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

Summary of findings

Overall summary

The inspection took place over three days; 14, 18 December 2015 and 7 January 2016. The inspection was unannounced.

This provider is in special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures.

CQC is now considering the appropriate regulatory response to resolve the problems we found.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

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 within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Dalton Court Care Home is registered to provide accommodation for people who require personal and/or nursing care. The home can accommodate up to 60 older people and people with complex healthcare needs.

Dalton Court Care Home is operated by Amore Elderly Care Limited, a unit of the Priory Group.

Accommodation is provided in single, en-suite rooms, over two floors, with the upper floor accessible via stairs or passenger lift. There is a separate unit at the home that provides accommodation for people living

with dementia.

There is a registered manager in post at the home.

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.

We found that staff worked very hard, sometimes working extremely long shifts, to try and meet the needs of the people who used this service. Their role was very task orientated with little time for staff to interact on a personal level with people who lived at Dalton Court.

We found that staff had not completed or updated essential aspects of their training, for example moving and handling training, basic life support and first aid.

We observed and people told us, that their experience of care, treatment and support was task orientated rather than in response to their needs as individuals. Staff were aware of some of the individual needs and choices of the people they supported but they were unable to effectively and consistently respond to them due to the lack of staff at the home.

Care plans relating to people's wishes when they came to the end of their life contained little information about preferences and choice.

We saw that staff were very busy responding to call bells throughout the day. There were times when people who used this service were calling out for assistance and we had to go and find a member of staff to help them.

People who lived at Dalton Court told us that the staff were, "mostly very good" but they also said that the staff were, "always in a rush"; they thought the home was short of staff. Although we noted some good interactions between staff and people who used the service, we saw that some people had not received support to meet their personal preferences and choices.

We looked at the way in which people were supported with eating and drinking. People we spoke to were not very complimentary about the standard of food provided at Dalton Court. We observed that the presentation of meals was of different standards. Great care had been taken with the soft diet options to make them look appetising and tempting. People told us that getting enough to drink was a bit, "hit and miss". When we checked people's care records, we found that people's nutritional needs were not adequately monitored.

At the last inspection in May/June 2015 we asked the provider to take action to make improvements to the management of medicines and this action has been completed. There were no significant concerns with regards to the management and administration of medicines but there were some areas that could be improved upon.

The home is well appointed and was generally clean and tidy. There were no unpleasant odours. However, we noted that there were areas of the home, and items of equipment that were not clean. Some food items were not appropriately stored because adequate provisions for refrigeration had not been made. This raised the risks of the spread of infection and contamination.

Despite high level management oversight, the service is not well led. We found gaps in record keeping and evidence of issues that had been identified during internal audits but had not been addressed. The ways in which people were able to express their views and opinions on the quality of the service they received were limited.

We have made a recommendation about the staff recruitment and selection processes.

We have made a recommendation about the management of medicines.

We have made a recommendation about involving people in decisions about their care.

We have made a recommendation about best practice for end of life care.

We found breaches of the following Regulations:

Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service did not receive appropriate treatment that met their needs and reflected their preferences. At the last inspection in May/June 2015 we asked the provider to take action to make improvements to the way in which people were supported with their needs and this action has not been sustained.

Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people did not always receive respectful and dignified care.

Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people did not receive their care and support from people who had the skills, competence and experience to do so safely.

Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were not protected from the risks of infections and contamination.

Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were placed at risk of having unlawful restrictions placed on their liberty. At the last inspection in May/June 2015 we asked the provider to take action to make improvements to the way in which Deprivation of Liberty safeguards were managed at the home and this action has not been sustained.

Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were placed at risk of malnutrition and dehydration. At the last inspection in May/June 2015 we asked the provider to take action to make improvements to the way in which people were supported with their nutritional needs and this action has not been sustained.

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because there were no effective systems and processes in place to ensure compliance with the Regulations. At the last inspection in May/June 2015 we asked the provider to take action to make improvements to the way in which quality and safety were assessed and monitored and this action has not been sustained.

Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were not enough staff to meet the needs of people who used this service and people were placed at risk of receiving unsafe care and support because staff did not have up to date skills and knowledge. At the last inspection in May/June 2015 we asked the provider to take action to make improvements to the staffing levels and this

action has not been sustained.

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The management of the service is not open and transparent, with no clear lines of accountability in place.

You can see what action we told the provider to take at the back of the full version of the report.

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.

Incidents, accidents and safeguarding concerns were not dealt with promptly or consistently. People who used this service were placed at risk of receiving unsafe care or treatment.

Staffing levels were often inadequate, which meant that people who used this service did not receive the support they required, when they needed it.

Medicines were generally managed safely. There were one or two areas where improvements could be made to help ensure people who used this service were consistently protected against the risks associated with the administration of medicines.

Is the service effective?

Inadequate

The service was not effective.

Staff did not always have the skills and knowledge to help them appropriately support the people who used this service.

The service did not consistently engage with health and social care agencies. This meant that people who used this service did not always experience positive outcomes regarding their health care needs.

