Mr Brian Jack

Duckyls Farm Centre

Inspection report

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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?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

About the service:

Duckyls Farm Centre is a residential care home providing personal care and accommodation for people with learning disabilities and autism. There were eight people living at the home on the day of our inspection.

The home was a large adapted farm house building that combined a self- contained flat and main building over two floors. The building was bigger than most domestic style properties. It was registered for the support of up to 10 people. The service applied the principles and values of Registering the Right Support and other best practice guidance. These ensure the 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.

People's experience of using this service:

Since the previous inspection, there had not been sufficient improvements in relation to quality monitoring and governance. The provider did not have effective quality assurance systems to ensure a good level of quality and safety was maintained.

People were potentially at risk due to shortfalls in relation to the management and oversight of; accident reporting, restraint practices, epilepsy care planning, mental capacity assessments, gaps in staff knowledge and/or training and inconsistent record keeping. In addition to this the provider was not always meeting their regulatory responsibility to notify the Commission of significant events.

People were not consistently safe from the risk of abuse. Staff were trained and had an awareness of how people with learning disabilities could be placed at risk. However, incidences of abuse were not always identified and reported in a timely way so that they could be investigated, acted on and learned from.

People were not consistently supported in the least restrictive way possible; the policies and systems in this service did not support this practice. Staff received some training and told us they felt well supported. However, staff had not received accredited training in positive behaviour support and restraint in line with their policies and best practice models. This placed people at potential risk of not having their legal right to

liberty respected.

The provider recognised they needed to make further improvements to the oversight of the governance of the service. They were in the process of recruiting a 'registered manager' to ensure the day to day running of the service was sufficiently robust.

The outcomes for people living at Duckyls Farm Centre were personalised and reflected the caring values of the staff supporting them. One person told us, "The staff know how to help me, all the staff are nice and like me, they give me help, care, love and kindness."

There were enough staff to meet people's needs and they were recruited safely. People were comfortable with staff and were cared for in a safe, friendly and calm environment.

People had access to a range of activities that met their interests and reflected their diverse needs and cultures. A relative told us, "My relative enjoys watching sports, listening to music and going to church is a big part of their life. They go horse riding and really like being on the land with the animals, we come from a family of farmers, the outdoor life is something that they love."

People were supported to maintain a healthy nutritious diet and had access healthcare services and professionals as and when needed. One relative told us, "They motivate people and ask them to do things and ensure they are active and enjoying themselves. My relative recently joined a gym. They have had a lot of operations and for a long time were less capable. Now they can walk more easily and are getting fitter."

People were encouraged to express their views and their communication needs were met. A relative told us, "The staff support my relative very well, they understand their facial expressions and demeanour. They are listened to and have a key ring with pictures that they use to make choices." Staff were asked for their opinions on the home and felt supported within their roles. When needed end of life care could be planned for and people and their relatives' wish's respected.

People's privacy, dignity and independence was important to staff and promoted. One person told us, "Staff always ask before they help me." Another person told us, "I like to cook and help people. I can make an apple crumble and the people love it."

Medicines were managed in accordance with current regulations and guidance. There were systems in place to ensure that medicines had been stored and administered appropriately. Risks associated with some people's care and the environment had been identified and managed. Emergency and infection control procedures were in place and people knew what to do, as did the staff.

Rating at last inspection:

At the last inspection the service was rated Requires Improvement, including breaches of regulation and we serviced a Warning Notice. (Published 24 December 2018). At this inspection the service remained Requires Improvement.

Why we inspected:

This was a scheduled comprehensive inspection based on our methodology. At this inspection we identified areas that required improvement, including breaches of regulation.

Enforcement / Improvement action we have told the provider to take

Please see the 'action we have told the provider to take' section towards the end of the report.

Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.

Follow up:

We will be in contact with the provider following this report being published to discuss how they will make changes including; seeking an action plan, requiring positive measures and working with partner agencies to ensure they improve their rating to at least good.

For more details, please see the full report which is on the CQC 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?

Requires Improvement

The service was not always safe

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

Duckyls Farm Centre

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:

The inspection team consisted of one inspector.

Service and service type:

Duckyls Farm Centre is a 'care home' that provides personal care for a maximum of 10 people. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of inspection eight people were living at Duckyls Farm Centre.

