Leonard Cheshire Disability

Dorset Learning Disability Service - 11 Friars Close

Inspection report

11 Friars Close, Dorchester, Dorset, DT1 2AD
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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 caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

11 Friars Close is a small service providing care and support to 4 people with learning disabilities in a residential road.

At the last inspection of 11 Friars Close on 16 January 2014 we found breaches of regulations related to: information not being available in ways the people living in the home understood; how decisions were made about some areas of people's care and support and systems used to monitor quality not being effective. The provider wrote to us and told us what changes they would make to meet the relevant legal requirements. They told us they would achieve these changes by April 2014.

We undertook an inspection of 11 Friars Close on the 6, 7and 10 August 2015. We announced the inspection the day before we visited because we wanted to check there would be people and staff around when we visited. We found that some improvements had been made but that not all the actions detailed in the provider's plan had taken place and the regulations were not all met.

Summary of findings

This service needs to have a registered manager and there was one in post. 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.

Staff were caring and knew people well but we found a number of issues relating to how people were supported.

There were quality assurance systems in place but these were not always effective.

Staff and managers had regular communication and meetings about the support people received and service issues. The service was not always fully focussed on fulfilling outcomes for people but was sometimes delivered to meet the needs of the service. For example, staffing rotas did not always reflect people's preferences.

People were at risk of cross infection because soap was not available for staff and people in one toilet and equipment was not cleaned effectively.

People were protected from avoidable physical harm because risks had been assessed and guidance was available to staff. Staff knew how to identify most types of abuse and knew who they should report any concerns to.

People who could not make decisions about their own care and support had most appropriate decisions made on their behalf within the framework of the MCA 2005. However some decisions about restrictive practices had not been made clearly within the best interest framework. This meant there was a risk that some decisions being made about people's care and support would not reflect the least restrictive option which is a principle of the Act. We have made a recommendation about identifying restrictive practices.

Staff were attentive to people's immediate needs that could be easily met. People's needs that required changes at a service level such as to staffing or to where someone lived were not assessed or responded to effectively.

Opportunities for people to develop their communication skills were not addressed consistently. Plans that had been introduced by a Speech and Language therapist had not been reviewed and followed effectively.

People's care plans included information about personal preferences and provided individual detail about how people were supported day to day, but not all support was provided in ways that respected people's autonomy or their religion. People were involved in activities during the day time. Evening activities were planned in advance as they required additional staff to work. Evening activities were, therefore, dependent on individual staff availability and were not a frequent occurrence.

Deprivation of Liberty Safeguards (DoLS) had been applied for people who needed their liberty to be restricted for them to live safely in the home.

People were supported by staff who had received appropriate training to do their jobs and cared about their welfare. Interactions between staff and those living in the home were gentle, familiar and kind.

People had access to appropriate healthcare for on going and emerging health needs. This included dental care, psychiatry and input from their general practice. They received their medicines safely and staff had liaised with health professionals to ensure they could receive them in a way that suited them individually.

Summary of findings

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

People were protected from avoidable physical harm because risks had been assessed and guidance was available to staff.

People were at a reduced risk of experiencing abuse because staff knew how to identify most types of abuse and knew who they should report any concerns to.

People received their medicines safely in a way that suited them.

People's personal equipment was not part of a regular cleaning schedule and a wheelchair was dirty during our inspection. Soap was not available to staff or people in a toilet. This put people at risk of cross infection.

Is the service effective?

Requires improvement

People who could not make decisions about their own care and support had most appropriate decisions made on their behalf within the framework of the MCA 2005. There was a risk that some decisions being made did not reflect the least restrictive option which is a principle of the Act.

Deprivation of Liberty Safeguards (DoLS) had been applied for people who needed their liberty to be restricted for them to live safely in the home.

People were supported by staff who had received appropriate training to do their jobs.

People had access to appropriate healthcare for on going and emerging health needs.

People were supported to eat safely but they were not supported to make choices about their meals.

Is the service caring?

Requires improvement

People were not effectively supported to develop their communication skills.

Staff were attentive to needs that could be met easily. When staff believed a person to be unhappy about a bigger problem in the home due to their behaviour this did not lead to change for the person.

People were supported by staff who cared about them and interactions were gentle and familiar.

Is the service responsive?

Requires improvement

People had plans about their care that were written in ways that focussed on the individual preferences, but not all support was provided in ways that respected people's autonomy or their religion.

Summary of findings

People were involved in a range of activities during the day time. Evening activities were planned to ensure staff availability. Additional staff had to be booked to enable evening activities to take place and this was dependant on staff availability.

