Leonard Cheshire Disability

Dorandene - Care Home Learning Disabilities

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 24 March 2016 and was unannounced. At our previous inspection on 13 November 2013 we found the provider was meeting the regulations we inspected.

Dorandene - Care Home Learning Disabilities is a detached house located in a quiet residential area close to Reigate in Surrey. It provides accommodation, care, and support for up to 10 adults with physical and learning disabilities. It is arranged over 2 floors and has a large lounge, spacious dining room and a sensory room. At the time of the inspection, there were seven people living at the service.

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We were unable to hold meaningful conversations with most people who used the service due to their limited verbal communication. However, we observed care workers supporting people and interacting with them during activities and over lunch. Care workers demonstrated empathy and an understanding of people's needs. They spoke to them in a calm manner and it was clear that people felt comfortable in their presence and enjoyed their company.

Each person was assigned a key worker and an assistant key worker who made sure that their needs were met and records were up to date. They made sure they had everything they needed, and arranged activities and co-ordinated any appointments for them. Relatives told us they were kept informed by key workers.

The provider was meeting the requirements of the Mental Capacity Act 2005. Where restrictions were in place for people and they needed to be deprived of their liberty, this was done in accordance to law. Best interests meetings took place where people did not understand reasons for their care or treatment. Independent Mental Capacity Advocates were used where people did not have family members who spoke on their behalf.

Care workers received induction and ongoing training relevant to the needs of people using the service. This meant they were able to support people in an appropriate manner. They received regular supervision and attended regular staff meetings.

They contacted health and social care professionals if needed, and followed appropriate guidelines in relation to managing behaviour that challenged or with regards to nutrition and hydration. People had appointments with their GP or other health professionals for their ongoing health needs.

The provider had systems in place for monitoring concerns, complaints and any incidents and accidents. Regular checks took place to ensure the environment was fit for purpose.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Relatives told us their family members were happy and content and they had no concerns about safety at the home. Guidelines were in place to protect people from harm and care workers were aware of safeguarding procedures.

Behaviour management guidelines and risk assessments were in place which helped to keep people safe from harm.

There were robust recruitment procedures in place.

Medicines management was safe.

Is the service effective?

Good

The service was effective.

Staff received comprehensive induction and ongoing training which helped them to support people appropriately.

The provider was meeting the requirements of the Mental Capacity Act 2005 (MCA). Staff had received training and were able to demonstrate that they understood issues surrounding consent.

People's healthcare needs were being met by the provider and referrals were made to relevant professionals when needed.

People were provided with a varied diet and those that needed additional support with nutrition were referred to professionals whose guidance the provider followed.

Is the service caring?

Good

The service was caring.

Relatives told us care workers were caring.

Family members and advocates were involved in care planning.

Care workers were provided with guidance on how to communicate with people and they demonstrated that they understood these.

Is the service responsive?

Good

The service was responsive.

Each person was assigned a key worker who supported them and made sure their needs were being met.

Care records were individual and comprehensive in scope.

Relatives told us they had no complaints but knew who to approach if they wanted to raise them.

Is the service well-led?

Good

The service was well-led.

Care workers told us there was an open culture at the service and the registered manager listened to them.

The registered manager carried out audits to monitor the quality of service and met with peers to facilitate learning and look at ways of improving the service to people.

Dorandene - Care Home Learning Disabilities

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 24 March 2016 and was unannounced. The inspection was undertaken by one inspector.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service.

During our inspection we spoke with two staff members and the registered manager. We spoke with one person who used the service and also observed staff supporting people during the inspection. We were unable to speak with more people because they were not able to communicate verbally. We reviewed two care records, three staff files, and other records related to the management of the service.

After the inspection we spoke with relatives of two people who used the service.

Good

Is the service safe?

Our findings

People were safe because the service protected them from potential abuse and avoidable harm. We saw that people were happy and content throughout our inspection. They appeared comfortable in the presence of staff. One relative told us, "Never any sign of distress, when staff approach [my family member] they will laugh and chuckle, which gives me reassurance."

Care workers demonstrated a good awareness and understanding of potential abuse which helped to make sure that they could recognise signs of abuse. One care worker said, "Safeguarding is looking after them, protecting them from harm." Another said, "You can tell from people's body language, if they are not themselves that something may be wrong."

