Amore Elderly Care Limited

Dalton Court Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Dalton Court Care Home 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.

The home provides accommodation for people with both nursing care and personal care. The home can accommodate up to 60 people. At the time of our inspection 53 people lived at the home.

This inspection took place on 3, 4 & 12 July 2018 and was unannounced.

There was no registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. An interim manager had been in post since the departure of the previous registered manager in December 2017 and had made an application to CQC to become the registered manager.

Our last inspection in December 2017 was a focused inspection to check that breaches in legal requirements found on the last full comprehensive inspection of July 2017 had been met. We found that the breaches and the warning notice had not been met and we found further cause for concern with new breaches on the focused follow up inspection of December 2017.

The overall rating given in December 2017 for this service was 'Inadequate' and the service was placed in 'special measures'. Services in special measures are kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, we will inspect again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this time frame.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

At this inspection July 2018 we identified continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Regulation 12 (Safe care and treatment), Regulation 17 (Good governance) and Regulation 18 (Staffing). Three new breaches were found: Regulation 13 (Safeguarding service users from abuse and improper treatment); Regulation 16 (Handling complaints); and Regulation 11 (Need for consent).

The service has now been rated inadequate once again for the second time in 6 months. Where we take higher levels of enforcement action we will publish full details once all relevant representation timescales have elapsed.

While we did find that the provider and interim manager had made improvements in areas that had been prioritised by them, we found that the initial pace of improvement had not been sustained and other important areas were still giving cause for concern. These were that people did not always receive safe care and treatment that met their changing needs. There were not always sufficient numbers of staff on duty to meet people's needs. People with needs that were complex and challenged the service were not being supported by staff with the appropriate skills and training.

Risks to people were still not being well managed. Risk assessments were not being carried out when a person's needs changed so that care plans were still relevant and people received person centred care and safe treatment from staff.

The management of falls within the service was poorly managed and not in line with current nationally recognised good practice. While some auditing of falls risks for the service as a whole was now undertaken, the individual risk assessment reviews were still not effective in managing falls prevention.

We found a similar lack of action and recording for people at risk of developing pressure sores. The nursing staff were not using, or using effectively, the assessment tools to monitor changes to people's conditions and needs.

We found the service was operating a reactive model to addressing people's health care needs; making a referral once the condition had worsened. Rather than being proactive in putting measures in place that prevent the likelihood of problems occurring or re-occurring.

We found the service was accepting people with complex health needs without sufficient numbers of skilled and trained staff to meet their needs. This was particularly the case on the top floor, Daffodil unit, which specialises in the care of people living with dementia. Staff had not received adequate training to meet the needs of people who may challenge the service and had more complex needs related to living with dementia.

Staff lacked leadership, support and guidance on how to support people living with dementia and the service lacked a cohesive dementia care strategy. This meant people living on that unit were not in receipt of safe care and support that met their needs. A lead nurse for this unit had just been appointed two days before our inspection who had plans to develop the unit.

All care plans had been reviewed and updated since the last inspection however, key information for safe and effective care was not available to all staff. Documentation was disorganised, incomplete and ineffective in communicating clear plans of how individuals should be supported.

The service did not always work effectively with key external health practitioners and advice given by external professionals was not always followed or updated into people's care plans.

This is a continued breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014: Safe care and treatment.

At our last inspections, in July 2017 and December 2017, we had found the provider had failed to protect

people against the risks associated with the unsafe use and management of medicines. At this inspection we found that medicines were being managed safely.

We made one recommendation about ensuring that medicine prescribed for calming people and reducing agitation had a care plan to instruct staff on how it should be used.

Staff did not always recognise the signs of potential abuse and therefore failed to take action. We found a number of incidents that had not identified by nursing and care staff that warranted independent assessment through a safeguarding alert to adult social care. We asked the service to make a number of safeguarding referrals during the inspection. This meant that people were not being adequately protected from potential abuse.

This is a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment.

The provider had put resources into a staff recruitment drive since the last inspection. However, there continued to be occasions when there were insufficient staff to consistently meet people's needs. We found there was particularly a shortage of staff on weekend shifts. This was made worse by other key staff not being on duty at weekends, for example activity coordinators, housekeepers and hostess staff.

We found that nurses were given lead roles in important areas without having the training to support these roles, such as lead in nutrition, medicines, tissue viability and falls management.

This, and the lack of training to meet people's needs, is a continued breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014: Staffing.

We found that how the Mental Capacity Act was being applied was inconsistent across the service. Assessments of people's capacity was done in a very general way and was not specific to decisions of varying types and complexity. This is a breach of Regulation 11: Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured that people's rights were being protected.

Some staff were not giving good care and did not demonstrate a caring attitude. On this inspection we received more mixed views and opinions from people living in the home and their relatives about the care given and the attitude of staff. Some people living in the home and their relatives continued to be happy with the staff. However, more people told us that there a number of staff who were described as "letting the side down" who were not giving good care and did not demonstrate a caring attitude. One person, who had experience of staying in other homes said, "They don't think much of you here."

