Caring Homes Healthcare Group Limited

Dormy House

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

Dormy House is a care home with nursing which is registered to accommodate 88 older adults, some of whom may require specialist care associated with dementia. Dormy House is located in Sunningdale near Ascot, Berkshire and overlooks a famous golf course. There are beautiful landscaped gardens around the building. At the time of the inspection 73 people lived at Dormy House. The location is part of the Caring Homes group of care homes. The service is divided into three units; Surrey unit provides specialist dementia care. Dormy unit provides nursing care and Wentworth unit provides mainly residential care. In 2016, the provider was undertaking an extensive refurbishment and redecoration programme with particular focus on communal areas for people.

At the time of the inspection, there was no registered manager. 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. The home manager had applied for registration and was awaiting an interview with our registration team to determine they were a fit person to oversee the regulated activities.

The current inspection was a focused inspection in response to concerning information we received. The inspection was prompted in part by notification of an allegation of abuse. This incident was subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. Systems were in place to protect people from harm, however, these had not protected all people. Immediate action was taken to protect people and the service was working with partner agencies.

We looked at one key question: "Is the service safe?" The inspection occurred on 18 August 2016 and was unannounced. The location was last inspected under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on 3 February 2015 and 10 February 2015. At the time we rated the service good overall.

We spoke to people who told us they liked to live at Dormy House. We observed people enjoying themselves and participating in activities. Relatives visited throughout the day of the inspection and were also observed to be actively involved in the lives of people who used the service.

Individual risks to people were assessed and managed. People had risk assessments and care plans in place for a variety of their activities of daily life. For example, we saw assessments related to eating and drinking, mobilising, risk of developing pressure ulcers, and the use of bed rails. These were detailed documents and person-centred. The care documentation protected people, as far as possible, against harm that could occur.

People were protected against abuse and neglect. There were systems in place which staff and managers would use to deal with allegations people might not be safe. The service communicated with us when these

kinds of concerns were raised and kept us informed regarding investigations. Staff were required to attend mandatory training to understand how to protect people and what to do if they had concerns.

Sufficient staff were deployed to provide nursing and personal care for people. The service had a system to determine how many staff should work on each unit and shift. We found this was a satisfactory way to determine staffing levels. We observed staff were able to spend time with people and not in a hurry. Busy periods like breakfast and lunch were managed well by the team leaders and workers in each unit.

Robust recruitment checks were carried out before staff commenced work at Dormy House. The service kept evidence of the necessary checks in staff personnel files and was in line with the applicable regulation. Where staff misconduct occurred, we found that the management had acted professionally and ensured people's continued safety.

Appropriate maintenance of the building occurred. A range of checks and routine repairs were conducted to ensure that people were safe.

Where incidents or accidents occurred, these were formally reported, reviewed by managers and acted upon. Where necessary, other stakeholders like commissioners and safeguarding teams were advised.

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.

People were sufficiently protected against abuse or neglect.

People were protected from risks which were adequately assessed, mitigated and resolved.

People's care was safe due to sufficient staff deployment.

The service protected people by the use of robust recruitment procedures.

The premises and environment was maintained to ensure people were not placed at risk of harm.

Dormy House

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 was planned to check 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 18 August 2016 and was unannounced.

The inspection team comprised two adult social care inspectors and one specialist advisor. The specialist advisor was a team leader for an adult safeguarding service of a local authority.

In planning the inspection we reviewed all the information we held about the service. This included notifications regarding safeguarding, accidents and incidents and changes which the provider had informed us about. Before the inspection, the provider was not required to submit a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

In order to gain further information about the service, we spoke with people who used the service, relatives or visitors and staff. We spoke with the location's home manager, deputy manager, a regional operations manager, maintenance person, receptionist and administrator. We also spoke with 10 other staff, such as registered nurses and care workers who provide direct care to people. We had received information from two local authorities and the clinical commissioning group (CCG) prior to the inspection.

We looked throughout the service and observed care practices and people's interactions with staff during the inspection. We reviewed people's care records and the care that people received. We reviewed records relating to the running of the service such as staffing information, documents associated with staff training and maintenance logs.