A safeguarding poster was on display in the main office highlighting steps that care workers should take if they suspected abuse and telephone numbers of contacts they could call to report any concerns.

Management guidelines were in place so that care workers were able to support people when they displayed behaviour that challenged them. Guidelines included the person's profile, any typical behaviours, and intervention steps for staff to take. A list of medicines to manage behaviour if all steps failed was also documented and care staff were advised to document this on people's health action plan and medicine administration record (MAR) charts for audit purposes. The provider tried to understand and reduce the causes of behaviour that distressed people. People were referred for professional assessment at the earliest opportunity.

Risk assessments were proportionate and centred around the needs of people using the service. Risk assessments included the use of creams, seizures, bathing, hot drinks and choking. Each assessed risk had a description of the risk and measures were in place to protect people from harm.

Environmental risk assessments were carried out regularly looking at access to the home, minibus, maintenance and catering. Monthly health and safety checklists looking at the doors, fire safety, first aid, food safety, manual handling, documents, COSHH, infection control, electrical safety were done. We saw current certificates for gas safety, portable appliance testing and electrical safety.

Emergency lighting was tested monthly and fire evacuation carried out every three months. Fire safety equipment was tested monthly. Each person had a PEEP which had been reviewed within the past year, this looked at their level of mobility, sensory impairment, specialist equipment needed and their evacuation method. A fire risk assessment had been carried out in August 2015, a fire certificate of inspection from November 2015 was seen.

There were enough competent care workers on duty to make sure that practice was safe and enabled them to respond to people's needs. Staffing levels were adapted to people's changing needs. There were four staff on during the day and two waking staff at night. Extra staff were bought in for activities. The registered manager told us, "We use bank to cover for annual or sick leave, it's a good pool of staff. We use them

regularly."

Recruitment systems were robust and made sure that the right staff were recruited to keep people safe. We reviewed three staff files. A record was kept of all staff Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. Copies of proof of identity such as passport and national insurance numbers were kept and interview notes were retained along with, two references and their original application form.

Staff managed medicines consistently and safely. We saw that staff competency in safe handling of medicines was assessed for care workers that supported people with medicines.

Medicines were stored correctly and at the right temperature. Medicines were counted at every shift handover to verify quantities and medicines administration record (MAR) charts were signed. A list of signatures were retained to allow for identification of care workers that had administered medicines on a particular day.

Weekly checks were also done looking at whether medicines were stored and administered correctly, any omissions in MAR charts or errors were picked up and action taken.

To protect people with limited capacity to make decisions about their own care or treatment, the provider followed correct procedures when medicines need to be given to people. Each person had a medicines support plan and a risk assessment in place. These included how people consented to medicines and how they expressed if they were in pain. Risk assessments were completed in their best interests and looked at the level of support, their choices and preferences, homely remedies which included an authorisation form the GP and pharmacy and a record of when PRN medicines were administered.

Good

Is the service effective?

Our findings

The provider made sure that people's needs were met consistently by staff with the right knowledge, qualifications and experience.

Staff completed a thorough induction that gave them the skills and confidence to carry out their role and responsibilities effectively. The registered manager told us that prospective staff were invited to the service prior to completing an application form due to the unique support needs of people using the service. New care workers were vetted by the HR department but selected for interview by the registered manager. We looked at the induction checklist and training for new care workers. This took place over five days and time was spent at the service to allow new staff to familiarise themselves with the environment and people using the service.

Core training included manual handling, fire safety, health and safety, infection control, nutrition and hydration, food hygiene, people focus, safeguarding and whistleblowing, first aid and Mental Capacity Act 2005 (MCA). The provider held an annual refresher day during which these topics were reviewed by staff.

Additional training included autism and the principles of working with people with learning disabilities. The registered manager kept a service training needs spreadsheet which included courses due to expire, which meant they had a good oversight of the training needs of staff.

Care workers said, "We have a great team here", "If we have problems we can speak with [the registered manager]." "We have supervision every three months." Yearly appraisals took place and supervision was held every two to three months. The appraisal looked at the years' work and achievements, the years learning and development and objectives for the upcoming year.

The 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. The application procedures for this are called the Deprivation of Liberty Safeguards (DoLS).

Staff understood and had a good working knowledge of the DoLS and the key requirements of the MCA. These were put into practice, ensuring that people's human and legal rights were respected. There was an MCA and Best Interests flowchart on display in the staff office for care workers to refer to if needed.