The nutritional needs of people who used this service were not adequately assessed and monitored. People who used this service were placed at risk of receiving poor care and support with their nutritional needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were focused on the tasks in hand and did not have time to spend with people who used this service.

We observed that staff struggled to respond to people's needs in a timely and effective manner.

Gaps in people's care plans remained and important information had not been included. For example care plans did not detail how people wished to be cared for at the end of their life.

Is the service responsive?

Requires Improvement

The service was not responsive.

People who used this service were not protected from the risks of social isolation and loneliness.

Staff were not able to respond to people's needs in good time.

The provider did not have a consistent approach to ensure people who used this service had access to other health and social care services when needed.

Is the service well-led?

Inadequate

The service was not well led.

Internal quality monitoring audits were not robust. Where shortfalls had been identified, there was no clear line of accountability to ensure improvements would be made.

The provider did not have effective governance systems in place. Inadequate improvements had been made since our last inspection of this service.

People who used this were at risk of receiving poor quality services.

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 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 14 and 18 December 2015 and 7 January 2016. The inspection was unannounced.

The membership of the inspection team consisted of two adult social care inspectors, an inspection manager, a pharmacist inspector 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.

We looked at the information we held about this service before the inspection. This included notifications from the provider, action plans that had been sent to us by the provider and information that had been shared with us by the local authority, Cumbria County Council.

During this inspection of the service we spoke to people who used the service, their relatives and friends. We spoke to staff, including the registered manager and operations managers at the service and we spoke to social workers and health care professionals who were visiting the home.

We reviewed a sample of service user care records, 10 of them in detail. We looked at a sample of the records maintained by the provider in respect of quality monitoring. We looked at the staff recruitment process and sampled 8 staff personnel records. We observed staff working with people who used this service and we looked at the general environment at Dalton Court Care Home.

Inadequate

Is the service safe?

Our findings

One of the people, who used this service, told us that there were, "not enough staff." Another person told us; "This place is permanently short of staff. They take a long time to come to me and I am in bed all the time. I think they (the staff) put me to bed for their convenience."

We were also told by a person who lived at Dalton Court; "It can be awful. They (staff) have no time for you. If you push the buzzer you can wait forever." Another person who used a wheelchair said; "There's not enough staff. I just get parked here, nothing happens." We noted that this person did not have a drink to hand nor did they have a buzzer to summon staff assistance if they needed it.

A relative told us that they thought there were not enough staff. They said; I come to the home in the morning until lunchtime and then I come back at teatime so I can keep an eye on everything."

A relative contacted us via our website. They told us that the home was "Very, very short staffed. There are no carers available to help my 'relative' get out of bed when they want. It seems to be every weekend. My relative rings the nurse call bell for 20 to 30 minutes before they are helped."

Two other people who also used this service told us that they did not feel safe at the home. They told us that they had experienced poor support from staff with their mobility needs. We spoke to the management at Dalton Court about the concerns raised as well as bringing them to the attention of the local authority social work team.

We heard people calling for help from behind closed doors. In one case no one came to check and we had to go and find a member of staff to help this person.

We spoke to the staff on duty at the time of our inspection, including a member of staff that was just finishing the night duty. This person told us that the home had been, "short staffed" during the night. Two members of night staff had gone off sick. Their night shifts had been covered by two members of staff who had already worked all that day. The staff rotas confirmed this to be the case. The rotas also showed that this same situation had occurred earlier in the week too.

Another member of staff told us; "There are not normally this many staff on. They (the management) are getting extra staff in because CQC are here." The registered manager had earlier told us that two more staff were, "on their way in".

Further examination of the staff work rotas showed that the home was frequently short of staff and further examples of staff working long and double shifts were evident.

The registered manager told us that there was currently a recruitment drive in progress in order to recruit more members of staff. We looked at the information we held about this service and noted that staffing issues were long standing problems at Dalton Court.

Staff turnover was high and there was a poor history of staff recruitment and retention at Dalton Court. These concerns were reflected in the internal monthly audits. We asked the registered manager if she conducted exit interviews with staff who resigned from their post at the home. She initially told us that she did but at a later date said that outcomes of exit interviews were not formally recorded. This type of information could have been useful in helping the provider identify and address some of the issues around staff retention.

The internal monthly audit for November 2015, recorded that the registered manager was, "struggling" to cover staffing levels, particularly over the up-coming Christmas period. The provider had no contingency plans with regards to the staffing levels. We asked the provider to develop a contingency plan and give us assurances that the home would be safely staffed over the Christmas and New Year period. The provider gave us this information and arranged for staff from another of their homes to work at Dalton Court for an interim period. The manager told us that these arrangements would continue until staff could be recruited to Dalton Court. There were no clear assurances as to how this arrangement would be sustained in the future.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our last inspection of this service we told the provider that they were not complying with this Regulation. There were not enough staff to meet the needs of the people who used this service.

