Dolphin Homes Limited

Beachview

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

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
Beachview is a residential care home for 10 young people, at the time of our visit there were 9 people living at the service. It provides support to people who have a range of learning disabilities, some of whom also have a physical disability.

People's experience of using this service and what we found
The provider could not demonstrate how the service met the principles of right support, right care, right culture. This meant we could not be assured of the choices and involvement of people who used the service in their care and support.

Right Support
The service did not support people to have the maximum independence or have control over their own lives. We found record keeping needed to be improved in relation of the use of the Mental Capacity Act 2005 (MCA). It was unclear if conditions related to Deprivation of Liberty Safeguards (DoLS) authorisations were being met as there was inconsistency in recording. People did not always have the support they needed to meet their needs and keep them safe. This increased the risks to people's health and wellbeing.

Right Care
People's care, treatment and support plans did not always promote their wellbeing and enjoyment of life. Care was not focused on supporting people's aspirations. Staff were not always able to evidence people's level of participation in activities, how often outings took place and whether all the people at the service were included. People who were distressed or expressing emotional distress did not have proactive behaviour strategies in their care records. This meant they did not provide detail on the specific actions staff should take to ensure practices were reflective of a person's best interests.

Right culture
The service did not have a registered manager. The registered manager from one of the provider's other services was overseeing the management of the service with the support of an area manager. Staff told us there was a lack of leadership and staff did not always cooperate with each other. Relatives expressed confusion regarding the management of the service.

The area manager, acting manager and staff were not always completely open and transparent during the inspection. Although they did recognise that further improvements were needed at the service and showed

a willingness to listen and improve, they felt the issues identified were due to the previous manager, disgruntled staff and ex-staff members.

Following the inspection, the provider told us a new manager has now been recruited and is due to take up the post in the next week.

Care was not always person centred and people were not empowered to influence the care and support they received. We saw that whilst some people interacted with each other and staff, other people received little or no interaction for long periods of time. The systems for reporting were not robust. For example, incident reports and records used to record people's emotional responses to situations were not consistently completed. There was no evidence the provider had taken any action to mitigate future occurrences. The lack of reporting to relevant agencies led to a lack of external oversight and promoted a closed culture. The provider's governance systems were not effective. Governance systems did not ensure people were kept safe and received a high quality of care and support in line with their personal needs.

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 08 November 2018).

Why we inspected
We undertook this inspection to assess that the service is applying the principles of right support, right care, right culture.

We received concerns in relation to the culture at the service, staffing numbers, inexperienced staff, a lack of management and people's care needs. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

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

We looked at infection prevention and control measures under the safe key question. We look at this in all 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 will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to the management of the service, safe care, record keeping and governance at this inspection.

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 Beachview on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Beachview

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
One inspector carried out this inspection.

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

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 not a registered manager in post. The previous registered manager resigned their post at short notice in April 2022. The deputy manager had also resigned their post and was now employed as a senior care worker.

Notice of inspection
This inspection was unannounced

Inspection activity started on 21 June 2022 and ended on 7 July 2022. We visited the home on 21 June 2022

and 28 June 2022.

What we did before inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make.

This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We communicated with five people who used the service and observed how other people were being supported. We spoke with six members of staff including care workers, senior care workers, agency care workers and the area manager

We reviewed a range of records. This included people's care and medication records. We looked at a variety of records relating to the management of the service, recruitment, including policies, procedures and safeguarding incident records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service and made contact with six relatives to find out about their experience of the care provided. We also made contact with all staff we did not meet during our visits to the service.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to 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 of abuse

- The provider had systems in place to safeguard people from the risk of abuse including the training of staff in how to recognise and report abuse, however the systems and processes were not applied effectively meaning that people were at risk of avoidable harm. Staff told us they had received training in, "How to remove themselves and others from a situation." However, staff also told us about a recent incident when a person, "Shouted and screamed during personal care. [Name] punched [Staff member] in the thigh and groin".
- There was no evidence of action taken following incidents to consider what could be put in place to prevent reoccurrences and ensure people were protected. There was no record that any staff discussions had taken place to consider the management of incidents. A relative told us, "[Name] needs structure and pre-planning to minimise sensory overload." This was corroborated by a visiting professional who told us, "[Name] needs advance notice of activities. [Name] needs a plan so [they] can get used to it."
- Incident reports and records used to record people's emotional responses to situations were not fully completed. The local safeguarding team had not been notified of all of these events. Due to the lack of records and monitoring it was unclear if people had suffered any harm. Staff told us about an incident the previous week, however this had not been recorded, no incident form had been completed. They said, the staff on duty during the incident were asked to record the incident, but, "Staff do not do what they are asked. They should have completed the form. Staff don't listen."

