Leonard Cheshire Disability

Dorset Learning Disability Service - 56 Maiden Castle Road

Inspection report

56 Maiden Castle Road
Dorchester
Dorset
DT1 2ES

Tel: 01305265097
Website: www.leonardcheshire.org

Date of inspection visit:
14 June 2022
15 June 2022
24 June 2022

Date of publication:
22 July 2022

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Dorset Learning Disability Service - 56 Maiden Castle Road is a residential care home providing personal care to four people at the time of the inspection. The service can support up to four people.

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.

Based on our review of the safe, responsive and well led key questions the service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

People's experience of using this service and what we found
Right Support
Some people were not always safe from harm from the people they lived with. There were restrictions in place and some punitive practices had developed. The service did not always support people to have the maximum possible choice, independence or have control over their own lives.

Staff did not consistently follow people's risk management plans and this placed some people at risk of harm.

Staff were committed to supporting people to live full lives. However, this was difficult to achieve because the high use of agency staff impacted on people ability to do the things they enjoyed both in and out of the house.

The registered manager had not reviewed incidents when people had harmed each other. There was also no opportunity for staff to learn from these situations and improve practice.

Right Care
Staff did not always support people in respectful ways. This was because they asked them not to do things without explanations, or reasoning, or in line with their support plans. Improvements were needed to make sure people were supported by staff in a personalised way.

We observed caring interactions between some staff and people. Some staff were observed to encourage people to be as independent as possible. Staff told us they were very fond of and cared about the people at the home. Some people sought out staff's company and laughed and smiled with them.

Right culture
People's care and support was not always person centred and there was a culture of doing things a certain way because that was what had always been done. We were not assured people's support plans were being followed.

Governance systems did not ensure people were kept safe and received a high quality of care and support in line with their personal needs and preferences.

The registered manager resigned with immediate effect during the inspection. The provider was responsive to initial feedback and ensured that an acting manager who knew people well was covering the home.

Both the acting manager and provider's representative addressed the shortfalls and concerns we identified during the inspection. We have not yet been able to check the impact of these changes in practice on people's experiences.

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 27 April 2018).

Why we inspected
This inspection was prompted by a review of the information we held about this service. We undertook this inspection to assess that the service is applying the principles of Right support right care right culture.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from Good to requires improvement based on the findings of this inspection.

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

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Dorset Learning Disability Service - 56 Maiden Castle Road

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.

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
The inspection was carried out by one inspector.

Service and service type
Dorset Learning Disability Service - 56 Maiden Castle Road 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.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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

Notice of inspection
This inspection was unannounced

What we did before inspection
We looked at all the information we had received about and from the home. We used the information gathered as part of monitoring activity that took place on 19 April 2022 to help plan the inspection and form our judgements. We sought feedback from commissioners and the local authority. We used all of this information to plan our inspection.

During the inspection
Inspection activity started on 14 June 2022 and ended on 1 July 2022. We visited the home out of hours on 14 June 2022 and during the day on 15 June 2022.

We spoke, Makaton signed and communicated with four people and one relative about their experience of the care provided. People who used the service who were unable to talk with us used different ways of communicating including using Makaton, pictures, photos and their body language. Makaton is a form of sign language.

We spoke with four members of staff including the registered manager and support workers. We spent time observing people as they were not all able to tell us their experiences.

We reviewed a range of records. This included two people's care records and four medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We held two video conference calls with the provider's representatives and the acting manager. We continued to seek clarification from the provider to validate evidence found. We looked at training and quality assurance records.

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 Good. At this inspection this key question has now deteriorated to inadequate.

This meant some aspects of the service were not always safe and there was limited assurance about safety. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- We could not be assured people were protected against the risk of abuse.
- Staff were provided with safeguarding training and told us they knew how to report any allegations. However, we identified multiple incidents of where people had harmed others that had not been reported to safeguarding teams or CQC. Actions had not been taken to minimise the risk of reoccurrence and a person had continued to be harmed.
- Some punitive and restrictive practices had developed at the home. People's care and support plans were not followed and there was a restrictive culture. For example, people's favourite drinks and snacks were stored in a locked cupboard and people would have to communicate to staff when they wanted access to these.

The failure to safeguarding people was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- One person told us they felt safe and another person Makaton signed 'happy home. A relative told us they felt their family member was safe with longstanding staff who knew them well.
- The registered manager and provider took immediate action and referred the safeguarding incidents to both the local authority safeguarding team and CQC.
- The provider and acting manager addressed all of the restrictive practices with staff to ensure people were safe and that people's care and support plans were followed.

Assessing risk, safety monitoring and management

- Risks associated with people's care were assessed and management plans were included in their care and support plans. Risk management plans guided staff on the action they were to take to mitigate risks to people and themselves. However, people's risk management plans were not consistently followed. For example, staff gave one person fluids that were not thickened in line with their Speech and language Therapist (SALT) plan.
- Another person had a very clear risk management plan in place to support them with their communication needs and minimise the risk of them harming other people. Staff were not following this plan, and this had resulted in incidents where another person was harmed.

