Leonard Cheshire Disability

Dorset Learning Disability Service - 56 Maiden Castle Road

Inspection report

56 Maiden Castle Road
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Ratings

Overall rating for this service	Inspected but not rated

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

Summary of findings

Overall summary

About the service
Dorset Learning Disability Service – 56 Maiden Castle Road (Known as Maiden Castle Road) is a residential care home registered to provide personal care to up to 4 people. There were 4 people with learning disabilities living there, when we visited. The home is in a residential area of Dorchester.

People's experience of using this service and what we found
People were supported by staff who cared about them and knew them well. There had been a time in April 2020 when staffing levels were not sufficient to keep people safe. This had been addressed and we were assured it could not be repeated.

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

Staff had a good understanding of indicators of abuse and felt confident any safeguarding concerns reported were listened and responded to.

Quality monitoring systems were being embedded to ensure that people's care plans and risk assessments would reflect any changes to their needs. We were assured by the registered manager that they were focussed on ensuring these systems were effective.

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

The provider was working to improve communication with statutory agencies and other interested parties. This included relatives who did not always feel informed about strategic and personnel changes.

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

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good. (report published April 2018).

Why we inspected
This targeted inspection was prompted to review areas of concern that had been identified during discussions with the management of the service during the period of coronavirus lockdown. These issues had been monitored and communication with the provider indicated that they were being addressed. The inspection was timed to ensure the impact of the newly appointed mentors supporting staff in the service

could be reviewed.

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

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

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

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Dorset Learning Disability Service - 56 Maiden Castle Road on our website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

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.

Inspection team
One inspector visited the service.

Service and service type
Dorset Learning Disability Service – 56 Maiden Castle Road (Known as Maiden Castle Road) is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement. The CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the CQC. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider had submitted a Provider Information Return since their last inspection. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We reviewed monthly progress reports from the provider related to all their residential services in Dorset. We looked at notifications received from the service. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive.

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

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

We spent time in the office. We could hear the interactions between staff and people from the office without causing unnecessary anxiety to people. We also spent brief time in communal areas observing staff supporting and interacting with people. We sought feedback from relatives and advocates of everyone who lived at the home by asking the provider to send them our contact details. We received feedback from a relative and a legal representative. We also spoke with one member of staff before we visited.

Whilst at Maiden Castle Road, we spoke with the registered manager, a provider representative, two members of staff and one agency care worker. Following the inspection, we spoke in more detail with the registered manager, a further representative of the provider and another member of care staff. We reviewed quality monitoring and training records. We also spoke with a health care professional who had worked in partnership with staff in the home.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We sought some infection control advice about aspects of policy and practice we discussed with the service and shared that advice. We continued to gather evidence through telephone calls up to the 7 September 2020.

Inspected but not rated

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At the last inspection this key question was rated as Good.

We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about. The purpose of this inspection was to explore the specific concerns we had about Dorset Learning Disability Service – 56 Maiden Castle Road.

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

Assessing risk, safety monitoring and management

- Following calls with the previous managers of the service, we had concerns about how people's rights were being respected alongside the support they received to stay safe. We found that staff had been committed to protecting people from the coronavirus and that this protection had not always been balanced with access to the community as lockdown measures were eased. However, this was being addressed before we visited.
- Staff understood the risks people faced. They spoke confidently about how to reduce these risks. People received support that reflected their care plans to reduce risk. We saw people eating their meal and drinking in the ways outlined in guidance provided by Speech and Language Therapists to reduce the risks associated with eating and drinking.
- The systems designed to ensure risks were monitored and managed had not been fully effective. Information had not been put onto the provider's system for monitoring and some records such as weights had not been completed.
- The registered manager had not been directly line managing the service for a period of time. This had been due to a restructuring of the organisation. They returned to the service in August 2020 and had started to ensure that systems designed to monitor risk were fully embedded. People were starting to enjoy getting out of their house and this was being monitored by senior management.

Systems and processes to safeguard people from the risk of abuse

- People were relaxed with the staff supporting them.
- People were protected from potential abuse and avoidable harm. Staff had undertaken safeguarding training and demonstrated a good understanding of how to protect people from abuse. They felt confident safeguarding concerns reported were listened and responded to.