Observations, where they took place, were from general observations. The provider was asked to send information to us after the inspection and we received and reviewed this as part of the evidence we considered.

Requires Improvement

Is the service safe?

Our findings

The current inspection was a focused inspection in response to concerning information we received. The inspection was prompted in part by notification of an allegation of abuse. This incident was subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. Systems were in place to protect people from harm, however, these had not protected all people. Immediate action was taken to protect people and the service was working with partner agencies.

People told us they felt safe living at Dormy House. One person was keen to speak with us and told us their experience of living at the service. We were in the presence of the home manager at the time. The person said, "I can't fault anything here. The staff are lovely. You couldn't have a better person to run it." Activities ran throughout the day in all units, and people who wanted to were involved in them or observed. In the afternoon we saw people and relatives actively enjoyed a large group activity in a communal lounge. People were happy, smiling and socialising together in a group exercise.

People were provided with safe care because their risk assessments and care plans reflected their individual needs. We looked at paper based records for seven people who used the service. We could see that people's risks were thoroughly assessed and documented. In the risk assessments and care plans we examined, we saw a comprehensive range of documents. Examples included falls risks, environmental risk assessments, bed rail risk assessments, moving and handling and Waterlow scores (pressure ulcer prevention). People's allergies were noted within care plans and on the pre-admission assessments. We looked at how the service protected people from weight loss which could be caused by malnutrition. We saw that people's weights were recorded and any weight gain or loss was assessed over time to determine risks. In some instances, we found people who were underweight were safely gaining weight. This meant that where individualised risks were determined, staff used appropriate interventions to avoid harm.

We reviewed reporting of people's incidents and accidents. There were records which showed satisfactory reporting of injuries by staff and review of the reports by managers. The monthly number of incidents was checked by the management. The service had recently commenced analysis of incidents and accidents so they could determine trends or patterns. This was to help managers determine whether action was needed to reduce recurrence of similar incidents. We did find in the dementia unit that stair gates were installed on some people's bedroom doors. This was a historical practice as relatives had communicated concerns when other people inadvertently wandered into bedrooms. The stair gates were installed on people's bedrooms where the person was unable to mobilise on their own. We pointed out the use of the stair gates posed a risk to people who did wander about because they could fall over them. In addition, the stair gates could have prevented emergency access, such as that required in a fire evacuation. The home manager noted our concerns and advised they would consult with the deprivation of liberty safeguards team from respective local authorities. Review of the use of the stair gates had to occur only following consultation with people who used the service, family members and relevant professionals including social workers.

We looked at the prevention of abuse and neglect at Dormy House. The service had a robust safeguarding procedure in place. This was underpinned by a localised policy which guided assessment and decision

making in the event that allegations of unsafe care occurred. The management were aware of the Berkshire area procedures for safeguarding. When we checked our records, there was evidence that the management of the service contacted us promptly when there were alleged reports of abuse or neglect. The service complied with regulations that required them to mandatorily report issues to us. On some occasions, the service also provided us with updated information in relation to allegations they had previously reported. Within the premises, we found there were contact details for local safeguarding stakeholders and clear instructions for managers and staff to follow in the event of allegations of abuse or neglect. This meant that in the event of a safeguarding matter, a clear process would be followed to ensure a person's safety or protection. There was promotional material available pertaining to safeguarding older adults. In addition, staff had access to information about how to anonymously report issues via whistleblowing procedures.

Staff were also required to undertake training about safeguarding vulnerable adults. This occurred at induction, in line with mandatory requirements for new starters, and then in an ongoing process throughout a staff member's employment at the service. Although frequency of attendance varied between staff for various reasons, a reasonable percentage of staff had up-to-date knowledge to help protect people against abuse and harm. The service sent us training statistics following the inspection. We also spoke with the regional operations manager regarding safeguarding training for staff. We found a reasonable and proportionate amount of staff had received necessary training. We also saw evidence that an ongoing programme of safeguarding training was in place at the service.