The shortfalls in following people's risk management plans was a breach of regulation 12 (safe care and

treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the SALT team confirmed all fluids needed to be thickened for the person. The acting manager took immediate action to ensure that all staff followed the person's risk management plans.

● The environment was well maintained. Risks associated with the environment were monitored and there were systems in place for the servicing and maintenance of equipment.

Preventing and controlling infection
● We were somewhat assured that the provider was preventing visitors from catching and spreading infections.
● We were somewhat assured that the provider was using PPE effectively and safely. On the first evening of the inspection none of the staff were wearing face masks as per the current guidance. On the second day of inspection all staff were wearing PPE in line with current guidance. The registered manager told us staff should have been wearing face masks and they had continued to wear masks at all times. However, this contradicted feedback from staff. The provider has confirmed that all staff will be wearing PPE in line with current guidance.
● 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.

The failure of staff to wear appropriate PPE 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
● There were not sufficient staff employed to meet people's assessed needs. There were only two members of support staff who had worked at the service for over a year. There was a high staff turnover and high sickness levels. In addition, there were a number of vacancies and there was ongoing recruitment. This meant people were being supported by a staff team who did not know them well.
● The provider tried to employ regular agency staff to cover staffing vacancies. However, not all agency staff were deemed competent to support people out of their home and this had impacted on people's abilities to do things they liked to do out of the house.
● Staff told us they were frustrated about the impact of using agency staff on people's ability to live their lives as they would choose.
● People were not provided with the staffing that had been commissioned by their funding authorities. For example, one person only received one to one support for 14 days in month of May and six times in June 2022. This person was funded for three hours one to one support each day.
● A relative raised concerns with us about the staffing levels and the high use of agency staff and the impact on their family member's quality of life.

The shortfalls in providing people with their commissioned staffing hours was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had systems in operation to help ensure safe recruitment practices for both permanent and agency staff. Pre-employment checks for potential new employees were carried out, to help prevent

unsuitable staff from working in a care setting. This included Disclosure and Barring Service (DBS) checks.

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).

● The registered manager and staff had some understanding of the principles of MCA. However, there were restrictive practices in place that had not been considered under the MCA. These had developed from longstanding practices at the home. There had been progress on removing some longstanding restrictions at the home. However, the registered provider or manager had not acknowledged or identified that there were remaining restrictive practices in place until we identified this.

It is recommended that the principles and code of practice for the MCA is followed and there are systems in place to identify any restrictive practices. This is to ensure people's rights are protected and any decisions are made in their best interests and the least restrictive option.

● The registered manager took immediate action to remove the restrictions that were in place for people. The acting manager has confirmed that there are now no restrictions in access to snacks and drinks for people. The acting manager immediately worked with staff to ensure they understood why the previous practices and culture were punitive.
● Where people were being deprived of their liberty appropriate applications had been submitted to the local authority.

Learning lessons when things go wrong
● The provider had a system for recording and submitting safeguarding allegations, incidents and accidents. The registered manager had not reviewed or analysed any incidents in line with the provider's policies and systems. The provider had not identified the shortfalls in the monitoring and reporting of incidents by the registered manager.
● The acting manager told us how they planned to share lessons learnt and this included sharing information at handovers, staff meetings and in writing and asking staff to confirm they have read and understood the information.

Using medicines safely
● Where there were any medicines errors or omissions, this was followed up with individual staff members and their competency reassessed. A relative told us they were informed of any medicines errors and what actions were taken in response.
●People received their medicines as prescribed. People's medicine were administered by trained and competent staff.

● Staff assessed, planned and delivered the support people needed to take their medicines safely. People's care plans described what medicines they took and why.
● People's medicines were stored securely and in line with manufacturers' guidance.
● Staff had worked with health professionals to reduce and review people's medicines

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were not receiving a personalised service based on their preferences or needs. We found a culture and acceptance of situations and quality of life which would not be acceptable for most people. This was not in line with statutory guidance contained in Right Support, Right Care, Right Culture.
● People or their representative's views and preferences were not always considered. For example, one person's representatives had raised concerns with us prior to the inspection that they were not consulted or involved in the decision about the gender of staff lone working and providing personal and intimate care to their family member. It was only following them raising the matter with the registered manager that their concerns were addressed.
● Three of the four people were funded for daily one to one support hours. These hours were to be used both at home and doing things the person valued doing out of the house. Due to staffing shortages and the skills of agency staff these hours were not being routinely provided to one of the people. A relative told us how people were isolated through a lack of meaningful activities. They described their family member as being; "Damn bored."
● Staff, a relative and records confirmed there had been occasions when people had time with family and friends cancelled as there was not enough staff to support people.
● People had started to return to activities they enjoyed that had been halted during the pandemic. Some of these included meeting up with friends, going to the gym, sailing, swimming and dog walking. However, these could only happen when there were staff who had the skills and knowledge to safely support people out of the house. This meant that not everyone had the opportunity to do things they enjoyed out of the house.

