Care Quality Commission

Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Dorset Learning Disability Service - 3 Cranford Avenue

3 Cranford Avenue, Weymouth, DT4 7TN

Tel: 01305839318

Date of Inspection: 05 December 2013

Date of Publication: January 2014

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Management of medicines	✓ Met this standard
Staffing	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	Leonard Cheshire Disability
Registered Manager	Mr. Keith James Brown
Overview of the service	3 Cranford Avenue is a detached property near the centre of Weymouth. The home provides accommodation, personal care and support for up to four people with a learning disability.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 5 December 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

What people told us and what we found

During our visit we were unable to speak directly with most people who lived in the home due to their complex needs. We spoke with one person who lived in the home.

The registered manager was on sickness leave at the time of our visit. A team leader, from one of the provider's other homes, was in attendance to assist with our inspection.

We spoke with the relatives of two people who lived in the home, via the telephone. People's relatives told us that they felt positive about the quality of care people received; and with their families relationships with the staff. We observed residents moving freely around the home and interacting with the staff in a relaxed way.

People and relatives told us that they were asked for their consent when making choices and decisions about their daily lives; and that people's choices and decisions were respected by the staff. A person told us, "The staff are nice – Staff ask me what I would like."

The service had procedures in place to ensure that people received their medicines as prescribed. Medicines were handled in a secure way.

We found that there were sufficient numbers of staff, with the right competencies. A support worker told us, "I've been here since the house opened – I can use some Makaton – I have NVQ 3."

The home was taking account of people's comments or complaints. Relatives told us that they could be sure that their comments were listened to, and responded to appropriately.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

Overall, we found that people's consent to care and support was valid. People understood and knew how to change any decisions about their care and support, and that people's human rights were respected.

We saw that people's agreement was sought prior to staff supporting them. For example, we saw a person being asked if he would like to accompany staff on a trip. We saw staff asking another person if they wanted to assist in the kitchen. The member of staff gained the person's agreement. A person told us, "The staff ask me what I would like – I get to choose what I would like to eat"

A senior support worker told us that there was no person in residence at the home who was the subject of a Deprivation of Liberty Safeguards (DoLS) assessment. DoLS ensure that there are systems in place so that if a person lacks the capacity to consent to their care or treatment, their freedom is not restricted more than necessary, and any restriction is in their best interests.

We looked at three people's care records. We noted that people's care records were cumbersome. None of the records we viewed contained signed consent forms in regards to people's care and treatment and the use of photographs in records. However, a team leader showed us the new procedures the provider was introducing. This included care planning and consent documentation. The team leader told us, "We are introducing comprehensive person centred plans, commencing in January. All the information in these files will be transferred into the new PCP documentation."

The team leader showed us the new care planning documentation on the provider's intranet. This contained comprehensive materials for the planning of people's care, and a consent form that comprehensively covered data protection, discussions about service provision, medication, support preferences, audio/visual materials, and consent to personal care. The team leader told us, "We are working on providing written evidence of

people's consent. This will be rolled out in January."

We saw that the care records we viewed contained the provider's procedure, 'Making decisions on behalf of the service user in line with the Mental Capacity Act 2005.' This gave guidance to staff on testing people's capacity and who they should consult in the event that a person lacked capacity. A senior support worker told us, "The people here have capacity for day to day decisions. They can let us know what they want." This meant that people were not at risk of being excluded from making decisions for which they were mentally capable on a day to day basis.

We spoke with the registered manager via the telephone during our inspection. They told us, "People can make day to day decisions, and we are very good at asking people for their consent. But, if it involved a complex decision, we would hold a best interest meeting, and involve families and social workers – If staff were unsure about someone's capacity, they would ask either myself or the senior on duty."

We spoke with a senior support worker and three support workers. They all confirmed that if they were concerned about a person's capacity, then they would inform their manager. Three of the staff we spoke with told us that they had received training in the Mental Capacity Act 2005 (MCA). We viewed staff training records, and saw that most staff had received MCA training in 2010. However, staff we spoke with told us that they felt unsure about the MCA procedures. A support worker said, "I think we would all benefit from refresher training around mental capacity." Following our inspection we spoke with the service manager via the telephone. They told us, "We are planning to do some internal training with staff on our mental capacity act procedures. We do recognise that we need to do some internal training to back up the training provided by the county council."

We noted that where people had a power of attorney (POA), their records did not contain details as to the type of POA held, and whether it gave the holder the right to make health and welfare decisions on behalf of the person. The registered manager told us, "Two people have family who hold POA. I don't know what types of POA's they have, as the families have been reluctant to provide us with of details of these. But, as all the families are supportive here, I will ask them to clarify."

We saw that two of the three records we viewed contained information on advanced decisions. One person's record contained a co-op funeral care plan. This meant that the home could follow any advanced decisions people had made.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

Overall, we found that the people who use this service were involved in their assessment and care planning, and were treated with dignity and respect.

