Lifeways Inclusive Lifestyles Limited

The Duke's House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Duke's House is a residential care home providing accommodation, support and personal care for people who have a learning disability, autism or a mental health support need. At the time of our inspection three people were living at the home; the service can support up to eight people. The home is across two three storey Victorian properties which have been joined together, in a residential area of New Brighton. Each person has an en-suite room; there were communal areas, and on the top floor office space and a room for staff to sleep in.

At our previous inspection The Duke's House shared the same staff team, management team, outdoor space, office and many other systems with the providers location The Duke's House 3 which was next door.

At the time of this inspection the provider was in the process of making changes that they had assessed would align the service with the values of Registering the Right Support. The provider was in the process of closing The Duke's House 3 and remodelling The Duke's House. Works planned included the redesigning and remodelling of outdoor space and changing some aspects of the outward presentation of the home. The provider told us that these changes will result in The Duke's House fitting in with properties within the local community.

There were some indicators that the three people living at The Duke's House had benefited from living with fewer people. Some progress had been made in aligning people's support with the principles of Registering the Right Support. However, we are aware that most of the changes planned had not yet happened. Many of the changes to the interior of the building had not yet taken place and a further five people were due to move into the home. This will make the home larger than typical domestic style living arrangements, with eight people living in the home supported by a larger staff team. This is the third inspection when the home has not been full; it is not known if the redesign of the accommodation will mitigate any impact on people's choice, control and independence.

The provider had completed an internal audit of the service against the principles of Registering the Right Support. We recommended that the provider continue to assess themselves against these principles which include the values of choice, control and independence when providing care and accommodation for people.

People's experience of using this service and what we found
Leadership of the service remained inconsistent and the systems for checking on the quality and safety of the service had not always been effective. The manager in place during our last inspection had left; and the service had been led by interim managers since then. An existing manager who is registered with the CQC from one of the providers other services had recently been appointed as manager of The Duke's House.

We have made a recommendation about the health and safety systems at the home.

We have also made a recommendation about the management of some medicines.

At times there remained some disconnect between the described ethos of the service, care planning and how staff supported people on a day to day basis. Staff gave us mixed feedback regarding the atmosphere and culture within the home. Some staff still described aspects of the culture as negative.

Communication and partnership working had improved in some areas. However, family members of the three people living at The Duke's House told us that although they think that the changes at home sound "great"; the communication with the provider during these changes had been poor. The provider still did not have a coherent vision that was agreed and understood across all health and social care professionals, family members, managers and support staff.

People told us that they felt safe living at The Duke's House and staff were kind towards them and treated them well. They told us that they felt comfortable speaking with staff members and would be confident if they needed to raise a concern. Family members praised the support staff, one called them "wonderful"; another relative told us that their family member felt "happy and safe at the home".

The provider had made some positive changes to their approach towards supporting people at The Duke's House. For example, any restrictive practices in place had been reviewed and a restraint reduction plan had been put in place. Each person had an individual risk screen in place. This outlined the identified risks in a person's care and support and ensured that guidance was available for staff.

There had been an improvement in the application of the values and principles of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence. Some of the redesigning of the home was focused on people increasing their independence, for example, building a second more accessible kitchen area for people to use. Also, some of the internal doors within the home that had previously been locked were now unlocked so that people had access to the kitchen, including food storage and preparation areas.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 3 April 2020) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection some improvement had been made; however, the provider was still in breach of regulation.

Why we inspected
We carried out an unannounced comprehensive inspection of this service in December 2019. Breaches of legal requirements were found. We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions 'Is the service safe?' and 'Is the service well-led?'.

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 coronavirus and other infection outbreaks effectively.

The ratings from the previous comprehensive inspection for those key questions not looked at on this

occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from inadequate to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Duke's House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified breaches in relation to assessing the quality and safety of the service provided for people. Please see the action we have told the provider to take at the end of this report.

Follow up
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.

This service has been in Special Measures since 3 April 2020. During this inspection the provider demonstrated that some improvements have been made. However, this was a focused inspection and the rating of every key question was not reviewed. The service is no longer rated as inadequate overall but remains inadequate in at least one key question. Therefore, the service remains in Special Measures.