The shortfalls in providing personalised care was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● One person showed us a scrap book of photographs of things they and the other people they lived with had been doing at home and out of the house. This included cooking, art, having a party and celebrating birthdays.
● One person had specialist sensory equipment purchased for their use at home. Staff reported that the person found the equipment engaging and relaxing at times.
●We observed caring interactions between some staff and people. Staff were observed to encourage people to be as independent as possible. Staff were clearly very fond of people and some people and staff smiled

and laughed together. Some people sought out the company of staff whilst others chose to spend their time in different areas of the house and garden.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers

● People had individual communication plans/passports that detailed effective and preferred methods of communication, including the approach to use for different situations.
● The long-standing staff knew people well and how they communicated. New staff told us they had read people's communication plans/passports. They said they also relied on the longstanding staff who knew people well to support with people's communication.

Improving care quality in response to complaints or concerns
● The provider had a complaints procedure in place which was displayed using pictures and photographs.
● A relative told us their concerns or complaints were addressed when they raised them with the registered manager. However, they felt that if they had been consulted and involved in decisions made there would have been less reason to raise any concerns.

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 now 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Governance processes were not effective to keep people safe, protect people's rights and provide good quality care and support. This was both at the registered manager and provider level.
- The provider representatives had been undertaking remote monitoring of incidents and the provider's quality team had undertaken an assessment of the systems and records/support plans at the home. This monitoring and assessment had not identified the concerns we identified about the culture of the home. There had not been any out of hours visits or observations of people being supported at the home. This meant they did not see how people were supported on a day to day basis rather than what was written in documentation and care and support plans.
- We had previously identified shortfalls in the provider level oversight of other services in the area. We would have anticipated there would have been improved in person oversight of the home based on the previous assurances given by the provider and following the appointment of a new registered manager.
- The progress on reviewing restrictive practices at the home by both the provider and registered manager had not been sustained.
- The registered manager told us they were not aware of their responsibilities to report incidents of harm between people under safeguarding procedures. However, they had previously reported such incidents to safeguarding and CQC.
- The registered manager resigned with immediate effect during the inspection. The provider was very responsive and an acting manager who knows the people well agreed to cover the service following the departure of the registered manager.
- There was no analysis of accidents or incidents by the registered manager. This included incidents where people had harmed each other when staff were not understanding people's attempts to communicate their needs. This meant there was no analysis to understand why the incidents were happening.
- The provider's audits that were required to be completed by registered managers had not been completed in line with their policies. The shortfalls in these audits had not been identified until this inspection.
- There was an improvement plan in place based on the findings of the registered manager and provider's governance and oversight systems. The improvement plan did not identify the shortfalls found at this inspection that had a significant impact on people's quality of life.

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

● There was not an open, person centred, inclusive or empowering culture at the home. There were some restrictive practices by staff. These practices had not been considered under the principles of the MCA or considered as part people's positive behaviour support plans. For example, one person was twice asked by staff to stop something that they found self-soothing and stimulating. This was not part of their support plans, nor the rationale to stop explained to the person.

● Records showed that another person was routinely sent to their bedroom following incidents where staff were not able to understand their attempts to communicate their needs. This person's communication support plan was not followed to ensure staff provided them with support they needed before they harmed others.

The shortfalls in the assessment, monitoring and improving the quality, safety of the service and wellbeing of people was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The acting manager immediately addressed the concerns about restrictive practices with staff and provided us with assurances about the changes made and how these were to be monitored. This included daily contact from the provider's representatives and unannounced visits.

● Both the acting manager and provider's representative addressed the shortfalls and concerns we identified during the inspection. We have not been able to check the impact of these changes in practice on people's experiences.

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

● Pictorial surveys were completed with people. They were overall positive. However, negative responses had not been explored with people, or included in the home's improvement plan.

● A relative told us they were not routinely asked or involved in decisions about the care and support of their family member. They said they were routinely told by managers what was going to happen rather than be consulted. They gave the example of where their preference for gender of carer to provide personal care to their family member was not respected. The relative felt this placed their family member at risk.

The shortfalls in the assessment, monitoring and improving the quality, safety of the service and wellbeing of people was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff sat with one person to complete their daily diaries and checked with them how their day had been.

● There were good working relationships with the people's advocates and other health and social care professionals. Positive feedback from a professional had been shared with the staff team.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider met their responsibilities in relation to duty of candour where they had identified failings. Duty of candour requires that providers are open and transparent with people who use services and other people acting lawfully on their behalf in relation to care and treatment. However, as detailed throughout the report the provider had not identified the multiple failings found at this inspection.

● The provider had been in contact with people's families and representatives during the inspection in relation to the future of 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 9 HSCA RA Regulations 2014 Person-centred care The shortfalls in providing personalised care was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The shortfalls in safeguarding people and having effective safeguarding systems was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The shortfalls in following people's risk management plans and the failure of staff to wear appropriate PPE was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

	The shortfalls in the assessment, monitoring and improving the quality, safety of the service and wellbeing of people was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The shortfalls in providing people with their commissioned staffing hours was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.