The interim manager had used the providers disciplinary procedures to improve staff performance. However, there continued to be reports and concerns from people in the home, their relatives, staff working in the home and visiting professionals about staff attitude and work ethic of some staff.

People and their relatives did not feel their concerns and complaints were listen to and action taken. Some people did not feel comfortable about speaking up. One person told us, "It goes against you here if you complain."

The provider had failed to operate an accessible system for identifying, receiving, recording, handling and responding to complaints by people living in the home and other persons. This is a breach of Regulation 16:

Receiving and acting on complaints.

The audit mechanisms in place were not being carried out effectively and staff were not held to account for tasks not completed to ensure practices were improved on. Staff reported that there was a blame culture with poor staff morale.

The service had not been well-led or well managed over a number of years, as demonstrated by the poor history of non-compliance with the regulations.

People continued to receive unsafe and poor quality care and treatment.

This is a continued breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Good governance.

We had not seen the improvement required to take the service out of our Special measures or to change the rating.

We are considering what action we will take in relation to these breaches. Full information about the CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected from abuse; staff did not always recognise the signs and therefore were not reporting allegations of abuse.

Staffing levels were not always meeting the needs of people in the home.

Risk assessments were not being carried out effectively to reduce risk to people in the home.

Medication was being safely managed within the home.

Staff were recruited appropriately and relevant checks on their background were carried out.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received a programme of training however, more specialist training was required in dementia care and for behaviours that may challenge the service.

People told us the food was good. People were supported to stay well hydrated.

People's ability to make decisions was not always assessed in accordance with the Mental Capacity Act.

Is the service caring?

Requires Improvement

The service was not always caring.

Some people's care was not provided consistently or in accordance with their care plan. This did not demonstrate a caring approach.

The majority of people spoke positively about staff. However, this

was not consistent across the staff team.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Pre-admissions assessment were of a variable quality and many did not cover all the individual support needs of each person.

We found gaps in person centred care planning.

Complaints were not being carried out thoroughly. Verbal complaints were not recorded.

Is the service well-led?

Inadequate

The service was not well-led.

The service has a poor record and history of not meeting legal requirements.

Systems in place to monitor the quality and safety of the service were ineffective.

Previously identified risks had not been addressed by the provider.

The provider informed us following the last inspection that they were taking action to address these shortfalls.

Dalton Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 3, 4 & 12 July 2018. The visit to the service on 3 July 2018 was unannounced. We told the provider that we would return to the service for the other days.

This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection 18 & 21 July 2017 and the focused inspection in December 2017 had been made.

The inspection on 3 July 2018 was carried out by two adult social care inspectors, a specialist advisor with expertise in occupational therapy and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The following visit on 4 July was carried out by the lead adult social care inspector for the service and a CQC pharmacist inspector. The third day was undertaken by the lead adult social care inspector for the service. We put up posters in the home and left our contact details so that we could be contacted about the inspection for further feedback.

During the course of our inspection we spoke with 21 people living in the home and with 10 relatives of their relatives. Immediately after the inspection visit we were contacted by other relatives and by one out of county social worker.

We spoke with six registered nurses, seven care staff, and four ancillary staff that included a house keeper, a cook and activities staff. We spoke with the interim manager, the nurse clinical lead, the operations manager, the dementia care unit led, a Priory Quality Improvement Lead Support (QIL) and the Priory's Director of Performance and Regulation.

We looked at the care plans files and medicines records for the people living in the home and at 16 people's

care records in greater detail. We observed the care and support staff provided to people in the communal areas of the home and at meal times. We observed medicines being handled and discussed medicines handling with the staff involved.

Some people had communication difficulties or dementia and were not able to communicate with us easily. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed five staff recruitment and training files. We checked documentation that was relevant to the management of the service including quality assurance and monitoring systems.

Before the inspection we reviewed the information we held about the service. We contacted health and social services commissioners who contracted with services for people's care. We also contacted the local safeguarding and adult social services teams. We spoke with health care professionals who supported people who lived in the home. We had received information directly into our CQC website from relatives of people in the home over the last few months and used this as part of our planning.

We checked the information we held about statutory notifications sent to us about incidents and accidents affecting the service and people living there. A statutory notification is information about important events that the provider is required to send to us by law. We used a planning tool to collate all this evidence prior to visiting the home.

Inadequate

Is the service safe?

Our findings

At the last inspection we found a breach in Regulation 18: Staffing as there was a shortage of trained nurses, senior staff and care staff on some shifts. There had been occasions when only one nurse had been on duty when there should be a minimum of two.

On this inspection July 2018, the interim manager informed us that the required staffing level should be a minimum of two qualified nurses per shift on each floor and five to six care staff on the ground floor and four to five on the upper floor. This was worked out using the Priory dependency tool based on assessment scores of people's needs. The provider had recruited staff across the board at all levels since the last inspection. While the recruitment process was underway the home had used the same regular agency staff. The interim manager told us that there was still 99 hours of care staff and 44 hours of nursing staff yet to fill. However, offers of employment had been made to care staff who were awaiting clearance checks. While the home had an on-going recruitment to employ more staff, high sickness levels and ineffective deployment was still hampering this process.