Prior to the inspection, we had received information that staff may not be following the provider's policies regarding people's safety. The service had informed us promptly and provided information about actions they had taken to ensure people's safety. We checked whether people were safe following these concerns. As an example, we looked at the service's systems in place about taking pictures or videos of people who used the service. We found staff employment contracts were clear regarding the use of personal mobile phones and breaches of the service's policies. We saw the latest version of a staff contract which documented that use of personal mobile phones was not permitted for staff and they were required to be locked away during working hours. The provider monitored this policy closely. Staff who failed to comply were subject to disciplinary action. When we spoke with 10 staff during the inspection, they knew about the policy and were aware of why it was in place. Nine staff demonstrated they had locked their personal mobile phones away during their shift. One agency registered nurse had their personal mobile phone in their pocket when we spoke with them, so we alerted the manager and they ensured the nurse was appropriately informed of the policy. The service showed us evidence of memos and staff meeting minutes that demonstrated they communicated those actions which placed people at risk would not be tolerated.

The ability of staff to take pictures of people who used the service was also controlled by the requirement to gather satisfactory consent from relevant persons. Sometimes pictures of people were necessary, for example to identify them for the purpose of medicines administration and to document any wounds. Written consent was obtained in every instance. Where the person had the capacity to, they consented to pictures and signed relevant documents to document this. Where the person could not give valid consent, staff obtained consent from other parties like the legally-appointed power of attorney. These processes ensured, as far as reasonably practicable, that pictures of people were taken only for their intended use.

We examined safety of the premises and routine safety checks with the maintenance person. This staff member had a good understanding of maintenance and safety procedures and was able to demonstrate the continued mitigation of risks at the service. There was extensive evidence and documentation that regular examination and testing of building and grounds safety occurred. For example, we saw records such as risk assessments and maintenance plans for fire safety, portable appliance testing (PAT), lifting equipment (hoists and lifts), window restrictors and bed rails. We also reviewed prevention and control

measures for Legionella. We examined a Legionella risk assessment conducted at the location by an external contractor in June 2015. This showed remedial actions required by the service. For instance, a section of the risk assessment was not signed off to show completion of recommended tasks. We wrote to the provider after the inspection and requested further evidence to show that the risk to people from Legionella was mitigated. The provider sent us information which showed necessary actions were undertaken to prevent the growth of Legionella in the building's water supply. Some minor building risks we observed during the inspection were immediately reported to the home manager, and resolved before we departed Dormy House.

We checked staffing deployment of the service during the inspection to determine whether people received safe personal and nursing care. We observed that safe clinical leadership of care teams within all units was evident. When we asked, staff were aware of who was in charge in their unit and the team leader was available for them to consult as needed. We could see that staff knew and understand what was expected of them in their respective roles. Registered nurses were sometimes out of sight of care workers whilst they performed tasks like administration of medicines or documentation of care. However, we found that care workers were able to locate registered nurses when they needed to, and there was good communication between respective members of staff. The service completed regular dependency assessments of all people who used the service. This determined how complex the person's needs were and how many hours of care the person needed within a given time period. This was then used as the basis for staffing in each unit. Where care was complex or people displayed challenging behaviours, for example in the dementia unit, staffing ratios were higher. This ensured that enough staff were present when people required assistance.

We looked at the personnel files of six staff. We found that the service had completed the necessary checks for new staff and had records of required documents in the personnel files. Contents of personnel files included proof of identity, checks of prior conduct in similar roles, complete job histories and reasons for staff leaving prior jobs. We saw the provider performed criminal history checks of new staff via the Disclosure and Barring Service (DBS). We found that for all six personnel files, criminal record checks were either copied and stored in the file or scanned and held electronically on a computer. We checked another three personnel files to examine the process of staff resignations, investigations and disciplinary procedures. We saw the service had evidence that a fair and reasonable process was followed and executed when there were allegations of misconduct. The provider demonstrated that they referred staff, when necessary, to other regulators such as the DBS and Nursing and Midwifery Council (NMC).