There had been some DoLS applications that had been submitted for people that were under continuous supervision due to their learning disabilities and lack of understanding that these restrictions were in place for their safety, two had been authorised and the provider was waiting to hear back regarding the others.

There was evidence that decisions taken for people lacking the capacity to understand were done in their best interests and were made in consultation with appropriate health professionals.

An Independent Mental Capacity Advocate (IMCA) service was used to provide additional safeguards for people who lacked the capacity to make certain important decisions, and who had no appropriate family or friends to consult. In one example, we saw that an IMCA visited every six months to look at the support a person was receiving.

People were asked to give their consent to their care, treatment and support. Staff considered people's capacity to make particular decisions. Where people did not have the capacity to make decisions they were given the information they needed in an accessible format, and where appropriate, their friends and family were involved. The provider was aware of the importance of asking for consent where people were not able to communicate verbally. For example, records for 'how do I consent to taking my medication' were kept for people, advising staff on tell-tale signs that people were happy to receive medicines. Care workers said, "You offer a choice, they smile and you can tell from their expression" and "Even though they may lack understanding in some areas, you still have to offer a choice."

Care workers were familiar with people's routine health needs and preferences and consistently kept them under review. The provider engaged with health and social care professionals and acted on their recommendations and guidance. Relatives told us, "Staff take him to the doctor and a physio comes to the house and does his exercises. He goes to the dentist and an optician comes to the house" and "Even if she has a cold they will call."

People had health action plans which included details of professionals involved in their care, medicines support, a medicines profile and any health issues such as mobility or eye care. Health action plans included any steps that staff needed to take to support people. There was evidence that people had access to and were reviewed by their GP, physiotherapist, optician, dentist, and podiatrist.

Appropriate referrals were made when needed. For example, the community team for people with learning disabilities carried out an occupational therapy review for a person using the service. There was evidence that people were reviewed by their psychiatrist at regular intervals where relevant. Specialist care plans, for example an epilepsy care plan, along with a seizure monitoring chart were in place.

There was a varied menu for people using the service. Food that was available to people included burgers, soups, curries, sandwiches, sausages and pasta. Some people using the service were able to articulate what they wanted to eat whilst family members were asked if appropriate where people were unable to choose. Opened, perishable food was labelled with the date that it had been opened. Fridge temperatures were recorded to ensure that food was stored correctly and safe to eat.

Care workers supported people to manage the risk of poor nutrition, dehydration, swallowing problems and other medical conditions that affected their health. Meal time guidelines were in place for people. These had been developed by the provider, advising staff what tasks people were able to do independently, such as pouring milk for breakfast and which tasks they needed support with such as eating. Speech and language therapist (SALT) eating and drinking guidelines were on display for staff to refer to for people with complex needs.

Records related to nutrition included 'what is important to people about food and drink'. These included, seating position, size of pieces, how they indicated preference or dislike for certain foods, types of utensils and likes and dislikes.

Good

Is the service caring?

Our findings

Relatives that we spoke with praised staff for their caring attitude, telling us they were "More than happy, no problems", "It's relaxing, it's a lovely atmosphere. Everyone is friendly, always ask if you want tea. It's always like it whoever is on duty" and "Not just in terms of their health but personal care and friendship, it will be difficult to find a better placement."

People were supported to express their views. We observed both the registered manager and care workers supporting people during lunch, they took their time when giving people the information and explanations they needed and the time to make decisions. People's preferences in relation to their personal care were recorded, for example, how they liked to take their bath and what were their preferred times for waking and going to bed. There were detailed instructions for staff to refer to, advising them on the level of support required and where people were able to do tasks independently. Where people needed prompting, the level of prompt was recorded. This allowed people to maintain a level of independence and have some control over aspects of their lives.

Staff communicated effectively with people using the service, even though the majority of people were not able to communicate verbally. Care workers were given detailed guidelines on how to communicate effectively with people. These took the form of 'when person does this', 'we think it means this' and then detailed how staff could support people. It also included common phrases or behaviours exhibited by people and their meaning. A care worker said, "We communicate with body language. [Person] still understands but can't communicate, she smiles a lot."

People had access to advocacy support and the provider had links to local advocacy services where available. Other people were supported to maintain family relationships, one relative said "He comes home once a month. I visit him every Saturday. He says "I love it, which says it all." Another relative said, "They invite us to barbeques, we feel part of the family."