When we spoke to staff and people living in the home and their relatives they told us that staffing levels had improved during the week. However, most people we spoke with told us that at weekends the staffing levels often dropped and people's needs were not being met. One person living in the home told us, "They come if you call them, there is usually enough of them but sometimes they are a bit short." While another person told us about staffing levels, "It's fine, it's just the weekends really, they are so short of staff then it's awful sometimes but I suppose it can't be helped."

A relative of a person on the ground floor told us, "I've just gone to look for staff now, there's never enough around when you need them. We pressed the buzzer ages ago. But now it's too late [relative] has had an accident as [relative] needs two staff to go to the toilet. It's hopeless in here." Another relative told us, "Well it's very variable really. There is a shortage of staff sometimes."

When we checked the last four weeks rotas we saw that for the weekend prior to the inspection there had been only three care staff on one shift and four care staff for other shifts. We were told by nursing staff and by care staff that this was a "common occurrence" and that nurse levels could also drop to only one nurse on a shift at weekends. One member of staff said "Weekends are the issue with staff ringing in sick at the last minute. It's the same ones all the time and the same reliable staff who are asked to cover. I do the cover because I don't want people not getting the care but really I'm putting my PIN (nurse registration) at risk working on my own and being tired with the length of hours as well."

Staff also told us that they had additional duties to carry out at weekends as some weekday staff roles were not covered at weekends, such as a housekeeper, hostess role (a person on each floor who supports the dinner service and drinks trolley and assists some people with their meals) and the activity coordinators. Also there was no manager or deputy role for weekends.

Nursing staff reported to us that they were short staffed at times and that this meant they had little time to

carry out risk assessment or update people's files. While care staff said they often struggled to see to everyone's care needs in a timely and unhurried manner. A number of staff pointed out that some staff were "getting away with things, like having too many cigarette breaks."

We noted that some people spent significant amounts of time alone in their rooms or sitting in wheelchairs for prolonged periods. For these people we observed that there was little staff interaction or inventions, such as position changes to promote good skin integrity to reduce the risk of pressure sores and some people had meals left out on trays that had gone cold.

This was a continued breach of Regulation 18: Staffing of the Health and Social Care Act (Regulated Activities) Regulations 2014 as the provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet people's care and treatment needs.

At the last inspection we found risks, both for individuals and for the environment, were not always assessed effectively to enable risk reduction measures to be implemented. The environment was not always risk assessed to ensure it was safely maintained. On this inspection July 2018 we found the environment was now being sufficiently assessed to manage risk.

However, risk assessments for individuals continued to be poorly managed. Risk assessment records were either not completed, not accurate, not up to date or were incorrectly filled in. We found that people identified as being at high risk of falling did not have up to date falls risk assessments in place. This meant that that care plans and the instructions for staff on how to prevent falls were not accurate. For example, one person identified as a high risk of falling had a fall that was not assessed or reviewed to check if the measures in place were effective. This person had a further fall later in the same week which resulted in a fracture and hospital admission. A falls risk assessment tool went from a score of 12 to 22 in one month, however nothing was found to indicate why the score and risk had increased or what actions had been, or needed to be taken. The lack of a post falls risk assessment meant that an opportunity to prevent this fall may have been missed.

This was a continued breach of Regulation 12: Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) 2014 relating to assessing the risks to the health and safety of service users and doing all that is reasonably practicable to mitigate any such risks.

We looked at how people were protected from abuse and avoidable harm. Staff had received training on safeguarding vulnerable adults and recognising the signs of abuse and the actions required. However, we found staff did not always recognise incidents that required a safeguarding alert to adult social care. We asked the service to make three referrals during the inspection. One was for a person who was described in nursing hand over notes as having been "restrained" to control them during a period of being "extremely challenging." We could see no further explanation of this incident and there was no care plan written up for managing challenging behaviours or for using restraint with this person. This has the potential to be classed as an assault unless proper steps and procedures have been taken, including input from relevant professionals.

There were two other incidents where we asked the provider to make safeguarding alerts. These were incidents of bruising; one was unexplained and a body map had been completed by care staff and reviewed by senior nursing staff but there was no explanation or review carried out. The bruising seen on the person and on the body map was indicative of incorrect moving and handling or of the person being grabbed. We found another person had a bruise, recorded very briefly in a generic staff hand over sheet, caused by another person's relative who felt it necessary to intervene to keep their relative safe from this person.

We saw that some relatives had purchased child safety gates to put up at their relatives bedroom door to keep them safe from some residents who they described as being, "disruptive and wandering into people's rooms." The service had sent into us, as required, a number of notifications about verbal and physical aggression since March 2018. These incidents had all resulted from people newly admitted to the home who had posed challenges arising from living with dementia that the service was struggling to manage.