During our inspection we looked at three people's care records. A team leader also explained the home's assessment procedures. At the time of our inspection we could not view people's pre-assessment records, as the registered manager was on sick leave, and the staff could not locate these. However, the senior support worker provided us with copies of these, following our inspection. The senior support worker told us, "People's individual support plans (ISP's) are drawn from the pre-assessment initially. But the ISP's are built up over time by reviewing people's care."

We viewed three people's paper based care records. The records contained support plans that followed the home's procedures for assessment and care planning. These included assessments of people's eating and drinking needs, daily routines and personal hygiene, and communication needs. For example, a person's communication care plan contained a communication passport, this gave guidance to staff on how to meet the person's communication needs. The support plan recorded, "I need people to use clear concise language -- When I am upset I need direct instructions." The person's communication passport also included guidance for staff on 'total communication', a communication system the person used that involved the use of pictures and symbols; and guidance for staff on the use of Makaton, this is a language programme designed to provide a means of communication with people who cannot communicate efficiently by speaking

The senior support worker demonstrated how the home's care planning system was used to ensure that assessments and care plans identified people's specific needs and risks to people's wellbeing. For example, we saw that people's ISP's contained behavioural support plans. One person's plan included a 'traffic light' system. This provided guidance for staff on interpreting the person's behaviour, and recognising the person's behavioural cues. The support plan recorded, "The first thing to do is use his communications book."

We saw that people's records contained risk assessments. These included plans for supporting people in the home; and when 'out and about' in the community. This meant

that the risk of people receiving inappropriate care and treatment was reduced because the home was assessing people's needs, and planning appropriate care to meet people's identified needs.

We noted that people's care had been reviewed regularly. We saw that people had been involved in their care reviews and that these were signed and dated to indicate that the person had been involved. We saw that people's care records included information about whether people were able to make decisions and the kind of decisions they could make independently. However, we noted that where people's care records recorded that someone else acted on their behalf, the record did not clearly clarify the legal status.

During our visit we spoke with one person who lived at the home. They told us that they were involved in how their care was provided. We asked them how staff maintained their privacy and dignity. They told us that staff knocked before entering their room. They added, "The staff knock on the door when I am in the shower."

We heard staff speaking to people in a respectful and polite manner. A person told us, "I get to choose what I would like to eat." A senior support worker told us, "We try to get people to do as much as they can for themselves. We encourage them to keep the home clean." A person told us, "I like hoovering, and I make my own bed."

We spoke with the relatives of two people who lived in the home. Relatives told us that their family members were supported to access healthcare professionals if needed. A person's relative told us, "If he's been to the doctor's they let me know. He had his flu jab the other day and I was told." A senior support worker told us, "We would talk people through things. When they need annual health checks they might say no. We would make another appointment – We have a service user who won't go to the doctor's surgery. But they know him, and they come to the house."

We saw that people's records contained records of people's appointments with or visits to other professionals. These recorded who the professional was, the reasons for the appointment, and any outcomes and advice given.

The home had procedures for recording accidents and incidents. We viewed the provider's 'reporting of and learning from serious incidents guidance and procedure'. This gave staff guidance on the reporting procedure for accidents or incidents. The guidance also included information on how the provider would monitor incidents, to ensure that lessons were learnt and to reduce the risk of similar incidents occurring.

We asked a senior support worker about the home's procedures in the event of emergencies or situations that could lead to disruptions in services. The senior support worker showed us the home's emergency plan. This included: the telephone numbers for utilities providers in the event of a disruption to services; the location of the home's mains supplies of electricity gas, and water; G.P lists; hospital contact details; and the contact details for the local authority emergency planning unit. The plan also contained the procedures in the event of missing people.

The team leader told us that in adverse weather conditions, "We have an employee with a 4X4. We could get people in to work." This meant that people were protected from emergencies or situations that could lead to disruptions in services.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

Overall, the home was protecting people against the risks associated with the unsafe use and management of medicines, by means of the appropriate administration and management of medicines.

During our visit we saw that medicines were stored securely in locked medication safes in people's bedrooms. This meant that the home had appropriate arrangements for the safe keeping and handling of medications.

A senior support worker told us that no medicines were in use that required refrigeration. They said, "We don't have any medicines that require refrigeration at the moment. We would store medicines that required refrigeration in the kitchen fridge, and record temperatures daily."

We did not see any medicines being administered to people at the time of our visit. However, we viewed people's Medical Administration Records (MAR). Staff we spoke with told us that they provided people with drinks of water to enable their swallowing of tablets. Staff told us that they supervised people until they were sure the medicines had been taken. A senior support worker told us that the home did not have anybody in residence that self-administered their medication at the time of our visit. We saw that people had signed consent agreements for staff to administer their medications.

We noted that entries on the MAR had been signed. We spoke to the registered manager via the telephone. They told us, "I audit medications monthly."