Staffing and recruitment

- We had concerns raised by staff and a relative that during the initial phase of the COVID-19 pandemic there were not always enough staff working to meet people's needs. We discussed this with staff and senior management. We reviewed the rotas from this time period. The staffing in the home had fallen below safe

levels on three days. The staffing was not safe because only one member of staff had been working and this did not reflect the needs of the people living in the home.

● The senior management acknowledged this and explained both how it had happened and the changes that in oversight and management expectations that had been made to ensure it would not happen again.

● Since the changes in oversight there were enough staff to keep people safe and meet their needs. Some vacant hours had been filled and the home was using a long term member of agency staff to ensure consistent cover could be established by staff who people new well.

● The service was focused on training staff in areas of greatest risk to improve staff skills and confidence. All staff had completed their core training. Further training was being undertaken to enhance specialist knowledge. A mentor was working in the service to help staff to support people to take a more active role in their home.

● We did not look at staff recruitment on this targeted inspection. However, on previous inspections no concerns had been identified in this area

How well are people protected by the prevention and control of infection?

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules within the understanding of people living in the home.

● We were assured that the provider would admit people safely, however, there were no plans for anyone to move into the home.

● We were assured that the provider was using PPE effectively and safely. We have signposted the provider to resources to develop their recording of their approach.

● We were assured that the provider was accessing testing for people using the service and staff in line with current availability.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

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

● We were assured that the provider's infection prevention and control policy was up to date.

Inspected but not rated

Is the service well-led?

Our findings

Our findings - Is the service well-led? = Requires Improvement

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Staff had been through a period of unsettled leadership. They acknowledged that this had been difficult for them as a team.
- There had been failings of oversight that had impacted on the quality and safety of the support people living in the home received. These failings included not planning adequately for maternity cover and failure to ensure a safe number of staff. These issues had been addressed prior to our visit and a comprehensive improvement plan was being monitored by senior staff.
- Audits had led to changes in practice and these had been effective.
- People's care records had been updated and were more accurate and personalised about their care needs. Staff were working with senior management to ensure care delivery records were a good reflection of the support people had received and that they were useful in reviewing and developing support.
- Staff were confident about the skills and knowledge of the registered manager who had returned to work in the home and were positive about senior leadership who were present in the home providing mentoring support.

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

- We saw good practice. For example, staff knew people well and chatted and interacted with them in ways that were meaningful to them. Staff noticed when situations had the potential to cause a person unease and immediately pre-empted this both in their interactions and the way they advocated for people.
- Staff understood the changes being made and were starting to feel confident that their knowledge of people would be respected and valued during this process.
- A provider representative discussed how work with the Tizzard Centre was restarting after the restrictions imposed by COVID-19. This work involved research about introducing better support designed to enhance people's involvement in meaningful activity. They also described other tools that would be provided to the home. This included technological aids to communication that would assist staff to support people in consistent and clear ways. The use of technology was also important to support staff and to ensure continued progress should COVID-19 measures need to tighten again.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People and relatives were consulted and involved in day to day care decisions about care and support. Families and legal representatives confirmed they were consulted in any best interest decisions. Relatives were asked to feedback regarding the quality of care. Attention to the detail of these requests was not always sufficient and this meant a relative was asked to feedback on the care of someone other than their relative. Relatives did not feel they were always kept informed of strategic and personnel changes.

● The provider had kept in touch with families throughout the last few months, when visitors were not allowed to prevent transmission of COVID-19. Technology had been used to support relationships where it was meaningful to the person.

● Liaison between senior management and staff working in the home had been impacted whilst physical access had been restricted to protect people from the coronavirus. Staff explained they had not fully understood the changes in practice that were being implemented. They told us they felt more fully informed, consulted and engaged now that senior staff were available in the home.

Working in partnership with others

● Staff worked in partnership with health and social care professionals such as Speech and Language Therapists. There had been some concerns raised by local professionals regarding communication between Leonard Cheshire Disability and statutory agencies. Leonard Cheshire Disability had been responsive to these concerns and work was ongoing between the provider organisation and local health and social care teams to improve communication and so enhance partnership working.

● Leonard Cheshire Disability was responsive to requests made by CQC for information regarding the oversight of the Dorset Learning Disability Services including Maiden Castle Road. The senior management acknowledged the oversight issues that had arisen during the pandemic and offered reassurances that these would continue to be addressed robustly. We have not been able to review the sustainability of the changes put in place.