None of these incidents had been reported to Adult Social Care as a safeguarding alert, as is required by the local safeguarding and provider's policy.

We found the service had failed to provide people with care and treatment that was planned and delivered in a way that enables all a person's needs to be met. The service was failing those people who's behaviours were challenging. This also meant that staff and others were put at risk of harm. Abuse is defined as neglect of a service user and care and treatment must be provided in a way that does not significantly disregard the needs of a service user. We found the service had neglected people's needs and disregarded their need for specialist dementia care and treatment.

People were not protected as systems and processes to safeguard people were not being effectively managed. Policies and procedures were not in place to deliver effective care and to support staff delivering care to people living with dementia. This was a breach of Regulation 13: (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At previous inspections we found the provider had failed to protect people against the risks associated with the unsafe use and management of medicines. This was a breach of Regulation 12: Safe care and treatment of the Health and Social Care Act (Regulated Activities) Regulations 2014. On this inspection we found that the service was now meeting this regulation.

Since the last inspection, the interim manager had introduced daily stock counts and a monthly medication quality walk round. Staff reported any discrepancies to managers and each month these were assessed for trends to be actioned. Any issues or changes were discussed with nursing staff at monthly meetings. The medicines policy had been recently updated and staff had signed to confirm that they had read the documents.

We found that one person who was prescribed medicines to be taken when required, did not have any additional information to guide staff how to give the medicines. However, this was rectified during the inspection. Another had an incomplete additional recording sheet for a when required medicine and this was also rectified during the inspection. These omissions were found in the notes of people who may challenge the service and who had recently been admitted to the home.

We recommend that the provider ensures that medicines used 'as and when' for people who may challenge the service are reviewed in line with national good practice guidelines set out by NICE (National Institute for Care and Excellence).

We looked at how the service managed the prevention and control of infections. We saw that during personal care tasks staff were using appropriate disposable aprons and gloves. Staff reported having had training in infection control and in the safe handling of food.

We reviewed recruitment procedures in the service. We saw application forms had been completed, references had been taken up and a formal interview arranged. The files evidenced that a Disclosure and

Barring Service (DBS) check had been completed before the staff started working in the home. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helped to ensured suitable people were employed.

Requires Improvement

Is the service effective?

Our findings

At the last full comprehensive inspection in July 2017 we found a breach of Regulation 14 (meeting nutritional and hydration needs). This was because the registered provider had not made sure that appetising food was available; that food and fluid intake was accurately monitored and because appropriate action had not always been taken if people's weight had fluctuated.

People we spoke with now told us the food served was good. One person said, "The food is very good, I've even put weight on." Another person said, "I get to choose when and where I eat my food."

On this inspection we found that the monitoring of peoples' weights had improved and actions were taken if people were at risk of weight loss. We saw that people had nutritional assessments completed to identify their needs and any risks they had when eating. Where necessary people had been referred to their GP or to a dietician. We also saw that people's choking risk was being managed by referrals to speech and language therapist (SALT). One SALT we spoke with said, "The home has been good at making referrals and have also followed up on issues. They have been open to training. I've just arranged to come back next week and give the staff a session on the new scales for thickeners in drinks and food."

We observed the lunchtime on both floors and found these to be much better organised. People were not sat waiting for too long prior to their food being served. We saw that the hostess role was central to making the mealtimes run more smoothly. They assisted people with their meals, helped to dish up and clear away, offered drinks and helped complete records of what people had eaten.

The meals served looked appetising, with plenty of choice including fresh vegetables that seemed to be enjoyed by everyone. People who had difficulty with communication or comprehension were helped by staff members taking round 'show' plates so that they could make a visual choice of a meal. We spoke with the cook and kitchen assistant who told us of the systems in place so that they knew people's dietary needs and special diets. They were both knowledgeable about meeting the nutritional needs of older people and had received training for this.

We saw that people were well supported to stay hydrated. There were jugs of drinks in communal areas and in each person's room. We observed people had cold drinks to hand all day and staff frequently prompted people to drink. Where people had been identified as being at risk of becoming dehydrated fluid charts had been set up and were completed by staff to monitor intake. We did however find that people served in rooms did not always receive support in eating in a timely manner. We saw meals taken out by staff being left on people's trays and then seeing these meals still on trays untouched after half an hour and more when staff returned to help they were cold. However, staff were completing records in people's rooms of how much they had eaten and the fluid intakes. We raised this with the interim manager and this she said would be addressed by better deployment of staff.

The interim manager told us that the meal times and nutritional planning had been one of the areas they had particularly focused on since the inspection in December 2017. This had included audits of the dining

experience by the external Priory improvement team and on the first day of the inspection one of the home's nurses was carrying out a mealtime experience internal audit.

On this inspection we found the service was now complaint with Regulation 14: meeting nutritional and hydration needs.