We saw that people's prescriptions were up to date, and that new quantities of medication were recorded on the MAR. A senior support worker explained the home's procedure when medicines had not been administered. They told us that staff recorded the reasons why medicines had not been administered by completing a code on the MAR, and recording the reasons in full, why medicines had not been given, on the reverse of the MAR. This meant that people's medications were given to people in line with their prescriptions.

We were unable to view the home's controlled drugs storage or register at the time of our inspection. A senior support worker told us, "We don't have any controlled drugs." A team leader told us, "We would store controlled drugs for any of the area's homes in the area office, as the individual homes don't have controlled drugs safes. A member of staff would collect controlled drugs and bring them to the home for administration." The team leader said that controlled drugs were stored in a controlled drugs safe which was locked when not in use, and would be recorded in the controlled drugs register. The team leader said that two members of staff would sign the register when the drugs were received and administered, and that two staff members would complete the returns documentation if medicines were to be returned to the pharmacy. This meant the home had arrangements in place for the safe administration and disposal of medicines.

We saw the service's medications policy. This was comprehensive and available in the home's medications file. This gave guidance to staff on the safe supply, receipt, storage, administration, security, disposal, returns to the pharmacy; medication errors; and the safe handling of controlled drugs. The policy was also available to staff on the provider's intranet. Training records we viewed confirmed that staff had received training in medication administration.

A team leader showed us a quick reference guide that the Leonard Cheshire Dorset Disability Service had produced. This provided staff with accessible guidance on the safe administration of medication. We also saw that the home had a copy of the British National Formulary (BNF). This is a reference source that provides guidance on the selection, prescribing, dispensing and administration of medicines. A senior support worker told us, "We get the BNF updated regularly." This meant that the home was taking account of published guidance on the safe use of medicines.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

Overall, we found that people's care needs were met by sufficient numbers of appropriately skilled and experienced staff.

During our visit we spoke with a senior support worker and three support workers. A support worker told us, "I've been here since the house opened, four and a half years ago. I know the residents very well – There are definitely enough staff to ensure people's safety." Another support worker said, "There are always enough staff here. It's usually a ratio of one to one; but, we also have an extra on house member of staff who floats."

We viewed the home's staffing rota and shift plan. We saw that staffing levels were consistent with the rota. We asked relatives about the home's staffing levels. A person's relative said, "There are always enough staff. There are usually four during the day." Another person's relative told us, "There is always enough staff on duty."

A senior support worker told us that the home covered staff absence, holiday and training by staff volunteering to take on extra shifts. They said, "We've got quite a stable team; there is a big team of staff here; there is always staff who can pick up shifts -- This home needs familiar faces. It has to be staff who are familiar with the service users." This meant that there was enough staff who knew the needs of people who lived in the home, to ensure that people experienced a consistency of care.

The registered manager told us via the telephone that they audited staff: annual leave; sickness absence; and staff training hours on a monthly basis. This meant that the service had management structures and clear human resource procedures that were followed in practice, monitored and reviewed, that enabled the effective maintenance of staffing levels.

We saw that comprehensive policies and guidance, as well as e-learning, was available to staff on the provider's intranet. A senior support worker told us that printed copies of the provider's policies and procedures were available to staff in the home's office. However, the provider might find it useful to note that we spoke with three support workers, who all told us that they were unable to access the policies and procedures on the provider's intranet. A support worker told us, "We were told we would have log-ons over a year ago,

but it hasn't happened yet."

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

Comments and complaints people made were responded to appropriately.

Reasons for our judgement

Overall, we found that people's comments and complaints were listened to and acted on effectively. The home had systems in place to support people who used services or others acting on their behalf to make comments and complaints.

The team leader told us the home's complaints system was brought to the attention of people who live at the home, and their relatives, via the home's service user guide. We saw that the home also had a complaints leaflet that contained information on the providers complaints procedure and the contact details for the Care Quality Commission (CQC).

We spoke with the relatives of two people who lived at the home. They told us, "I've never made a complaint, as I've never felt the need. I don't think I have a guide to services. I would be happy to make a complaint; but, I wouldn't know how to do it. But if anything is wrong I contact the manager and we talk about. They are very good at listening." Another person's relative told us, "I think I have got some information, from when he first moved in. But I've got no complaints. The staff' are wonderful. He always looks nice and clean. I've got no concerns. They bring him here to visit me, and he's always happy to go back."

We saw that people's care records contained a 'Have your say' booklet. This detailed the home's complaints procedure in pictorial and easy read formats. However, the manager might find it useful to note that there were no records to confirm that the booklets had been discussed or read with people.

We viewed home's published complaints policy and procedures. The policy set down timescales for the acknowledgement of, and investigation into, formal complaints. We also viewed the provider's guidance for staff, 'dealing with customer feedback.' This gave staff guidance on how to manage people's concerns. A senior support worker told us, "We haven't had any complaints. If we received a complaint we would immediately forward it to the service manager." A team leader told us that complaints would be monitored by the service manager as an aspect of the provider's quality assurance monitoring. This meant that the home had procedures in place to ensure that complaints relating to the care provided to people were appropriately investigated.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk