Leonard Cheshire Disability

Dorset Learning Disability Service - 4 Romulus Close

Inspection report

4 Romulus Close
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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Dorset Learning Disability Service – 4 Romulus Close (Known as Romulus Close) is a residential care home registered to provide personal care to up to 4 people. There were 3 people with learning disabilities living there, when we visited. The home is in a residential area of Dorchester.

People's experience of using this service and what we found
People were supported by staff who cared about them and knew them well. Staffing levels had not always been sufficient during the COVID-19 restrictions. This had been addressed and we were assured it could not be repeated.

Incidents had not all been reported appropriately. This meant that they had not been reviewed to determine the impact on other people and whether any other statutory agency needed to be notified. Staff had understood the signs of abuse and felt confident any safeguarding concerns they reported were listened and responded to.

People's risk assessments and care plans provided information for staff about how to safely care for each person. Staff were confident in their understanding of how to mitigate risks.

Quality monitoring systems were being embedded to ensure that people's care plans and risk assessments would reflect any changes to their needs. We were assured by a representative of the provider that they were focussed on ensuring these systems were effective. They explained their work had been restructured to enable them to carry out this work effectively.

People's views were considered, and staff felt confident in advocating on their behalf. Relatives and people's legal representatives were consulted about care.

The provider was working to improve communication with statutory agencies and other interested parties. Professionals working directly with people in the home described positive working relationships with staff.

The service was clean and free from odours. Staff were wearing face masks and following Covid 19 government guidance to minimise risks to people.

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 Requires Improvement. (report published March 2020).

Why we inspected
This targeted inspection was prompted to review areas of concern that had been identified during

discussions with the management of the service during the period of coronavirus lockdown. These issues had been monitored and communication with the provider indicated that they were being addressed. The inspection was timed to ensure the impact of the newly appointed mentors supporting staff in the service could be reviewed.

As part of CQC's response to the coronavirus pandemic we are conducting a thematic review of infection control and prevention measures in care homes. This targeted inspection also looked at the infection control and prevention measures the provider has in place.

CQC have introduced targeted inspections to follow up on specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

We found no evidence during this inspection that people had been harmed or remained at risk of harm from these concerns. Please see the Safe and Well Led sections of this full report.

Follow up: We will work alongside the provider and local authority to monitor progress. The provider will continue to provide monthly reports to CQC as outlined in the conditions imposed on their registration. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner. We will continue to receive monthly reports from the provider outlining the improvements being made to improve the standards of quality and safety.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Dorset Learning Disability Service – 4 Romulus Close on our website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Inspected but not rated**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inspected but not rated**

Dorset Learning Disability Service - 4 Romulus Close

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
One inspector led the inspection: a second inspector visited the service.

Service and service type
Dorset Learning Disability Service – 4 Romulus Close (Known as Romulus Close) is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement. The 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 CQC. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The provider had a plan to appoint to this position as part of a restructuring.

Notice of inspection
This inspection was announced. We announced the inspection six days before we visited to request documents to review prior to our visit and to discuss the safety of people, staff and inspectors with reference to the Covid 19 pandemic.

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. The provider had submitted a Provider Information Return since their last inspection. 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 reviewed monthly progress reports as detailed in the conditions imposed on their registration after our last inspection of Romulus Close. We looked at notifications received from the service. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive.

We attended a professionals meeting on 8 July 2020 where health and social care professionals who work regularly with the services provided feedback about care at the homes. This included feedback about Romulus Close. We used all of this information to plan our inspection.

During the inspection
We saw all three of the people who live in the home whilst they were using the communal areas of their home. We looked at aspects of the records related to their care and support.

We sought feedback from relatives and advocates of everyone who lived at the home by asking the provider to send them our contact details. We received feedback from a relative and a legal representative.

Whilst at Romulus Close, we spoke with a provider representative who was mentoring the staff team and three members of staff. Following the inspection, we spoke with the provider representative again and a further representative of the provider. We reviewed quality monitoring and training records. We also spoke with a health care professional who was currently working with the staff to support a person living in the house.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We sought some infection control advice about aspects of policy and practice we discussed with the service and shared that advice.

Inspected but not rated

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 Requires Improvement.

We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about. The purpose of this inspection was to explore the specific concerns we had about Romulus Close.

We will assess all of the key question at the next comprehensive inspection of the service.

Systems and processes to safeguard people from the risk of abuse
At our last inspection systems in place were not operated effectively to ensure people were safe. There was a breach of Regulation 13 Safeguarding of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found sufficient improvements had not be made to evidence that these systems were being implemented.

- Staff had not reported incidents where a person had been agitated and distressed appropriately. This meant that the impact of this person's distress on their housemates had not been kept under appropriate review. A representative of the provider organisation acknowledged that these incidents should have been reported internally and reviewed to determine if any other agencies needed to be informed. They made assurances that this recording would be implemented.

There was a continued breach of Regulation 13 Safeguarding of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider will report their actions to address this as part of the current conditions on their registration.

- People were relaxed with the staff supporting them.
- People were protected from potential abuse and avoidable harm. Staff had undertaken safeguarding training and demonstrated a good understanding of how to protect people from abuse. Staff were confident in the processes they needed to follow and felt confident safeguarding concerns reported were listened and responded to.
- Actions were in place following a safeguarding incident. We were assured that further review would be undertaken by senior managers to ensure that these actions remained effective if people changed how they used their home environment.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we noted improvements had been made and there was no longer a breach of regulation.

● Following calls with the previous managers of the service, we had concerns about how people's rights were being respected alongside the support they received to stay safe. We found that staff had been committed to protecting people from the coronavirus and that this protection had not always been balanced with access to the community as lockdown measures were eased. However, this was being addressed before we visited and people's safe access to their community was improved.
●Staff understood the risks people faced. They spoke confidently about how to reduce these risks. People received support that reflected their care plans to reduce risk. Care plans outlining how people could eat and drink safely were followed, and staff understood how to use mobility equipment safely. We noted that a person had not had access to mobility equipment they needed for a short while because it had not been charged. Staff confirmed there were systems in place to ensure this equipment was fully charged.

Staffing and recruitment
At the last inspection the provider had to ensure there were enough, suitably qualified staff. There was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we saw improvements were being made and measures were in place to ensure adequate staffing levels based on people's current need. There was no longer a breach of regulation.

● We had concerns raised by staff during the initial phase of the COVID-19 pandemic there were not always enough staff working to meet people's needs. We discussed this with staff and senior management. We reviewed the rotas from this time period. The staffing had not always been adequate to ensure people's needs could be met.
● The senior management acknowledged this and explained both how it had happened and the changes that in oversight and management expectations that had been made to ensure it would not happen again. This included clear allocation of people's 1:1 support hours.
● Since the changes in the provider's oversight, there were enough staff to keep people safe and meet their needs. Some vacant hours had been filled although some staff were still working longer hours than they were contracted for. One member of staff commented they would rather not do this and would stop when recruitment was successful.
● The service was focused on training staff in areas of greatest risk to improve staff skills and confidence. All staff currently at work had completed their core training. Further training was being undertaken to enhance specialist knowledge.
● We did not look at staff recruitment on this targeted inspection. However, on previous inspections no concerns had been identified in this area.

How well are people protected by the prevention and control of 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 within the understanding of people living in the home.
● We were assured that the provider would admit people safely, however, there were no plans for anyone to move into the home.
● We were assured that the provider was using PPE effectively and safely. We have signposted the provider to resources to develop their recording of their approach.
● We were assured that the provider was accessing testing for people using the service and staff in line with current availability.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were mostly assured that the provider was making sure infection outbreaks can be effectively prevented or managed. There would be difficulty in ensuring people could isolate in the case of an outbreak. The provider has implemented a flow chart to support decision making should this situation arise.
● We were assured that the provider's infection prevention and control policy was up to date.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about. The purpose of this inspection was to explore the specific concerns we had regarding the oversight of the service. We will assess all of the key question at the next comprehensive inspection of the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At the last inspection the provider did not always operate effective systems and processes to make sure they assessed and monitored the service. 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. At this inspection we found that sufficient improvement had not been made and the provider remained in breach of regulation.

● There had been failings of oversight that had impacted on the quality and safety of the support people living in the home received. These failings included not ensuring adequate staffing and not monitoring all of the incidents that happened in the home. The staffing shortfall had been addressed prior to our visit. A representative of the provider outlined structural management changes agreed during our inspection. This change meant that they would be focussed, with additional management support, on the oversight of the services including ensuring systems were embedded and effective.

There was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider will report their actions to address this as part of the current conditions on their registration.

● Audits had led to changes in practice and these had been effective.
● People's care records had been updated and were more accurate and personalised about their care needs. Staff were working with senior management to ensure care delivery records were a good reflection of the support people had received and that they were useful in reviewing and developing support.
● Staff were positive about senior leadership who were present in the home providing mentoring support.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● We saw improved practice. Staff knew people well and chatted and interacted with them in ways that were meaningful to them. Staff engaged with people more and people were more involved in both pursuits they enjoyed and day to day home life activities.
● Staff understood the changes being made and were confident that their knowledge of people would be

respected and valued during this process.
● A provider representative discussed how work with the Tizzard Centre was restarting after the restrictions imposed by COVID-19. This work focussed on how people could be better supported to be more involved in meaningful activities. Whilst this was focussed in another home, they described the ways the work was being used across the services. This included technological aids to communication that would assist staff to support people in consistent and clear ways. The use of technology was also important to support staff and to ensure continued progress should COVID-19 measures need to tighten again.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and relatives were consulted and involved in day to day care decisions about care and support. Families and legal representatives confirmed communication was improved and they were getting the information they requested. Relatives were asked to feedback regarding the quality of care.
● The provider had kept in touch with families throughout the last few months, when visitors were not allowed to prevent transmission of COVID-19. Technology had been used to support relationships where it was meaningful to the person.
● Liaison between senior management and staff working in the home had been impacted whilst physical access had been restricted to protect people from the coronavirus. This had an impact on development work being undertaken.

Working in partnership with others
● Staff worked in partnership with health and social care professionals such as Speech and Language Therapists. There had been some concerns raised by local professionals regarding communication between Leonard Cheshire Disability and statutory agencies. Leonard Cheshire Disability had been responsive to these concerns and work was ongoing between the provider organisation and local health and social care teams to improve communication and so enhance partnership working. We spoke with two professionals who had current involvement at Romulus Close. They both spoke positively about the engagement of staff and the effectiveness of communication.
● Leonard Cheshire Disability was responsive to requests made by CQC for information regarding the oversight of the Dorset Learning Disability Services including Romulus Close. The senior management acknowledged the oversight issues that had arisen during the pandemic and offered reassurances that these would continue to be addressed robustly. We have not been able to review the sustainability of these changes put in place.