This means we will keep the service under review and, we will re-inspect within 6 months to check for significant improvements. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

The Duke's House

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
The inspection was carried out by two inspectors.

Service and service type
The Duke's House 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.

Since our last inspection In December 2019 the service still did not have a manager registered with the CQC. A manager who was registered with the CQC at another of the providers homes had recently moved to The Duke's House and was applying to CQC for registration. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we wanted to make sure arrangements could be made to make sure the inspection took place as safely as possible during the COVID-19 outbreak.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority's quality assurance team. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make.

During the inspection
We spoke with two people who used the service and three of their family members about their experience of the care provided. We spoke with ten members of staff including representatives from the provider, the area manager, incoming manager, health and safety lead, deputy manager and support workers.

We reviewed a range of records. This included three people's care records, multiple medication records and a variety of records relating to the management and safety of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with three health and social care professionals who are involved with the service.

Requires Improvement

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 inadequate. At this inspection this key question has now improved to requires improvement. This meant that, although there had been significant improvements some aspects of the service were still not consistently safe and further improvements were required.

Assessing risk, safety monitoring and management; learning lessons when things go wrong

At our last inspection the provider had failed to assess, monitor and manage risks. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, improvements had been made and the provider was no longer in breach of Regulation 12. However, we have made a recommendation about the management of some aspects of health and safety.

- The food safety recording system was disorderly and had not been maintained. Most records were missing going back to mid July 2020. These included records of storing food at a safe temperature in the fridge and freezer, and the records of food cooking temperatures.
- Since our previous inspection the kitchen area had been made accessible to people living in the home. However, this needed to be done safely. We identified cleaning products were in the cupboard under the sink which was not locked and accessible. These products had hazardous warning labels which would be covered by COSHH guidelines and needed to be stored safely.

We recommend that the provider review their health and safety systems at the home.

- Each person had an individual risk screen in place. This outlined the identified risks in a person's care and support and ensured that appropriate guidance was available for staff.
- Any medication administered to help people manage their anxiety or any physical restraint used by staff was clearly documented and reviewed to ensure that it was appropriate and was the least restrictive option when supporting people to stay safe.
- Records were maintained of any accident or incident that caused or had the potential to cause harm or injury to a person or damage to property. These records were completed by the staff members involved in supporting people and were reviewed by senior staff. These reviews looked for any opportunities for learning and helped ensure that people received appropriate support.

Using medicines safely

- Each person had a medication file which contained information about their medication support needs. Staff administering medication had all necessary information available to them and had been trained in medication administration. Records were kept of each person's medication administration. Medication was stored securely; however, records of medication fridge temperatures were not maintained as required.

We recommend the provider consider current guidance for maintaining medication records and take action to update their practice.

● People's use of as and when required medication (PRN) was recorded and monitored. Some people used PRN medication to help relieve anxiety. There was detailed guidance for staff on when it was appropriate to use PRN medication and what support should be offered to a person before administering PRN medication.
● We noted that people's care records had not consistently recorded what support had been offered to a person prior to the administration of PRN medication.
● People's medication had been reviewed with health professionals and this had led to some people's medication being reduced.

Systems and processes to safeguard people from the risk of abuse
● People told us that they felt safe living at The Duke's House and staff were kind towards them and treated them well. They told us that they felt comfortable speaking with staff and would be confident raising any concerns with them. Family members praised the support provided by staff, one described them as "Wonderful" and another told us that their relative felt "Happy and safe at the home."
● Staff had received training in safeguarding adults at risk of abuse. Appropriate referrals had been made to the local authority's safeguarding team.

Staffing and recruitment
● Staff and family members told us that there had been a very high turnover of staff and the staff team remained unstable. The provider told us they had enough staff. They told us that recent changes to the rota and the merging of three teams had caused some unsettlement and disruption to the staff team.
● There was enough staff to meet people's needs when we visited. The staff rota showed that appropriate numbers of staff had been planned.
● The provider had a centralised system across their services to ensure that new staff were recruited safely in line with best practice.