We looked at staff training records and the training programmes in place for staff. There was an on going programme of staff training in place and staff were being given the opportunity for supervision. There was a mixture of face to face and e-learning for a number of the training topics. We spoke with a new member of care staff who told us, "The training has been good and I did some shadow shifts until I felt confident in what I was doing." Staff told us they felt they could discuss their needs in an open manner and would be listened to and action taken to help them to develop. Staff also told us they attended regular staff meetings that supported them in their work.

The home had focused on nurse medicines training and competency since the last inspection and we now found this area was safe and met the regulations. The next area, the clinical lead had identified, working with the interim manager, had been to targeted nurse supervisions, checking competency across all areas, and identifying training needs for the nursing staff. This deputy role was a newly created post following the last CQC inspection to assist the manager of the home.

The home had a number of nurses who had been identified as leads in specialist areas such as in nutrition, medicines, tissue viability and falls management to name a few. However, when we checked staff training and spoke with these staff the levels of training and support they had received for many of these areas had only been on a basic awareness levels. We found that some nursing staff were deferring to and seeking guidance from these internal staff instead of seeking outside expert advice from NHS staff. This had led to inconsistency in some people's treatments and differing instructions given to care staff on how to best meet people's needs.

We found that not all staff had received training in how to manage people who could be verbally and physically challenging. Those staff that had training had a mix of different training types and models on how to manage physical aggression. We found the service was accepting people with complex health needs without ensuring that staff had the training, expertise and skills to meet their needs. This was particular the case on the top floor, Daffodil unit, which specialised in the care of people living with dementia. The service and the unit for people living with dementia did not have a strategy on how to support those people living with dementia. A dementia strategy based on nationally recognised best practice would include the philosophy of care and approach to people living with dementia, adaptation to the environment, activities and staff training and skills needed.

We found staff lacked leadership, support and guidance on how to support people living with dementia. Staff working in the unit for people living mostly with the effects of dementia did not have any additional specialist knowledge or skills than the rest of the staff team. This meant people living on that unit were not in receipt of care and support that had been adapted to meet their needs.

A lead nurse for this unit had just been appointed two days before our inspection who had plans to develop the unit. We saw that the activity coordinator had used her own initiative to make some areas of the upstairs unit more "dementia friendly", such as making some corridors more interesting to sit in and had turned an under-used sitting room into a café area with a seaside theme. The unit looked a lot more attractive with this input and changes. However, more work was needed on developing activities, approach, and the environment as part of a joined up cohesive dementia care strategy.

We therefore found that the registered provider did not have a systematic approach to determine the training needs of staff employed in the service in order to meet people's assessed needs. This was in breach of Regulation 18: Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular 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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw a number of appropriate applications had been made and authorisations were in place where people needed to have measures in place to keep them safe. This had improved since the last inspection. However, we were told by one person that that their relative had bed rails even though they had capacity, did not require them to be safe, and had asked for them to be taken down. The relative told us that they had to insist the rails were taken off.

After the inspection visits we had been contacted by a social worker from outside of the region who was responsible for reviewing the care of one person who lived at Dalton Court. They told us they had some concerns with the home's understanding of capacity and making unwise decisions and what actions the service may need to take in order to both protect people and to safeguard their rights. There had also been a delay in Dalton Court applying for a DoLS for this person.

We saw that consent to care and treatment documents in the care records had been signed by people, or by people with the appropriate legal authority. However, assessments of people's capacity was done in a general way and was not specific to decisions of varying types and complexity.

This is a breach of Regulation 11: Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured that people's rights were being protected.

We looked at how the service worked with external healthcare professionals. We found they did not always work effectively with key external health and care practitioners, for example there were a number of people who were at high risk of falls who had not had recent assessments by either a physiotherapist or occupational therapist. This was compounded by a lack of falls management plan for individuals.

We found that one person had required chiropody input due to very long nails and this had not been requested in a timely manner. When the chiropodist was called they deemed it necessary to make a safeguarding referral due to the poor condition of this person's feet. Some external health and care practitioners told us of staff in the home being defensive and did not follow advice given. One of these instances had led to a person developing a pressure sore that may have been preventable if the advice had been followed. This had also led to the healthcare professional making a safeguarding referral.

This is a breach of Regulation 12: Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the provider had not ensured that they worked with others, both internally and externally,

to make sure that care and treatment remains safe for people using services.

The newly appointed Clinical lead had continued the work of the interim manager in making the management of medicines more effective by working collaboratively with local GPs to review every person's medication in the home. This she said would ensure that medicines were appropriate, reduced or replaced with more effective drugs. While the main aim was to improve people's health the spin off from this she said would be to have "shorter medicines rounds and this would free up nursing time to be on the floor supporting people."

Requires Improvement

Is the service caring?

Our findings

People living in the home we spoke with gave us mixed views on the caring approach of staff. Some people and their relatives were complimentary about the staff team while others had a more negative view and experience.

People who were satisfied with staff told us, "The girls are very good, very kind." Another person said "I'm alright here, I'm not in my room today as they are giving it a deep clean. The girls are very nice." And another person said, "The girls are very kind, they do ask you what you want."