There had been no complaints but the service had a policy in place.

Is the service well-led?

There were quality assurance systems in place but these were not always effective in achieving improvements in the quality of the service people received.

Staff felt able to discuss issues with senior staff and at team meetings, senior staff had regular team meetings that focussed on operational issues.

The leadership of the service did not ensure people's right to choice and self-determination.

Requires improvement

Dorset Learning Disability Service - 11 Friars Close

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.

We called the home the day before our inspection because as a small care home for younger adults who are often out during the day; we needed to be sure that someone would be in.

The inspection was undertaken by one inspector.

Before we visited the home we reviewed information we held about the service. We had not asked the provider to submit a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We were able to gather this information in other ways including talking with staff, and the service manager.

During our inspection visit, we spoke with a person who used the service, observed staff interactions with the people who used the service and spoke with five care staff, the service manager, a registered manager employed by the provider to manage different homes and the registered manager.

We looked at records relating to the care of three people living in the home including care plans, risk assessments and medicines records. We also looked at records related to how the home was run including rotas, meeting minutes and audit records.

Requires improvement

Is the service safe?

Our findings

The house was clean, but not all of the equipment was clean, and there was not an effective system in place to ensure equipment was kept clean. For example, we pointed out that a person's wheelchair was dirty on the first day of our inspection, on the second day it still had not been cleaned. This undermined the person's dignity as they could not clean it for themselves. Some paintwork had been worn away and this meant that effective cleaning would be difficult. There was no soap available in the downstairs toilet on either day of our inspection. This meant that people and staff could not wash their hands effectively putting them at risk of infection.

Staff were not deployed in a way that ensured people's preferences were met. Staff were deployed to ensure that people could undertake activities during the day time and could be arranged for planned evening activities. Staff and managers told us that this was not restricted however, in the month prior to our inspection there had been no occasions when extra staff had been arranged so that people could go out in the evenings. This meant that it was possible people were not experiencing regular activities in the evening. Staff described a number of activities that people enjoyed doing that were evening activities such as shows.

People were protected from avoidable physical harm through risk assessment and staff guidance. For example, moving and handling information was available for all people who needed this support. The risks people faced inside the home including those posed by other people had been assessed. Plans were in place to minimise these risks. Risks relating to people being safe when outside of the home were also assessed and guidance was in place for staff in people's care record. Staff understood these risks and were able to describe in broad terms the measures in place to protect people. The procedure in the home was for staff to sign that they had read the risk assessments currently in use but not all staff had signed them. This meant there was a risk that staff might not have understood the detail of risk assessments or might not implement them appropriately.

Staff were able to describe what they would do if they thought someone was being hurt in the home. They understood where they could access information about external agencies they could report their concerns to. The home had made appropriate referrals to the local authority safeguarding team when there had been physical incidents between people living in the home.

People were supported to take their medicines in ways that met their individual needs. When necessary professional guidance had been sought to make sure that this was safe and effective for the person. This meant that people were able to take their medicines in ways that suited them. For example, staff had checked that a person could take their medicine on food as this was easier for them and that another person could continue to enjoy alcohol safely whilst taking medicines. People's medicines were stored in individual locked cupboards and checked regularly by staff. This meant that any errors would be picked up quickly reducing the risks to people. There was a thermometer available for staff to check the temperature of the room the medicines were kept in. Staff told us they were not recording this temperature but they did check it to ensure the medicines were stored at a safe temperature. The temperature that medicines are stored at is important to ensure they work effectively.

Staff were subject to appropriate checks when they were recruited to work at Friars Close. This meant that the risks of employing a member of staff who was not suitable to work with vulnerable adults were reduced. Records of interviews did not included reference to discussion about gaps in employment history. It is a requirement to check gaps in employment history as part of checking a candidate's suitability for a job. We discussed this with the service manager who explained that this was always discussed but they would start to record it.

Requires improvement

Is the service effective?

Our findings

At our last inspection on 16 January 2014 we found that where people did not have capacity to consent the provider did not act in accordance with legal requirements. This was a breach of regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010. The provider wrote to us and told us they would put systems in place to ensure that the Mental Capacity Act 2005 was adhered to in relation to end of life wishes and people's finances. They told us they would achieve these changes and meet the requirements of the regulation by 12 April 2014. These improvements had been made. However, we found that care may not have always been provided in a manner which was the least restrictive.

During this inspection we found that staff had received training about the Mental Capacity Act 2005 and understood they needed to make decisions in people's best interests on a day to day basis. Care plans recorded appropriately where people needed staff to do this because they did not have the capacity to do so. Specific best interest decisions had been made regarding financial matters such as one person spending money on a holiday. People's care plans were reviewed with other people who knew them well.