Relatives said, "They are caring, he is always clean, his clothes are always hung up, these are little things but they matter. I can't fault them." We saw people were well dressed and presentable. One person showed us their room which was furnished to their liking and painted a colour of their choice. People lived in single bedrooms, each with a hand basin.

Care workers were familiar with people's preferences in terms of how they wanted to live their life on a day to day basis. For example, what they liked to eat, their preferences in respect to personal care and activities they enjoyed.

Good

Is the service responsive?

Our findings

People received personalised care and support which was set out in written care records that described what care workers needed to do to make sure their needs were met.

Each person was assigned a key worker and an assistant key worker who made sure that their needs were met. Relatives said, "They are great at phoning or texting me and tell me exactly what's going on, the link worker is great. I live too far but they also keep me in the loop" and "Staff keep me informed. If I call them, staff tell me how he is doing." A care worker told us that in their role as a key worker, "I go and buy things for them, go shopping, arrange birthday parties."

People had access to activities both within and outside the service. Activity records were completed by care workers, documenting the activities that people took part in. There were pictures of activities and staff on display at the home. People's activities included going for a drive, walking in the park, using an activity box, cookery, music sessions, massage and bath time. We spoke with an aromatherapist who was visiting the service on the day of our inspection. A sensory room that was well used throughout the day was available to people, with lighting, various textures and a fish tank. Relatives told us, "He gets to go out for a meal and theatre", "He goes to a day centre, he enjoys it there" and "They go out for meals on a regular basis. We have been fortunate to go out with them. She goes shopping, theatre, and holidays." A care worker said, "She likes walking, is very active. We always go out if it's a nice day."

Relatives told us they had no complaints or concerns but would know who to speak to if they were unhappy about any aspect of care that their family member received. Comments included, "When I raised concerns, it was sorted out straight away" and "I would tell staff and also tell [the registered manager]." There had been no documented complaints in the last year. Feedback was sought from visitors including a phlebotomist, social workers, head of quality and advocates. Feedback surveys were sent to relatives and advocates who provided positive feedback about the service.

Care plans were split into person centred plans, health assessments, health plans, risk assessments, and care reviews.

Person centred plans recorded what people said they liked about the person they were written for, what was important to them, things staff needed to know and do to support them. This was written in bullet points and in plain English, making them easier for care workers to refer to.

A section entitled how best to support people looked at a number of outcomes including communicating, choice and control over daily life, food drink and diet, movement, personal support, physical and emotional health and wellbeing, managing money, friendships/relationships, work and leisure, keeping safe and future planning. Each identified outcome included steps that staff needed to take in order to support people with that aspect. Each area in the support plan included what people wanted to achieve or change, and things staff needed to know or do to support the person.

Each person had a communication profile. A record called 'communicating with others' documented people's level of understanding but also their behaviours and mannerisms and what they may mean. Their level of understanding and how they expressed a choice and how they had control over daily life routine were also recorded along with a typical day in their life and how to support people in their daily life and routine.

Good

Is the service well-led?

Our findings

Staff understood their role, told us they were happy in their work and had confidence in the way the service was managed. Some of their comments included, "It's the best place I've worked", "I'm so happy" and "[The registered manager] is great, so understanding and he listens to our suggestions."

The registered manager understood his legal responsibilities, including conditions of registration with CQC, and the requirements of other legislation such as the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards (DoLS).

The service had a positive culture that was open and inclusive. Staff meetings were held regularly and topics discussed included respect for people, health and safety, key working duties and rotas. It included an open session for care workers to raise any issues. Care workers told us they felt like valued members of the team.

The accident/incident reporting procedure flowchart was on display for staff to refer to if needed. Incidents and accidents were recorded in a timely and appropriate manner.

An out of hours visit took place every few months looking at care and support, staff conduct, the environment and general observations. Service manager meetings were held every two months with registered managers of other services within the region, the registered manager told us these were a useful forum for sharing good practice and to facilitate learning from a group of peers.

The registered manager told us there was an improvement plan for the service which included complete refurbishment of bathrooms.

Staff meetings were held on a regular basis and care workers were given the opportunity to raise any points in relation to people using the service, the environment, staffing levels and other issues. Residents meetings were also held regularly and people were kept informed of any changes or asked to contribute their ideas in the running of the service.