The relatives that were satisfied with the care told us, "I have to say they do their best, the girls try very hard but it has been so disorganised with the changes in management." While another person said, "(relative) has been in for several weeks now and we have just decided that (relative) is staying. (relative) is always clean but it's just the weekends when they are so short."

People living in the home that were less satisfied told us, "The girls, [staff] well some are alright and some are not. The nurses are alright but the unqualified ones are very variable, if you say anything here it goes against you, I've asked to see the Doctor but the answer is no." We had been contacted by a relative, via our CQC website feedback page, who told us their relative had said, "They don't think much of you here at all." This person had stayed in other care homes and had said they didn't want to come back to Dalton Court.

Relatives who were less happy with the care told us, "We don't hit it off with one of the nurses and some of the younger carers don't seem to know the basics of care, like making sure people's hands are cleaned. I frequently have to ask to have a pad change for [relative]. I'm always raising it with the nurses but nothing changes." Another relative said, "It's a worry, it's why I come in every day to make sure everything is done." While another relative told us, "I would have moved (relative) but they have settled here." One relative told us that staff frequently complained to them, and in front of residents, that they "hated working in the home."

The majority of people living in the home and their relatives told us that most staff were caring but this was let down by a few staff who didn't "pull their weight". People told us that they thought the problem lay with staff shortages and that often staff were busy and had to rush to get things done. One person told us, "The girls can be very abrasive if they are busy" and another person said, "Well it could be better, the girls are alright. They do their best when there is enough of them."

One relative described the care as being institutional. They reported to us via feedback on our CQC website "Generally they don't talk to [relative] as they do the personal care. Just do it like a conveyor belt and move on."

We did see examples where staff were patient and supportive when people needed assistance. We saw that the majority of staff sat down and gained eye contact with people if they needed assistance with their meals and this was done in an unhurried and calm manner. However, we did see one member of care staff in the dining room who approached one resident and started feeding the person with large spoonsful of food

rapidly. This person had not appeared to be struggling with their meal. They asked to do it themselves and when allowed to do so had no problems in doing this. We also had concerns about those people who ate in their rooms who required assistance as we saw meals left out on trays and by the time staff came around to assist them the meals were cold.

People were not always supported to be as independent. We found that some care staff were task orientated in their approach, as with the example of the person being able to eat themselves. We also saw some people struggling to eat who would have benefited from adaptive cutlery and plates. A relative also gave us another example of this telling us, "There are some issues as [relative] is very independent and still quite capable but needs reminding to do things as they forget so [relative] doesn't get a shower very often. I have said about this but they say '"we can't make him'" but that's not the issue [relative] just needs to be reminded, they would never refuse."

We spoke with the interim manager about these reports and attitude of some of the staff. She told us that she had been working with the provider and Priory HR for some time to improve staff performance. This had led to some staff undergoing disciplinary measures. She told us, "There's some way still to go. We are working on staff culture and trying to reorganise shift patterns so that all staff get a mix of who they work with. We are also trying to get staff to recognise that they are all responsible for tackling poor practice." We informed the interim manager of the staff who people had described as "letting the side down" and she confirmed she would take action by continuing to implement the providers disciplinary and competency procedure.

During our visit, we did note many positive interactions between staff at all levels and people living in the home. Staff were seen to talk to people in a warm and friendly manner and took the time to support people who became worried or upset. For example, one staff member sat holding the hands of a person who had become upset and another staff member provided comfort to a person when they became anxious. We saw that some staff knew people well and used this knowledge to start up a conversation or to distract people when they had become anxious, such as talking about a past job, hobby, or a pet or for one person the fact they had lived on a farm. When people needed support with their personal care, we saw that staff respected people's privacy by knocking on their bedroom door before entering and ensuring the person's dignity was maintained by closing their door before any support was provided.

At lunchtime in the dining rooms there was lots of conversation, joking and camaraderie between people in the home and staff. There were considerate touches at lunchtime by the home's hostess playing calm music in the background. She told us, that she had purchased the CDs herself as she knew some people liked the artist she was playing. There was friendly banter between the male staff and residents about the football and some men had a glass of beer with their meal.

We saw that people in the dining rooms received the right level of assistance they needed to eat and to drink and this was provided in a patient and discreet way. Meal times had been staggered and consideration had been given to sitting people with friends or with people with compatible needs, such as having a quieter dining room and some people having one to one support from staff in the quieter lounge area.

We saw, and were we told of, examples were individual care staff and other staff had been kind and considerate. For example, the activity coordinator decorating the hallway sitting areas and making them more interesting for people to spend time in, and developing a café area with tea and coffee making facilities for relatives. The hostess person buying CDs that she knew people really liked. We were told that the laundry was "brilliant" at looking after people's clothes and that the housekeeper and domestic staff worked really hard to "keep on top of things." The care staff had helped to organise a birthday party for one

person on the day we visited and this was in the form of a tea party out in the garden. People living in the home were asked if they would like to join in. It was a hot day and people were seated under large sun umbrellas and offered lots of different types of drinks as well as birthday cake.