The MCA principle of regard for decisions or actions being achieved in a way that is the least restrictive of the person's rights and freedom of action was not described or demonstrated by staff. For example, care plans and care practice included specific restrictions on people. These restrictions included people's toiletries being locked away, people eating in set places including in one instance in a separate room from everyone else and we saw that one person had a leisure activity hidden from them. Staff told us that these actions were made in people's best interests but care plans did not describe all of these practices or provide a rationale for why they were in each person's best interest. We saw the person looking for their leisure activity in the place it was usually kept. Staff told them it wasn't there but did not offer them an alternative activity. Staff explained to us that the person could become fixated on this activity. It was not evident from records or staff discussion that less restrictive options had been considered or that staff had identified these practices as restrictive.

People in the home required restrictions to be in place to keep them safe and for them to remain living in the home. These restrictions had been applied for, or authorised by the local authority for all people where required in the form of Deprivation Of Liberty Safeguards (DoLS). These safeguards aim to protect people living in care homes and hospitals from being inappropriately deprived of their liberty and can only be used when there is no other way of supporting a person safely. Staff were aware of the authorisations, but we found that one person did not have a clear record of who their representative was. People who are subject of a DoLS should have a representative allocated to them by the local authority (called a Relevant Person's Representative (RPR). The RPR remains in contact with the person and represents them in all matters to do with the DoLS. We asked who the person's RPR was and the registered manager did not know. They told us they would look into this. This meant the registered manager had not understood the importance of RPR's role in protecting the rights of people who are deprived of their liberty.

The food served during our inspection was varied and some was cooked using healthy ingredients. Most people ate all the food they were given and appeared to enjoy it. Staff made the decision about the main meal on both days that we visited. When asked about people's preferences and menu planning staff told us that the menus were usually planned in advance by staff, but sometimes staff decided on the day. They told us that people appeared to enjoy most foods. During our inspection, one person did not eat their meal and they were not offered another option. We observed that they sought out and ate crisps as an alternative. At one meal a choice was made available between two pudding options. People were able to make choices about food but they were not being involved in making meal choices because there was no framework in place for staff to consistently support people to make these choices.

People were supported to eat communally at the table in the kitchen. We spoke with a Speech and Language Therapist who had worked with the home. They told us that the staff at the home were good at following guidance to ensure people ate safely. Staff communicated with people individually and with each other during meals. One person initiated communication and this was always responded to and as a result there was a relaxed and social atmosphere during meal times.

Requires improvement

Is the service effective?

Staff followed an induction when they started working with the provider. This was complimented by annual refresher days to ensure that staff had the core skills and knowledge the provider had decided was necessary to support people living in the home. We spoke with the staff who organised this training who demonstrated they operated a robust system that was effective in keeping staff up to date. These training updates included infection control, safeguarding, and the Mental Capacity Act. Moving and handling and medicines training also included an annual competency check.

People had access to healthcare for on going health needs such as dentistry, opticians, and medicines reviews and for treatment due to emerging health needs. During our inspection one person visited the dentist. Records described regular contact with GP's and other health care professionals and there was evidence that where further action was necessary that this was arranged promptly. Care plans also included information about how staff might know if someone is feeling unwell.

We recommend the service seeks advice and guidance from a reputable source about identifying and reviewing restrictive practices.

Requires improvement

Is the service caring?

Our findings

At our inspection on 16 January 2014 we found that people were not supported to make decisions by means of communication methods they understood. There was a breach of regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2010. The provider sent us an action plan that detailed that they would meet the requirements of the regulation by 10 March 2014.

In the action plan, the registered manager told us staff were working with a Speech and Language Therapist to develop an appropriate communication plan for one person . The person had a care plan that stated the development of communication skills was a long term goal that required regular review. At this inspection we found that a speech and language therapist had been involved to develop a plan to support decision making for a person but this plan was not being followed. Staff told us that they didn't follow person's care plan because they thought it did not work. Staff did not, however, have a consistent understanding of the person's communication needs particularly in relation to how they communicate decisions. One staff member said, "They are able to make it clear when they don't want something." Another member of staff told us, "They communicate what they want." We spoke to the speech and language therapist who told us that they had not received this feedback or been asked to review the plan in order to support the person's long term goal. The manager told us that work would still be on going and they were developing some pictures of snacks as an alternative but this had not been introduced. The Speech and Language Therapist plan had not been reviewed since December 2014. The person had not been supported to achieve an assessed need.