Preventing and controlling infection
● The provider had completed an infection, prevention and control risk assessment (IPC) which included risks associated with COVID-19. This had been regularly reviewed and updated in line with current guidance.
● Visiting restrictions were in place due to COVID-19. There were measures in place to ensure it was safe for essential visitors to enter the home.
● Staff had received IPC training and they followed good IPC practice. There was a good stock of personal protective equipment and staff used it appropriately. People confirmed staff wore PPE.
● There had been a pause in the regular testing of staff for COVID-19 due to the availability of testing kits. This had been resolved and testing had resumed.

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 inadequate. At this inspection this key question has now improved to requires improvement. This meant that there had been some improvements to the management and leadership of the service; however, it remained inconsistent.

At our last inspection the provider had failed to assess and improve the quality and safety of the service provided for people. This included a failure to ensure people's fundamental human rights were being upheld, the promotion of people living as ordinary a life as any other citizen, including people in a meaningful way and failing to promote choice, people taking control and increasing in independence. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found some improvement to the providers oversight of quality and risks. However, some of the systems in place remained ineffective or were at an early stage and had not yet had an impact on people's lives. The service remained in breach of Regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.
● The providers oversight of quality and risks had improved in some areas. However, some of the systems had not been consistently effective. For example, some of the recording systems in place that helped to ensure safe practices took place had not been maintained.

The provider's assessing of the quality and safety of the service provided for people had not always been effective. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was a clear audit trail of how any incidents when supporting people had been managed and how people had been respectfully supported to remain safe during difficult times.
● Oversight of people's rights being maintained had improved.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Leadership remained inconsistent and there had been multiple changes of managers over the previous 12 months. The manager in place during our last inspection had left the service. The home now had a new manager in place who had moved from one of the providers other services. They were planning on registering with the CQC. The provider told us that they had been supporting the service over the previous 12 months using managers from other areas of the organisation.
● At times there remained some disconnect between the described ethos of the service, care planning and

how staff supported people on a day to day basis. Some aspects of the service remained institutionalised and didn't promote people living ordinary lifestyles. Senior staff within the organisation told us that although the service had improved, it was acknowledged that there were still many improvements to be made.

● Staff gave us mixed feedback regarding the atmosphere and culture within the home. Some staff still described a negative culture.

● The provider had made some positive changes to their approach towards supporting people at The Duke's House. For example, any restrictive practices in place had been reviewed and a restraint reduction plan had been put in place. Most documents when referring to people, had a more respectful tone and used non-judgmental and more everyday language.

● At the start of 2020 there had been plans put in place with people to have new experiences and achieve positive outcomes. Many of these had changed and some put on hold during the pandemic. There had been an understandable change of focus to supporting people to remain as safe as possible. However, people chose how to spend their day as much as possible.

● The provider was in the process of redesigning and refurbishing the Duke's House. Some of the redesigning of the home was focused on people increasing their independence, for example, building a second more accessible kitchen area for people to use. Also, less of the internal doors within the home were locked so that people now had access to the kitchen, including food storage and preparation areas.

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

● Since our previous inspection the provider has been in regular communication with the CQC providing us with regular updates. This communication was candid and highlighted events that had taken place and areas of the service that still required improvement.

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

● Relatives felt that although the changes at home sound "great"; the communication with the provider during these changes had been poor. They described a lack of proactive consultation. Some family members told us they had difficulty communicating with their relative during COVID-19.

● Feedback from the staff team remained very fragmented and mixed. The provider still did not have a coherent vision that is agreed and understood across all health and social care professionals, family members, managers and support staff.

● There was evidence that the three people living at The Duke's House had been involved in some of the changes being made and had helped to choose how the home was decorated. People had been consulted about the changes to the decoration of their rooms and with choosing new furniture. People told us they were happy with the changes being made.

Continuous learning and improving care; working in partnership with others

● The provider told us that our previous inspection has been a catalyst for them to make significant changes to the environment of The Duke's House and an overhaul of the systems used within the service. These changes had started and remained ongoing.

● The provider has been in regular communication with the lead local authority. Overall there was positive feedback from health and social care professionals; however there remained some concerns regarding the quality of communication and how learning from recent events was being embedded.

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 17 HSCA RA Regulations 2014 Good governance The provider had not consistently assessed the quality and safety of the service provided for people.