was not completing thematic reviews of incidents and behavioural monitoring forms to identify trends and ensure measures were put in place to mitigate risk of reoccurrence.
- Overall, staff training completion rates were low, with a lack of role specific training in place to ensure staff had the required knowledge and skills to meet people's needs and associated risks.
- The service had reviewed staffing levels and shift patterns but had not considered the fact staff would need to take breaks during their shift.
- There were quality audits and spot checks being completed, but shortfalls in the service and care environment found during the inspection had not been identified through these processes. Action points arising from checks undertaken were rolling from one month to the next without being addressed. We were therefore not assured that processes in place were robust, and that those staff completing the audits fully understood what they were checking for. This was of particular concern in relation to gaps in recording linked to management of risks for people and the care environment.
- The service has not made sufficient improvement to improve their rating since the last inspection, and multiple breaches of regulation have been identified at this inspection. In the absence of a registered manager, greater oversight of the service should have been in place by the provider as they have overall legal responsibility and accountability for how the service is run and for the quality and safety of the care provided.
- People's care records did not consistently demonstrate examples of collaborative working with healthcare professionals and the people receiving the service. Where people had Positive Behavioural Support (PBS) plans in place, these were not reviewed and updated to reflect changes in approach and people's presentation, following incidents. Further work around the development of person-centred care provision was required. Care records lacked key details and were not being routinely reviewed and updated following incidents, to reflect changes in risk.
- The management team had introduced regular staff meetings and incorporated discussions around

policies and procedures and areas of learning and development into these sessions. However, due to the level of concern identified at this inspection, we could not be assured these meetings were effective.

●We found examples of letters and written feedback given to staff in their handover book, from the provider and manager telling staff not to contact external agencies to share concerns regarding the care being provided at Dunsland. This did not reflect a healthy and open culture, where staff could be comfortable to raise concerns either internally or externally where they felt this to be required. This did not provide us with assurances that staff and the management team worked in line with their responsibilities under the duty of candour.

●The service did not have their most recent inspection report ratings on display at the service. This was misleading for people and visitors to the service.

Due to poor governance systems and processes in place, people were not protected from risk of harm. This was a repeated breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

●People their relatives and visiting professionals could provide feedback through the compliments and complaints process in place, with information accessible when visiting the service. However, the suggestions box was stored out of reach for visitors or people living at the service, impacting on the option to provide feedback anonymously.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The care provider did not always ensure that people and the care environment were consistently kept safe. Risks to people were not always well managed, including with medicines management Regulation 12 (1)(2)(a)(b)(c)(d)(e)(g)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The care provider was not consistently protecting people from risk of harm or abuse. They were not following their own safeguarding policies and procedures and had not ensured incidents and safeguarding concerns had been notified to CQC. Regulation 13 (1)(2)(3)(4)(6)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The care provider did not always have good governance and leadership in place. Audits and quality checks were not consistently identifying risks and shortfalls. Regulation 17 (1)(2)(a)(b)(c)(f)