A photograph board of staff on shift in the home was not updated on either day of our inspection. Staff described the communication needs of people in the home only in relation to their interaction with paid staff. For example, we asked a staff member who communicated with the public in places the person knew well. They told us, "Staff communicate for (person) in public. We know what (person) wants." Staff did not describe the person's communication needs in relation to social interaction and participation with a wider community. This reflects a paternalistic approach to support because it does not encourage participation or enhance independence. People's ability to make decisions was not being supported through a consistent approach to communication support.

The above was a breach of Regulation 9 of the HSCA 2008 (Regulated Activities) Regulations 2014.

People living in the home were not able to protect their own dignity. On the first day of our inspection staff took care to ensure that doors were closed to enable people to use the toilet in a way they needed to without being visible to us as visitors to the home. This was important because the layout of the home was such that people using the downstairs toilet came out into the view of people in the kitchen and lounge. On the second day staff did not protect people's dignity in this way but intervened as soon as they were made aware by us that someone had the left the toilet without being dressed. Staff need to be aware at all times of the risks to people's dignity inherent in the layout of the home.

People who lived at Friars Close did not always use words to communicate. They were relaxed around staff and their interactions were familiar and reassuring. Relatives also commented on the caring nature of the staff. One relative described the staff as "faultless" another told us they are "very caring". Staff knew people well and spoke with care about them. One member of staff described how some staff would notice, "if people had another grey hair on their heads". Staff interacted gently and used communication patterns that were familiar to people. This interaction supported the relationships between staff and individuals. There was a lot of laughter between one person and staff.

Requires improvement

Is the service responsive?

Our findings

People had detailed care plans that were written in person centred language. For example, there were one page profiles which detailed "what we like and admire about..." in the care plans. The things that were important to people were recorded. There was detailed guidance in place for staff about how to support people appropriately with their personal care tasks and health needs and this had been reviewed regularly. This guidance encouraged independence, focussing on the skills people have. For example there was detail about what parts of tasks people could do for themselves and what actions staff needed to take to support this. Other areas of people's care plans were not as well developed. For example information about community participation, employment and relationships was limited or absent. A social care professional commented on this stating they felt the service was, "caring but is not promoting broader independence."

People did not always receive support that reflected their preferences or needs. One person living in the home needed support from two staff to assist them to go to bed. This meant that they were supported to go to bed at 6pm and could not influence this. We spoke to staff about this who believed this to be as a result of the rota. The registered manager told us the person had always been tired and gone to bed early. The person's care records indicated that this was not always their preference. For example, one record described how they heard activity in the lounge and called out but were reminded by staff it was bedtime at 7pm. During our inspection the person was supported to get ready for bed. They were told what was happening but not offered any choice. There was no reference to the person needing to go to bed at this time in their care plan. Their care records indicated that they were a sociable person who relished staff attention and did not like to be left out. Care was not being planned to ensure individuals needs and preferences were being met.

A relative told us their family member had not been able to stay at a church event due to the need for staff to go back to support another person to go to bed. We spoke to the service manager and registered manager who told us that the rota could be changed to reflect what people needed and wanted to do. This had not happened and this meant the person had been stopped from taking part in an event that only happens four times per year and was an important part of the person's community beyond the service. The importance of these relationships was referenced in a communication passport that had been started for this person. People's autonomy and involvement in the community was not being respected. There was not due regard for people's religion.

Staff were attentive to needs that could be met easily. For example, we saw that requests for things like medicines and cups of tea were attended to quickly. Larger decisions about issues that people may be expressing through their behaviour were managed as behaviour rather than addressed as communication. For example, two people living in the home did not get on well. One of the people, who took medicine to help them manage their emotions and behaviour, was anxious and agitated around the other person. Staff told us that this person did not like the other person. One member of staff said, "They wouldn't choose to live together." We asked the service manager about this. They told us that they believed that if the person, who was anxious and agitated, moved out the other person would seek out someone else in order to get a reaction.

There was a plan to review the accommodation lay out to reduce the places where it was not possible for the person who was agitated to get away from the other person but there was no plan to review whether the people should live together. They told us this would be reviewed if the two people were at home together all the time because at the moment it was being managed by keeping the people apart as much as possible. This assessment reflected an acceptance of one person's experience of their home life being a place where they needed to avoid direct contact with a house mate and where they needed to be supported to avoid the anxiety and stress directly caused by this. This situation had been on going for over a year and there was no effective plan in place to ensure people's individual rights were upheld and individual needs and preferences respected.

The above was a breach of Regulation 9 of the HSCA 2008 (Regulated Activities) Regulations 2014.