Requires Improvement

Is the service responsive?

Our findings

On the last day of our inspection visit in January 2018 we reported that we found that there were more staff on duty, including a senior carer on each unit, and staff were better deployed and organised. This had improved the atmosphere it had been calmer and people had been engaged in numerous activities. We saw staff had more time for conversations, to engage with people and to be more responsive to people's needs.

On this inspection visit July 2018 we found that staffing levels had improved on weekdays however, the weekend proved more difficult to staff, and deployment and the effectiveness of staff continued to presented problems, as reported on in the other key questions. This had a knock-on detrimental effect to all aspects of the service and we found that the initial pace of improvements had not been maintained. This had impacted on this key question of Responsive.

We continued to find pre-admission assessments were of a variable quality and important information was not transferred into care plans in a timely manner. This meant that staff did not have the knowledge about peoples' needs and instructions on how to effectively and safely support people. We found the service was, after an assessment, accepting people with complex health needs without ensuring that staff had the training, expertise and skills to meet their needs.

Since the last inspection there had been a comprehensive review of care plans and evaluation sheets that were intended to ensure that care plans were now setting out clear instructions for staff to follow. However, we found that while some changes in people's needs were noted in the evaluations these had not led to changes in people's overall care plans. We found that monitoring of people's conditions was not consistently recorded. For example, we saw that the home had two separate systems for recording daily notes; one for nurses and one for care staff. When we checked these we found that they did not always match. For example, one person was recorded by care staff as having a worsening skin condition over a few days and the nurse's notes recorded no change for the same condition over the same period. This meant that staff did not have up to date information to meet people's needs.

We also continued to find that not all care plans provided appropriate information to enable staff to support people effectively. For example, one person's care plan reported that they didn't wear glasses but in an evaluation of care plan it states "cataracts both near & distance" and new glasses. The care plan had not been updated to include this or any instructions for staff about ensuring the person wears them. This is an important piece of information to do with the person mobility but this had also not been included in this section of the person Mobility care plan. We had been told by the service that on analysing the number of falls in the home that this person had fallen seven times in June 18.

As part of the inspection team we took with us a specialist adviser in occupational therapy. They found that moving and handling plans were not specific to the person and staff were unsure of how to assist in moving people. They found that plans were not updated after a fall. One person's records stated that they were at a high risk of falls and one plan stated uses a zimmer while another states a rotator. These are very different forms of mobility aids. This person had a fall in June 18 that resulted in a fracture and hospital admission

and five days after hospital discharge we found they had not had a care plan or risk assessment review or updates. The home was not carrying out post falls analysis and were therefore missing opportunities to prevent further falls. This meant that staff did not have sufficient information to enable them to support the person safely and effectively. This resulted in unsafe care.

On our visit 3 December 2017 people at the end of life had been prioritised to have their end of life care plans reviewed to ensure they were up to date and accurate. We saw how one person's care plan for end of life care had been updated to include wishes and requests as well as appropriate treatment plans, such as end of life medicines. Staff reported that they had been given additional time to do this.

We also saw how work had started in improving people's care plans to not only make them up to date but to also make them more person centred. Work had commenced on people's life stories, history and interests. While this had commenced this is an essential piece of work that needs to be completed and used by staff in the delivery of recognised good practice in delivering person centred dementia care. We found that where people's histories had been completed these had not been adapted into story books or into a form that could be used with the person. We did not see the use of technology in this type of work. There was limited use of technology for people in the home, such as tablets, computers, or the use of skype. We did see, as previously mentioned, that the activity coordinator had worked on the environment upstairs to make it more attractive for people to spend time in.

The interim manager shared with us plans to have a full dementia audit for the service in January 2018. This was to include an expert from the company delivering training for all the staff team and a review of the working practices and environment to ensure the home was dementia friendly and would meet the needs of people living with dementia. We found however that the service lacked a cohesive dementia care strategy setting out the philosophy of how they care for people living with dementia and how this was to be met through staff training, adaptation of the environment and suitable and activities.

We did not see that the home was making use of current best practice best in dementia care such as that from NICE (National Institute for health and care excellence) Guidelines on Dementia (2016, 2011).

We found these to be a breach of Regulation 12: Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) 2014. The provider had not done everything practicable to make sure that people who received care and treatment, based on assessments, that meets their needs and responds in a timely way to changes in their need. Effective systems, plans and pathways were not in place for staff to follow in meeting these needs.

We received mixed views on this inspection about how complaints were handled by the service. While some people who used the service knew how to make a complaint or raise issues others were less sure and some people told us they would not be comfortable about making a complaint.

We looked at the home's file for formal written complaints and found these to follow the providers policy and producers on handling complaints.
However, we were told by several relatives that they had raised complaints verbally and this had received in unsatisfactory responses and outcomes with very little improvement or change as a result. Relatives told us that they had complained numerous times to nurses and to the managers in the home and they had not been offered a complaint form. The home did not record these verbal complaints so we could not review the actions taken.