The home had a registered provider. A registered person is a person who has registered with the Care Quality Commission to manage the service. Like registered managers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. Day to day management of the service was carried out by an assistant manager and the provider was in the process of recruiting a manager.

The home had been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people using the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people

living with learning disabilities and autism to live meaningful lives that include control, choice and independence. People using the service receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

Notice of inspection:

We carried out this inspection on 7 and 9 May 2019. The inspection was announced as we wanted to ensure the relevant people were available at the service including the people who lived there.

What we did:

What we did before the inspection:

We reviewed notifications we had received from the home about significant events. We had not received any since the last inspection. Notifications are information that provider is required by law to tell us about. The provider had completed a Provider Information Return to tell us key information about their service including; what they do well and improvements they plan to make. We used this information to inform our planning of the inspection. We also considered information sent to us from other stakeholders including, one local authority commissioning team, two social care professionals and members of the public.

What we did during the inspection:

During the inspection we observed the support that people received in the communal areas. We spoke to six people, six relatives, three care staff, the assistant manager and the provider. We spent time throughout the two days observing how people were cared for as well as their interactions with staff and visitors. This helped us to understand their experience.

We reviewed two staff files, policies and procedures, compliments and complaints recording, incident and accident records, meeting minutes, training records and surveys undertaken by the service. We also looked at the menus and activity plans. We looked at four people's individual records, these included care plans, risk assessments and daily notes. We pathway tracked some of these individual records to check that care planned was consistent with care delivered.

Requires Improvement

Our findings

At the last inspection on 25 September 2018, we asked the provider to take action to make improvements. This was because people were not always protected from risk of harm, and risks to people's wellbeing had not always been reduced because the provider had not always fully investigated 'near miss' events. People's care plans or risk assessments were not always reviewed when their needs or behaviours changed. At this inspection some improvements had been made. However, we found further areas and practice that required improvement.

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse;

- People were not always protected from abuse. The provider had not consistently made the funding or host local authority aware of incidents in line with their safeguarding and restraint policies to help ensure people were protected from potential abuse, and that incidents were thoroughly investigated.
- There were two occasions where incidences had occurred which had not been reported in a timely way to the local authority or the Care Quality Commission (CQC). One incident related to the potential use of unlawful restraint by securing a door and another related to a person disclosing that they had been verbally abused by another person.
- One incident in November 2018 had been identified during a local authority review in January 2019. This related to an incident where one person had been restrained by being physically directed to their room. A door handle had been secured during the incident when the person had grabbed a staff member's arm.
- The provider had guidance in place for staff to support the person if they became agitated. There was also physical intervention guidance that had been provided in Deprivation of Liberty Safeguards (DoLS) documentation. However, when the local authority had reviewed the incident they had confirmed they had not received a consistent account of the methods used to move the person to their room. Further to this, there was no current DoLS on the local authority's system that authorised the intervention to take place. The provider had been informed that the concern would be escalated as a safeguarding incident.
- Staff told us, and guidance detailed, what actions staff could take to reduce the person's level of agitation. Guidance stated this 'can be done by persuasion, if resisted, should be moved in an appropriate manner' if the behaviours escalated. However, there was no assessment that the restraint used was the least restrictive

option or robust guidance on the physical intervention used to ensure the person's and staff safety.
● There was no current best practice guidance or training for staff about the type of physical intervention they should use to move the person in 'the most appropriate manner' and staff gave varying accounts of how they supported the person to their room.

● During feedback from a relative and the assistant manager, we were made aware of an incident where a person had needed support to attend an unplanned emergency hospital appointment in November 2018. However, they had initially been resistant to going and there were inconsistent accounts of how they were physically supported to attend the appointment. The visit and outcome to the appointment were recorded in the person's daily schedule, however the intervention used had not been recorded or any lessons learnt identified through incident reporting and care planning.
● Another incident was disclosed in March 2019 during a capacity assessment. This related to verbal abuse experienced in September 2018. This was recorded, but not identified as a safeguarding concern until the adult social care professional raised both safeguarding concerns with the local authority.
● We shared our concerns with the assistant manager and provider that safeguarding incidences had not been identified before the local authority had noted their concerns. They confirmed they had not been raised as safeguarding incidents as they believed had guidance in place. In response to the local authority feedback they had completed an urgent DoLS authorisation at the local authorities request and one safeguarding enquiry was continuing. The provider informed us following the inspection that all such incidents would now be reported to the relevant authorities.
● Although staff had received training and were able to describe the types of abuse people with learning disabilities may experience, people had been at risk of potential abuse due to shortfalls in the assistant manager and provider's understanding of safeguarding. For example, had not identified or escalated the concerns to safeguarding authorities in a timely way to ensure people were fully protected and further risks of harm mitigated.
● Failure to ensure people were protected from potential abuse placed them at risk of harm and was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● At the last inspection, the provider had not fully considered the potential risks to a person living with epilepsy taking a bath unsupervised and taken measures to lessen the risks to that person. At this inspection, some improvements had been made in relation to epilepsy awareness and training. Senior staff had attended epilepsy training and shared their knowledge with the wider team which had informed practice. For example, a daily record was completed to monitor seizures and general guidance on managing seizures was available to staff.
● The guidance needed further work to ensure staff could safely meet the person's needs. The person's care plan and risk assessments had been updated acknowledging the risk of epilepsy to the person when bathing and at night. Staff told us that the person had not had a recorded seizure for several years and had taken staff advice and not taken a bath unsupervised.
● However, the care plan did not work in line with the provider's own policies. For example, there continued to be a lack of guidance in relation to the frequency and types of seizures the person was at risk of having. There was no assessment to ensure the use of a listening device to monitor the person at night was the least restrictive support. This is important so that staff could identify the likelihood and severity of any seizure and ensure that the person's rights to privacy were considered and respected. This is an area we have identified for improvement.
● People and relatives consistently told us they felt safe. One person told us, "I like living here it makes me feel happy. If I didn't feel safe I would tell someone." A relative told us, "The safety is great, people know their

boundaries and staff are aware of where people are, if they are on the farm or shopping, they do that well." Another told us, "They take care of people very well, they are very attentive, they take them out and they are very safe".

● Environmental risks were identified and managed appropriately through health and safety checks including the management of food hygiene, fire safety and utilities. Personal Emergency Evacuation Plans were in place to ensure people would receive the right support in the event of a fire.

● Risks to people were assessed and managed for people's safety. For example, people at risk of malnutrition or intolerance of food types had their weight monitored and there was nutritional guidance provided for staff, so they could ensure the person ate a suitable diet and maintained a healthy weight.

● People's care plans included a range of risk assessments that guided staff on the level of risk, how it may occur, and how they could minimise the risk to people.

● Staff told us they understood the importance of protecting people and their colleagues from all types of discrimination and this was recognised in their equalities and diversity procedures. One staff member's religious beliefs were known and respected by colleagues and cultural observance in relation to a vegetarian diet supported through menu planning.

Staffing and recruitment

● There were enough staff to ensure people were cared for and supported safely.

● Staff told us, and we observed that staff were consistently present and attended to people when they were needed. One staff member told us, "The assistant manager ensures staffing levels are suitable, even in February and March when the last bits of annual leave need to be taken, they pace the leave, so we can take our leave without it impacting on staff or the people living here."

● Recruitment processes were followed to ensure that staff were safe to work with people. Improvements had been made and staff files were available at the home and included application forms and references from previous employers to ensure staff were suitable to employ.

● Checks had been made with the Disclosure and Barring Service (DBS) for new staff. The DBS is a national agency that keeps records of criminal convictions. One relative told us, "Staff tend to stay long term, that builds good relationships and I have never met any staff that have made me feel uncomfortable."

Using medicines safely

● People received their medicines safely. The home was following protocols including audits to ensure the receipt, storage, administration and disposal of medicines was carried out safely.

● People were receiving their medicines when they should and with their consent. For example, one person's medicines had recently been reduced. The senior carer told us that they had updated the person's, notes, shared the changes with staff and relatives to ensure everyone was informed. They said, "I felt it was important to get the changes right, the person was very aware of the changes too, they were really involved."

Preventing and controlling infection

● Risks associated with infection control were managed by the safe use of protective equipment such as staff wearing disposable gloves.

● People were reminded to wear the correct clothing when working on the farm site and encouraged to wash their hands and remove their working clothes when returning to the home.

● Staff told us they received infection control training, and infection control audits were completed regularly to ensure that the cleanliness of the home was maintained. One person told us, "The home is clean and well

looked after, we clean the house to make sure the mice don't come in from the farm. We have to be careful with food and keep it clean."

Requires Improvement

Our findings

At the last inspection on 25 September 2018 we asked the provider to take action to ensure that people's rights in relation to the Mental Capacity Act (MCA) were consistently protected. This was a continued breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection some improvements had been made, however the provider is still not meeting the legal requirements and we identified a continued breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

- The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
- People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
- At the last inspection, people were not always being supported in line with the principles of The Mental Capacity Act 2005 (MCA). The provider had not always assessed and regularly reviewed the use of a listening device to monitor epilepsy to ensure it was the least restrictive practice to support the person's well-being. At this inspection some improvements had been made but required further embedding.
- Where people were found to lack capacity; the provider had worked with guidance from funding authorities to review mental capacity assessments and best interest considerations in relation to specific decisions including; finance, health and accommodation.
- The local authority had identified the necessity for Mental Capacity Act (MCA) assessments and DoLS

applications to be made in relation to four people at reviews of their health and social care needs in January 2019 and the provider had made applications in response to this.
● One social care professional fed back that there were delays in how the provider was progressing and embedding their MCA practice. For example, actions agreed at a review to inform best interests' decisions in relation to the continued use of a listening device had not taken place in a timely way.
● We discussed with the provider and assistant manager our concerns that neither consideration of the use of a bed sensor, or a specialist epilepsy assessment appointment had been accessed so that risks to the person's right to privacy could be safely assessed and managed. They confirmed the appointment was due in June 2019. Their rationale was that there had been delays in accessing a referral appointment and they had received mixed feedback historically from relatives, health and social care practitioners and as to whether monitoring was required.
● Although the provider confirmed it was important to get further clarity on the use of monitoring, they had not completed an earlier assessment of capacity or recorded the historical decisions and actions in the person's care plan to evidence that they had taken reasonable steps as described to ensure the current arrangements were the least restrictive.
● Further embedding of the providers policies and processes were needed to ensure people's rights in relation to the Mental Capacity Act (MCA).
● People's right to consent to care and treatment remained at risk, as the provider did not always identify, record or complete actions in a timely way. This is a continued breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● We observed that people were offered choice in all aspects of their care. This included what they wanted to do, preferences for what they wanted to eat and drink. Staff had a good understanding of the balance between maintaining people's routines and respecting their choices. One staff member told us, "It's about giving people choices, you can't dictate to people. We give people daily choices going through what they want to do in the morning schedules."

Staff support: induction, training, skills and experience

● Some staff we spoke with lacked an understanding of best practice in relation to the use of restrictive practice within positive behaviour support, so they could ensure they could meet people's needs safely.
● The provider's guidance in relation to physical interventions was not up to date or accredited training in line with their own restrictive practice policy and best practice models. This is important to ensure staff are working in line with legal requirements and best practice.
● Staff told us they had training about the MCA and understood the importance of people's legal right to be enabled to make decisions where they could. However, they were not consistently putting this into practice.
● Some staff had not accessed refresher training in topics that the provider considered important for their role including; safeguarding, positive behaviour support and Mental Capacity Act. However, the assistant manager was aware of the gaps in people's training and had arranged future training accordingly.
● People and their relatives told us, staff were suitably skilled and knew how to meet people's needs. One person told us, "The staff know how to help me, they know me." A relative told us, "They know my relative likes routine and give them the continuity and confidence they need."
● Some staff had benefitted from attending local authority training courses in addition to online training including; Makaton sign language, Autism and epilepsy. These helped to promote staff awareness through external training as well as meeting other providers. One staff member told us they had more access to training and that, "I like going out to bounce ideas off other people."
● The staff team was very established and confirmed they had received inductions and some training. They had shadowed experienced staff when they first joined the service who had shown them how to support people according to their needs and preferences.

● A senior staff member completed medicines competency checks for staff who supported people with medicines to ensure they were safe to work with people.
● Staff received regular supervisions from their line manager and new staff could complete the Care Certificate. The Care Certificate is a set of standards for health and social care professionals that ensure workers have safe introductory skills and knowledge.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People and their relatives told us they were involved in pre- assessments and reviews of care plans and staff told us they had clear guidance to help them understand how people needed their care and support to be provided. One relative told us, "They support my relative in their ability to make themselves known and my relative gets what he needs because they know them so well."
● Written feedback shared with the provider from social care professionals involved with reviewing people's needs was positive and confirmed, 'We felt there was plenty of evidence to support this is a caring and compassionate service with the support of families.'
● Protected characteristics under the Equality Act, such as ethnicity, sexuality and gender identity were considered as part of care planning. For example, a relative told us that after initially living with one person of the same gender, the service had supported their relative to move to the main area as they stated they preferred the company of the opposite gender. They confirmed their relative had platonic friendships and felt the service would be open to considering and respecting people's wishes, safety and needs in relation to their sexuality if needed.

Adapting service, design, decoration to meet people's needs

● Duckyls Farm Centre worked in line with the values 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.
● People and their relatives told us that the home enabled them as adults living with learning disabilities and autism to be included in their community, to make choices and to live as independently as they could. One person told us, "I would tell new people coming here, I like my home, I like my room, I like the lounges. I can do things with people or be by myself with my pencils and books. It feels like home because it's clean and fresh. It's better than a 'home' home. I'll never be on my own here, it's safe and there's peace and quiet."
● People's current needs were met by the design and adaptation of the building and the provider told us that they would and had considered making changes to the use of areas of the building if people's specific needs changed. For example, the current office could be used as an accessible double bedroom for a couple and the self-contained flat be developed for more independent living.
● People had access to two sociable sitting rooms and an outside courtyard and farm, where they could enjoy good weather, take time away from larger groups and spend time with visitors in privacy. One relative told us, "It's clean and comfortable and open, people move around freely and living with the access to a farm couldn't be better. The amount of exercise my relative gets is really beneficial to their condition."
● The provider informed us that there had been some redecoration of communal entrance hall and that pictures of new residents had been displayed. The upper floor was being decorated and we were informed that carpets would be replaced. People and relatives told us that staff took great care in making people's individual rooms just right and people had access to the internet and computers if they wanted to use them or play games. Visual signs were used in communal spaces and on each person's door to aide communication, orientation and promote identity. These included; people's names and images specific to them including their interests and loved ones.

Supporting people to eat and drink enough to maintain a balanced diet

● People's nutritional needs were met. Mealtimes were relaxed and unrushed and people were involved in cooking, laying tables and serving their own meals.
● People and their relatives told us they had choice and control over what they wanted to eat and drink. A relative told us, "They have a couple of people who are vegetarians at Duckyls and they always have an option." People made their choices from a variety of pictures about their menus on a weekly basis and regularly went food shopping.
● Dietary needs were met. For example, one person had specific support needs with eating to reduce the risk of choking and to ensure they maintained a healthy weight. This included; staff weighing them regularly and remaining with them when they ate and ensuring their food was cut up. Records demonstrated that the person had achieved and maintained a healthy weight.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● People had regular input from health professionals to improve their wellbeing. This included input from GP's, specialist consultants, opticians, dentists and access to health screening appointments.
● A relative told us, "The staff know people's needs well, and always ring after medical appointments and let us know what's happened. My relative had a few operations and medicines over the last few years and they have been absolutely amazing with them."
● A relative of one person with complex health needs told us, "They motivate people and ask them to do things and ensure they are active and enjoying themselves. My relative recently joined a gym. They have had a lot of operations and for a long time were less capable. Now they can walk more easily and are getting fitter."

Good

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

● People and their relatives told us that they were supported by kind caring staff. One person told us, "The staff know how to help me, all the staff are nice and like me, they give me help, care, love and kindness." Another person told us, "They help me with all sorts of stuff, and ask me what I want to do." A relative told us, "The staff are very caring, my relative can be dramatic at times, but they always respect them and when they have hiccups with others they always help them sort things out, they sit and talk about things together."

● People's diversity and individuality were respected and promoted. A relative told us, "They manage the individuality of people very well. As an established staff team, they understand them and the needs of the 'individual person' as well as the group and one doesn't lose out because of the other."
● People were encouraged to have their own possessions in their rooms, including, computer games, music systems, family and super hero pictures, and furniture. A relative told us that they knew Duckyls was the right place for their loved one when they moved their 'precious items' out of the family home and took them to there.
● Religious beliefs, important relationships and how people chose to express them were detailed in care planning and activities provided. For example, one person had recently chosen to be confirmed at a different church, another regularly had their friends' round for meals and another told us, "The staff would help me find a girlfriend if I wanted one, but they're a bit hard work."
● People's relatives told us they were always welcomed in a friendly manner, "When I go there for a meal and they are eating pasta they make sure there is always another option for me because I don't like it."

Supporting people to express their views and be involved in making decisions about their care

● When people needed support to communicate their needs, their care plans provided guidance for staff. For example, staff described how they provided choice by offering and observing visual clues, simplifying language, using Makaton sign language or giving people time to process what had been said and to respond.

● When needed, people were supported to access relevant advocacy services, so they could be actively involved when making decisions about their care and treatment. An advocate is someone who can offer support for people who lack capacity to make specific important decisions; including making decisions about where they live.

Respecting and promoting people's privacy, dignity and independence

● People's privacy and dignity was respected throughout the day, staff were discreet and calm and asked people's consent before supporting them. One person told us, "Staff always ask before they help me."
● Staff listened to people and encouraged them to make choices and be as independent as possible. One person told us, "I like to cook and help people. I can make an apple crumble and the people love it." A relative told us, that their loved one had learnt and carried out household tasks independently when they visited them, "They even iron their own shirt."
● Care plans and electronic records were kept securely within the office where access was limited to staff.

Good

Our findings

At the last inspection on 25 September 2018 we asked the provider to take action to improve oversight of their complaints processes and further develop their care planning in relation to advance care decisions and wishes. At this inspection we found improvements had been made.

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

People's needs were met through good organisation and delivery.

Improving care quality in response to complaints or concerns

● At the last inspection, complaints were not consistently recorded to ensure the provider had suitable oversight of themes or acted on concerns in a timely manner. In addition, not all relatives felt confident in how to access the complaints process.
● At this inspection the provider had taken guidance and advice from a local authority and developed a complaints management file and accessed easy read complaints processes that were made available to everyone who visited the home.
● People and relatives were confident that complaints were taken seriously and were happy to raise concerns they had with the provider. One person told us, "I would talk to the assistant manager, provider or all the staff if not happy. The meetings we have are good, they are one of my favourite things." Relatives told us communication was good with the home and they could contact the provider by email if they needed to. One relative told us, "When my relative's property was broken by another person, we took it up with the provider who addressed it at the time, the items replaced and without any cost to my relative."
● We looked at the complaints records and saw that complaints were taken seriously, investigated and actions taken to resolve concerns in a timely manner. Where concerns were not resolved within the process there was guidance within the complaints policy of how to contact the local government ombudsman.

End of life care and support.

● The provider told us they were confident they could provide personalised care if anyone's needs changed and would support people to make decisions about their end of life care and arrangements and wishes with their families and health professionals.
●The provider had taken steps to review people's capacity in relation to their advanced care planning in line with their policy.

● No one was receiving end of life care at the time of the inspection.
● People living at the home were younger adults; some living with autism, and the focus of the home was to support them to live as independently and actively as possible. However, the provider understood that they would need to undertake conversations in relation to people's end of life wishes with sensitivity to the person's needs.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.

● The service identified people's information and communication needs by assessing them. Staff understood the Accessible Information Standard. People's communication needs were identified, recorded and highlighted in care plans. These needs were shared appropriately with others. We saw evidence that the identified information and communication needs were met for individuals.
● People's communication needs were met, menus were pictorial, which ensured people could see and discuss what choices they wanted to make at their weekly meetings. We observed people using pictures, objects of reference, sign language and gestures with staff to make their needs known.
● Pictures of activities and easily understood language was used within review meetings so that people's responses and views could be documented and responded to.
● Staff had a good understanding of people's communication needs and were consistent in their approach including; with those who were non-verbal. A relative confirmed this, "The staff support my relative very well, they understand their facial expressions and demeanour. They are listened to and have a key ring with pictures that they use to make choices."
● We observed staff to be responsive to people when they became anxious. One person began to pace as they were waiting to leave for an activity. Staff were observant, calm and discreet. They followed guidelines from the person's care plan, which included going outside and offering reassurance to help the person relax. This resulted in the person feeling less anxious quickly.
● People's preferences and support needs were regularly reviewed. Pre-admission assessments were completed with each person and their relatives before they moved in which identified their support needs, preferences and wishes. A relative told us, "The staff supported my relative's arrival well, initially they spent daytimes there trying out activities. We felt as a family the introduction needed to be done gradually and this was respected. I believe this really helped with the transition from home which was really hard for my relative."
● Care plans were person centred, detailing routines, life experiences, preferences, communication and emotional needs including; behavioural guidance.
● People and their relatives told us they were involved in activities that promoted their health and social wellbeing including voluntary jobs with local charity shops.
● Throughout the inspection people were engaged and positive about the activities they had completed or had planned at Duckyls and in the community. One person told us, "I'm going to the gym now. It's good for my arms, shoulders and legs. It's good for me and my muscles." Another person told us they had enjoyed the morning's music session, "Yes very nice music." A relative told us, "My relative enjoys watching sports, listening to music and going to church is a big part of their life. They go horse riding and really like being on the land with the animals, we come from a family of farmers, the outdoor life is something that they love."

Requires Improvement

Our findings

At the last inspection on 25 September 2018 there were continued shortfalls in the provider's governance systems and processes. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A warning notice was served on 4 December 2018 and we asked the provider to take action to ensure the quality and safety of the service was consistently assessed, monitored and improved on to safely meet people's needs by 5 January 2019. At this inspection some improvements had been made and parts of the warning notice had been met. However, the provider is not meeting the legal requirements and we identified a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.
Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

● Quality assurance is about improving service standards and ensuring that services are delivered consistently and according to legislation. The service has been rated as Requires Improvement for the past five inspections.
● At the last inspection the provider's systems of quality monitoring had not routinely identified and rectified issues including; the management of risk, regulatory awareness in relation to safeguarding and service development and the promotion of people's equalities-based choices. There were also shortfalls in how the provider ensured staff had suitable guidance to work in line with the Mental Capacity Act (MCA).
● At this inspection some improvements had been made in response to the warning notice including; the provision of an action plan, recruitment records, complaints management, some aspects of training, equalities support and service awareness of people's longer-term needs. However, the provider's systems of quality assurance and governance did not ensure a good level of quality and safety was maintained and it had been reliant on the support of the local authority social care and commissioning professionals involved to identify practice issues and solutions.
● People were placed at risk as accidents and incidents and other records were not consistently recorded, monitored or investigated so that lessons could be learnt, and actions taken to ensure further risks were

reduced. For example, staff were not appropriately trained to carry out positive behavioural support that could involve physical interventions or identify when people were at risk of being restrained unlawfully.
● Reviews of care plans were completed but did not ensure actions agreed in partnership with social care professionals were managed in a timely way. Epilepsy guidance was not consistently provided in line with best practice and the provider's epilepsy policy.
● There were inconsistencies and gaps in the information the service held in respect of some people's treatment and how decisions were made. For example, information shared during the inspection by a relative and the assistant manager highlighted that an incident record had not been completed and led to a safeguarding referral to the local authority being made as an unplanned restraint may have taken place. However, the information verbally shared at inspection did not match the incident report account subsequently shared by the provider.
● A social care professional fed back that while discussing safeguarding concerns in relation to another person with the provider there were inconsistencies in the account given of how the restraint guidelines were used and what was recorded.
● Some improvements had been made, but the provider's systems of quality assurance and governance still did not ensure a good level of quality and safety was maintained. People were potentially at risk as staff were not appropriately trained to deliver safe practice in relation to restraint and systems and policies in relation to accidents, safeguarding and epilepsy care, were not routinely followed to ensure lessons were learnt and future risks mitigated.
● People remained at risk, as the provider did not have systems or processes established and operated effectively to assess, monitor and improve the quality and safety of the services provided. This is a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● The provider did not fully understand their responsibilities in relation to their registration with the Care Quality Commission. Certain events must be notified to the CQC by law, however the provider had not notified us of two incidences of alleged abuse that they had been made aware of by a social care professional in January and March 2019.

● The failure to notify CQC is a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.
● Daily meetings, team meetings and care planning schedules underpinned the day to day service delivery tasks, ensuring individual support needs were planned for and met. For example, health and social activities were noted on the schedules and rotas and shared at handover meetings. The service could when needed respond to short notice changes, for example, people were supported during the inspection to take a boat trip in London when an opportunity was provided by a charity at short notice.
● People and their relatives spoke positively of the assistant manager, the provider and their staff team and how responsive, caring and approachable they were. One person told us, "I see the provider, like today, I ask them about new things when I see him." Another person told us, "I like my carer they help me with my books and listening to my music" A relative told us, "We can always send emails to the assistant manager and provider and get in touch when we need them. For example, our relative recently had a falling out with someone, they are all one big happy family now, some of the staff have been there so long, it's a family thing."
● The provider was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guideline's providers must follow if things go wrong with care and treatment.

Continuous learning and improving care; Working in partnership with others

● The provider had recruited a new manager, with the intention of them applying to be the 'registered manager' for the home so they could 'take a step back' and enable the service to improve and to provider regular support and guidance to the team.
● The provider and assistant manager told us they felt the home was improving while recognising they had more progress to make. For example, the assistant manager felt they would benefit from having more support and time to attend training and local care home forums but didn't have the time to do so. They told us, "I'm really looking forward to having a new manager to bounce ideas off and have someone here on a day to day basis to support me to move things forward." The provider felt the assistant manager would use the policies and procedures more regularly with an experienced manager to support them.
● Local authorities' social care and commissioning professionals had been actively involved with the service, in response to the last inspections ratings. They fed back that they felt that people were happy at the home and that the support was caring and personalised. However, the timeliness of some actions they had required could be improved and they felt it was important that the newly appointed manager had a clearly defined and autonomous role.
● The provider told us they had found partnership working with the local authorities useful when they had been provided with clear practical advice in relation to the Mental Capacity Act, complaints and what they had to do. The assistant manager told us, "The local authority social care professionals have been brilliant, they have talked through issues and know more about things, so it's not just me talking to the provider. They help me understand how to do things."
● The provider, assistant manager and staff had a clear understanding of the culture and value base of the home. The provider told us, "The thing I'm most proud of is that the Duckyls is a home and not an institution or establishment. If people tell me Ducklys is friendly and homely and they like it, I don't think you can get much better than that." A relative told us, "It's a community. We would be very sad if anything happened that our relative would need to move from here as they like it and it is their home." Another relative told us, "My relative really enjoys living here, they live with autism and it was difficult to find the right place for them to live. Duckyls is a big part of their life and it means the world to them to live here."
● Throughout the inspection the staff showed their understanding of this ethos through their interactions with people and each other, the environment was friendly, calm and respectful.
● A relative told us, "I feel the home is well managed otherwise the people at Duckyls would not be so happy. The thing that has held it back is changing legislation along with a provider who has not stayed current. Staff are invested in carrying out the best care they can. In general, the home is well led as people are at the centre." Another relative told us "A new manager is a good thing, I think it can bring better recording which will help ensure necessary part of the role. I think it will bring a measure of comfort to the staff and stability to the team."

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

● At the last inspection relatives and staff had given mixed feedback in relation to how much contact they had with the provider and how they were involved in the development of the service.
● During this inspection relatives and staff were positive about the communication they had had with the provider in relation service developments. A relative told us, "The provider has involved us and contacted us about the new manager." A staff member told us the assistant manager had kept them up to date about the changes and the provider had been more present at the home, due to interviews and local authority reviews.
● People and relatives were positive about the new manager. One person told us, "I've been told about and met with the new manager, I know I get on with them from knowing them." A relative told us, "We think the assistant manager is great, but the provider needs to take a step back and they probably don't want to do

this. We think a new manager coming in will have more pulling power. We have a lot of contact with the assistant manager and like them, but there are aspects they are not aware of including; finances. It's ideal a new manager coming in."

● Staff were positive about the new manager acknowledging that it would support their and the assistant manager's workloads.

● Staff told us they were listened to and could share their views on how the home could improve. One staff member told us, "I raised with the assistant manager that staff were using their mobiles in the workspace and that this was not respectful, they addressed it straight away and this improved interactions with people."

● People and relatives were encouraged to complete surveys and provide feedback and make suggestions for improvements in the home. The provider told us that from the last feedback survey they had learnt that people liked meals out, going to church and having festival events, such as the Harvest Festival and Christmas Carols and ensured these activities continued. For example, they were planning a harvest festival event to welcome the new manager.

● People's diverse cultures were considered and promoted. The provider designed activities to support people to celebrate their own identity and experience others. For example, they celebrated Christmas, birthdays and harvest festivals events. The provider told us that relatives would be invited to meet the new manager at a harvest festival event they were planning so that they could start to build relationships.