People were involved in daytime activities over a fortnightly cycle. These included on going therapeutic activities, music sessions at home, trips out, time spent at local day centres and activities such as art at the provider head office. Decisions and plans that related to community activities were made by staff during our inspection. Evening activities

Requires improvement

Is the service responsive?

happened when staff arranged them. One person had recently been to see a tribute act of a singer they liked. These activities were dependent on individual staff input rather than a system to ensure local events were accessible to people living in the home. This did not reflect a person centred approach to people's care and support. We spoke to staff about this and comments reflected this. One member of staff said, "Whenever we (staff) want to go somewhere someone will come in." Another member of staff told us that it could be difficult to arrange evening activities.

There had been no formal complaints received by the home but a complaints policy was available. One relative told us they had not felt listened too, with specific reference to how spiritual needs were met, and they were addressing this with the provider. People's behaviour was not considered as comment on the service they were receiving. When people do not use words or pictures to communicate their actions are the only means available to them to complain about the service they are receiving. The provider policy on complaints stipulated that complaints can be made freely and in line with people's communication needs.

Requires improvement

Is the service well-led?

Our findings

At our last inspection on 16 January 2014 we found that quality assurance systems were not always effective. There was a breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010. The provider wrote to us and told us they would meet the requirements of the regulation by 1 April 2014. At this inspection we found that improvements had been made to the quality assurance systems but they had not been maintained and so continued to be ineffective in ensuring the quality of the service.

After our inspection in January 2014 the provider told us that risk assessments would be stored in daily charts until they had been read and signed by all staff, and that these would be checked along with cleaning charts in a fortnightly check by senior staff. These checks were taking place but had not resulted in an improvement in quality. For example a risk assessment reviewed on 2 June 2015 remained with the daily charts and was unsigned by some current staff. The cleaning schedule did not include checks on people's equipment and as such was not effective in ensuring appropriate standards of hygiene.

The provider monitored some aspects of quality through monthly reports from each home. These included financial records, cleaning records, vehicle records, food temperature and fridge/freezer temperature records. We spoke to another registered manager employed by the provider as the registered manager was away at the time of our inspection. They explained that discrepancies should be picked up by the registered manager as part of this monthly return process and be addressed with staff. Staff had varied views regarding how robust this process was within Friars Close. One member of staff told us that 'nothing can be neglected' whilst another commented staff weren't always 'picked up' if things weren't done. These monthly reports and their outcomes were sent from the home to the area office however they were not reviewed by the service manager as part of the quality assurance process.

Some aspects of the service people received were not being monitored and this meant planning was not effective. For example, there were no checks being made on how often people were not able to undertake community activities or how often the person who went to bed early indicated that this was not their choice. At a management meeting in April 2015, staffing levels were described as optimal across the whole service without reflection on the experience of people living at Friar's close in relation to their evening support.

There was a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014.

There was a caring approach seen from all staff and senior staff however there was a restrictive element to this. People's ability to make choices about their day to life was restricted by the working practices in place in the home and solutions were all sought within the service. For example the senior manager reflections on the situation between two people in the home did not include consideration of a different model of support for either person. This reflected a paternalistic culture. The success of a service supporting people with learning disabilities and behaviour which can challenge is dependent of staff understanding and behaving in line with the organisations values and vision. The Leonard Cheshire Homes website states "We work for a society in which every person is equally valued. We believe that disabled people should have the freedom to live their lives the way they choose - with the opportunity and support to live independently, to contribute economically and to participate fully in society. That belief is at the heart of everything we do." This vision was not fully recognised in the support people received at Friars Close.

People had some involvement with their local community. For example a recent barbeque had been held to support relationships with neighbours. However, opportunities to develop people's involvement and participation in their communities were not always taken and people's care plans around community participation were not developed. There is a risk that people are present in their community but not participating in valued ways that are meaningful to them if this is not addressed.

There were regular staff meetings held which gave staff the opportunity to discuss the people who lived in the home and service issues. Staff reflected that these meetings were open that they were able to state their views. One member of staff said, "They are polite but nothing is hidden."

Requires improvement

Is the service well-led?

Most staff felt supported. One member of staff said there was, “a lot of support… a lot of talk… we can ask questions.” The registered manager was present in the home on a regular basis and could also be contacted by phone if necessary.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 Person centred care People were not supported to understand and make decisions about their care and treatment. People's preferences were not taken into account when care was planned. Regulation 9 (1) (a) (b) (c) (2) (b) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014. The provider was not effectively monitoring and improving the quality of the service provided to people. Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 (1) (2) (a)