The service was not using these concerns and complaints to improve and shape the service. One relative

told us, "I've got sick of complaining now, so I just come in as often as I can and try to sort things out as we go along." Another told us of going to the manager's office with a lengthy complaint and that none of this was written down and a complaint procedure form was not offered to them. A number of people told us that they didn't feel comfortable raising a concern. One person living in the home told us, "If you say anything here it goes against you." While a relative told us that staff were defensive and instead of dealing with their issue had "made excuses and tried to prove them wrong."

This is a breach of Regulation 16: Receiving and acting on complaints. The provider had failed to operate an accessible system for identifying, receiving, recording, handling and responding to complaints by people living in the home and other persons.

Inadequate

Is the service well-led?

Our findings

At our last inspection the provider failed to have robust systems in place to ensure the service met the requirements of the Health and Social Care Act. At this inspection, the provider had still not addressed the governance issues at the service. This was despite the home being placed into the provider's special measures of the "Priory accelerated improvement plan" and providing to us a comprehensive action plan to show how the service would be at least Good by this inspection of July 2018.

At this inspection July 2018 we identified continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Regulation 12 (Safe care and treatment), Regulation 17 (Good governance) and Regulation 18 (Staffing). New breaches were identified in Regulation 13 (Safeguarding service users from abuse and improper treatment), Regulation 16 with regard to complaints and Regulation 11 (Need for consent).

This showed that there remained concerns about the service delivery and the service was still not well-led. Furthermore, we found that some of the improvements identified during the last inspection had not been sustained. This meant the breach of Regulation 17 continued again at this inspection.

The service did not have a registered manager in post, as required by their registration with the CQC, at the time of this inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The provider was actively recruiting for the post. In the meantime the interim manager was completing the forms to become the registered manager for the home.

In December 2017, the home was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as we found medicines were not always administered as prescribed. Since the inspection, the provider had employed an independent consultancy firm to focus on improvements to medicines management. The interim manager had also introduced new processes and documentation to help staff manage medicines safely. Although there were still some issues with documentation, at this inspection we found medicines were safe.

On the inspection of July 2017 we found that the registered provider had not ensured that we had been notified of the all the accidents and injuries that had occurred in the home as they were required to under the regulations. We prosecuted the service and issued a fine for this offence. The service was now reporting incidents and events as required by law to CQC.

There were systems in place to monitor the quality of the service at Dalton Court however these systems had failed to identify or to address in a timely way the areas of concern identified at this and previous inspections. These included concerns with risk management, insufficient staffing, and with the way in which care was provided to people who were vulnerable. There was a delay in the provider picking these up and therefore also taking action. This meant that people living in the service had been at risk of unsafe care and

treatment.

We continued to find key information for safe and effective care was not available to all staff. Documentation was disorganised, incomplete and ineffective in communicating clear plans of how individuals should be supported.

The service did not always work effectively with key organisations, for example there were a number of people who are at high risk of falls who have not had recent assessments by either a physiotherapist or occupational therapist. When professional external advice was sought it was not always communicated to other staff or transferred into care plans. This meant staff did not have up to date information on how to meet people's needs. This was not picked up by the providers auditing systems.

Staff reported that there was a blame culture with poor staff morale. People and relatives in the home told us that they didn't feel listen to and received a poor response to any complaints or concerns they raised.

This was a continued breach Regulation 17: Good governance as the service was not being well-led and the systems to monitor the quality of the service were not being applied effectively.

We were contacted immediately after the inspection by the provider who told us that they a responsive and responsible provider and took immediate actions as set out in an action plan. The Operations Director wrote to inform us, "We have put a voluntary suspension on admissions on the dementia floor whilst we do the improvements and the admissions to the nursing floor will have Operation Director sign off prior to admission to ensure we don't add acuity and complexity. We are determined to do this but it is a hard slog. We are committed as a provider."

After the previous inspection of November 2017 the provider had put in place a recovery programme termed 'Older people accelerated plan for quality improvement' so that the service was placed under greater scrutiny and offered support and additional resources.The provider had told us following the previous inspection that the isolated geographical location of the home presented some challenges with providing support and monitoring. We saw that electronic systems were in place for monitoring and the home had regular dial-in teleconferences. However, staff in the home said they would like more support and to see senior people from the organisation more often.

Following our inspection and feedback the local authority arranged meeting to discuss with stake holders and the provider the issues and what support could be offered to the home. The interim manager, clinical lead and dementia unit lead engaged positively in the meeting however, there was no senior representative from the organisation.

We also judged that the staffing levels in the home also presented challenges to how quickly and effectively the home made improvements. We saw that staff were stretch carrying out their day-to-day jobs and this meant that they were not always able to dedicate the time needed to bring about improvements.

Unfortunately we had not seen the improvement required to take the services out of our Special measures or to change the rating.