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

- The assessing, monitoring and management of risk was not effective. The culture of the service was such whereby incidents of behaviour which may challenge, were deemed as normal. This meant people and staff were exposed to the risk of harm and abuse including verbal, emotional and physical abuse. One person told us, "Sometimes [Name] gets upset and we have to go to our rooms so he can calm down. He gets very upset sometimes. It makes me sad".
- Some risks to people had been identified, however this information was not consistently translated into people's care plans. There was no guidance for staff to manage or reduce the risks to people. For example, one person's care plan stated, 'Risk of self-harm'. However, there was no further information recorded. Staff spoken with gave conflicting information regarding this including, "It shouldn't be there, it's a mistake, not a risk," "There have been occasions when [Name] has expressed a desire not to live. We do hourly checks if [Name] is like that, but he hasn't been for ages." And, "I don't know about that."
- There was no analysis of incidents and accidents to identify triggers or trends. This meant the provider did

not have oversight of the service and information to help them learn from such incidents. This placed people at risk from harm as measures were not put in place to reduce the potential of similar incidents.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate risk was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● We received feedback from the local authority that people who were assessed as needing 1:1 care did not always receive this level of support. We were told, "Beachview were not using [Name's] 1:1 hours effectively. They were unable to evidence how the hours were used, nothing was recorded, there was no information." Another visiting professional told us the same person, "Has 1:1 community funding and doesn't get it."
● Staff told us they were sometimes short staffed. "There was only four on Sunday. It was one down, but it was fine. Today there is five. It feels rushed, but we have got everything done." Other staff comments included, "Sometimes we are short staffed, so we have to work harder. Activities get missed." The duty rota and allocation sheets showed that the staffing numbers were usually higher as agency staff were regularly used.
● The provider had a recruitment system that ensured only suitable staff were employed. Staff applications contained reference checks on previous employment and also checks with the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely

● Staff told us medicine had gone missing from the service. They told us of an incident were a Schedule 3 controlled drug (without safe custody requirements) had gone missing from the service. During our inspection we saw evidence that this had been reported to the Local Authority as a medication error, however the provider had not considered the potential theft.
● The incident had not been reported to CQC and the provider had not shared any information regarding any investigations or actions they had taken following this incident. This meant we could not be assured that appropriate action was taken following the potential theft.
● People's medicines were administered safely, there was a dedicated place for storing people's medicines. Each person had a medication administration record (MAR) detailing each item of prescribed medicine and the time they should be given.
● People and their relatives did not raise any concerns regarding medicines.

Preventing and controlling infection

● 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 personal protective equipment (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.
● 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.

● Visitors were welcomed to the service to see their relatives and we saw people receiving visits during the day.

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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; 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 Act 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- DoLS conditions included the provision of activities and accurate recording of any behaviour which may challenge and any expression of desire to leave the service. It was unclear if conditions related to DoLS authorisations were being met as there was inconsistency in recording. We found staff were not able to evidence people's level of participation in activities, how often outings took place and whether all the people at the service were included.
- Staff were inconsistent in their responses to people's expressions of distress or need for attention. The culture of the service was such whereby incidents of behaviour which may challenge, were deemed as normal. There was inconsistent recording of incidents (this is reported on under the safe key question). This was in part due to the lack of guidance for staff to follow. This meant people using the service continued by responding to situations and showing signs of potential unrecognised anxiety, frustration, boredom, excitement or confusion, as they had no goals or targets in place and staff had no strategies to follow to decrease such incidents.
- We found record keeping needed to be improved in relation to the use of the Mental Capacity Act 2005 (MCA).

●There was some information in people's care plans around likes, dislikes and choices.

Staff support: induction, training, skills and experience

● Staff we spoke with told us that they did not always feel supported. Staff told us the lack of manager was difficult. They said, "It's a surprise who is going to be in" referring to the management team. The registered manager left in April 2022 and the service was being overseen by the registered manager of another of the provider's services with the assistance of an area manager.

● Staff we spoke with told us they had not received regular supervision and were not supported. We were told staff had raised issues with the overseeing manager and the area manager and had not been given adequate support or assistance to deal with the issues they raised. For example, a senior care worker told us they had asked staff members to complete tasks, including taking people out, and they had refused. They told us they, "Don't feel staff respect me." They told us they had raised this with the area manager who suggested they got the person to ask for assistance, so it came from them, rather than as an instruction from the staff member in charge. The area manager suggested if they got the person to ask the staff for assistance then staff may cooperate.

● Records showed staff had received training in topics including learning disabilities, person-centred care, safeguarding and protection of adults, medication, documentation and record keeping, MCA and DoLS.

● Relatives told us staff either had, "No time or no experience. They don't see things that need improving."

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support

● People were supported to eat and drink, they were protected from risks of choking with modified food and fluids.

● There were enough staff to support people to eat and drink. People who needed help with their meals were supported by staff. Staff knew peoples' preferences and needs, for example, what type of cup a person liked or if they required plate guards to support them to be independent. Cold drinks were topped up regularly and hot drinks were offered.

● Peoples' individual food preferences were respected and catered for.

● During our visit we saw that people were supported to attend appointments with healthcare professionals, including GPs.

Adapting service, design, decoration to meet people's needs

● Most peoples' rooms were personalised with things important to them. We saw the service was clean and tidy during our visit. One person's advocate told us, "The cleanliness of [Name's] bathroom is not always good". They also raised concerns regarding the position of the bathroom window, the lack of window covering and the implications to the person's privacy. This had been addressed by the service. No other concerns were raised regarding the building.

● The lounge was spacious and pleasantly decorated.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to 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.

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; Working in partnership with others; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider's systems and processes were ineffective and failed to identify concerns found on this inspection. This included failing to appropriately manage risks to people and failing to ensure records were fully maintained and accurate.
- Records were not always present or accurate. People's care records and incident records were not fully completed or did not contain all of the relevant information for staff to support them.
- Systems were not in place to ensure incidents were consistently shared with the local authority to allow investigation of people's safety. The lack of reporting to relevant agencies led to a lack of external oversight and promoted a closed culture. Incidents were not always recorded or reported as required (the specifics of which are reported under the Safe key question).
- Prior to this inspection, we were made aware of concerns people had about the care and support people received. Some of those concerns were confirmed during this inspection.

Continuous learning and improving care

- The lack of governance and oversight by the provider and management team did not promote change, improvement or learning from when things went wrong.
- Relatives we spoke with said they found that the communication was poor. One relative told us they, "Had a difficult relationship with the home and communication was poor." We found no evidence that people had been harmed however, the provider had failed to operate an effective complaints system. When we discussed this with the area manager, they told us they had not received any complaints since the last inspection, from relatives.
- Feedback was varied. Comments ranged from, "[Previous manager] did a lot to change the culture" to "If you complained you were locked out of information". We were also told, "We had a lot of communication from [previous manager] but nothing happened, no action was taken."
- The provider did not have effective oversight of the incident records completed by staff thus, no actions had been taken in relation to the actions staff were taking, in response to people's emotional and physical responses to situations. This meant lessons had not been learnt.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate the service was well managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The culture of the service did not meet best practice for supporting people with a learning disability. We saw that whilst some people interacted with each other and staff, other people received little or no interaction for long periods of time. We saw that some of the people were engaged and occupied during our visit, however other people were sat alone without any meaningful activities.
- We found from documentation, that the service did not always promote a person-centred approach. People's level of participation in activities was not demonstrated by the records available during the inspection. This was discussed with the area manager who was able to provide photographs of people enjoying outings. However, information was not provided regarding how often outings took place and whether all the people at the service were included.
- One person's visitor told us they felt more could be done to stimulate people. They told us they had given examples of activities people would enjoy and, "They [staff] can't be bothered… they have a complete lack of interest".
- A visiting professional told us, "All [Name] seems to do is sit in front of an iPad. If [Name] is sitting quietly he is no work for the staff, they don't need to do anything."
- Relatives expressed confusion regarding the management of the service. Relatives we spoke with were not aware that the deputy manager had stood down from the position and was working as a senior carer. They also told us they had not been informed of their relative's change of keyworker.
- The provider was not able to evidence they had used feedback from people, relatives and those important to them to develop the service.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to adequately assess, manage, monitor and mitigate risk to people's safety and wellbeing. Regulation 12 (1)(2)1,2

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to demonstrate the service was well managed. The provider failed to ensure the regulations were being met. Regulation 17(1)(2)