On the first day of our visit, the ground floor communal bathroom was in a poor state. The clinical waste bin was overflowing with used continence pads, empty feed bottles and associated waste products. The waste bin was left in this condition for over three hours, with the bathroom door left open. We showed the registered manager this situation. She told us that the night staff were responsible for emptying this bin, even though they had been very short staffed on the shift. The registered manager arranged for the bin to be emptied after we had spoken to her about this matter.

The sink and toilet were not clean, the bath was dry and dusty. All of these facilities could not be accessed as the bathroom was also being used to store equipment such as cushions, walking frames, wheelchairs and other handling equipment. This was despite a sign requesting staff not to use this area as a, "dump store". On our next visit to the home, this area had been significantly tidied up and was accessible for use.

We observed that people's wheelchairs were not cleaned. These items of equipment were covered in food debris and bodily fluids. We showed some examples to the registered manager at the time of our visit.

The monthly operations director visit report for September 2015, identified that there was no longer a head of housekeeping and that there were shortfalls in the completion of cleaning records. It was noted at that time that the home was "clean and tidy". Their report in October 2015 continued to identify issues with evidencing what cleaning has been done and when. However, when the operations director visited in November, the "cleaning records were not reviewed."

The registered manager told us that she had asked the provider to allocate more hours for housekeeping and cleaning tasks.

We saw from the staff training matrix that there were 22 members of staff who needed to complete infection control and prevention training, with a further 17 members of staff unaccounted for as they had not been included in the training matrix.

We visited the dining rooms and kitchen areas of the home during our inspection. We noted in the

downstairs dining room that there were two jugs of milk stored on the side in this warm room. We asked the cook about this matter. We were told that one of the fridges in the kitchen had broken at the beginning of October and had not been replaced. The fridge normally used in the dining room for storing milk jugs had been taken to use in the kitchen until a new fridge arrived. The kitchen staff told us of other pieces of equipment, including the dishwasher that had recently broken and taken a long time to replace. Everything they told us was confirmed in the provider's monthly operations directors visit reports.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were not protected from the risks of the spread of infections because the provided did not have robust processes in place to assess and manage infection prevention and control.

We looked at the processes in place for the recruitment of new staff to the home. We found that the provider carried out pre-employment checks on all prospective staff including the PIN numbers for qualified and registered nurses. Although the provider had sought references as part of the pre-employment checks, there was little satisfactory evidence that the provider had carried out all of the required pre-employment checks.

We recommend that the service considers a review of their recruitment processes to ensure all of the required checks, so far as reasonably practicable, are carried out robustly, and with outcomes recorded.

The pharmacist inspector looked at the way in which medicines were managed and administered during our visit to the home. We found that there were no significant medicines concerns but there were some areas that could be improved upon.

We observed the administration of medicines taking place on the ground floor at the home. None of the people who used this service were responsible for managing their own medicines. We noted that the nurse was careful, considerate and particularly helpful towards people who used this service. Medicines were carefully checked before administration, patient identification was good and the nurse witnessed all medicine doses being taken before signing the administration records.

We found that the medicines in use were stored safely and securely. We saw some medicines that were for "destruction". These had not been stored securely. We spoke to the nurse about this matter at the time of our inspection.

We noted that there were several people who received their medicines covertly. We found that in all cases there was evidence that a best interest discussion had taken place, involving a nurse, a relative and the person's GP. There was no evidence that a pharmacist had been consulted, which is contrary to good practice, to advise on the stability of any medicines that needed to be crushed or mixed with food or liquids.

There was an inconsistent approach for recording the administration of "when required" medicines. The medication administration record did not always record the time of administration or whether the medicines had been offered or refused. This meant that staff could not be sure that it was safe to administer further doses and ensure the correct time interval.

The administration of topical medicines was undertaken by care staff. Records of the administration of these types of medicines were not always accurately maintained and there was no oversight of this by the registered nurse. Additionally, topical medicines were stored in people's own room, usually in their bathroom. These arrangements do not comply with the standard medicines storage guidelines.

We recommend that the service considers current guidance about the management of medicines and take

action to update their practice accordingly.

We found that the provider had procedures and protocols in place with regard safeguarding vulnerable adults. A checklist/aide memoir had been developed to help staff make sure all the information was collected and reported appropriately should allegations of abuse be made. We noted that not all staff were up to date with their safeguarding vulnerable adults training. We spoke to the registered manager about this at the time of the inspection.

Inadequate

Is the service effective?

Our findings

One of the visitors to the home told us; "They (the service) just keep losing the staff and the new ones don't know what they are doing."

Two of the people who used this service had raised concerns both with us and the manager they felt they had been handled roughly by staff.

A member of staff told us that new staff "Sometimes only get 2 days or nights induction training and some staff have not had any moving and handling training when they start work." This person thought that new staff were not always prepared for the, "intensity of the work on the units."

We asked the registered manager for a copy of the staff training matrix. We noted that there were 49 staff recorded on the training matrix, including ancillary staff such as the gardener, handyman, housekeepers and kitchen staff. We looked at the training matrix in conjunction with the care staff work rotas. We found that there were 17 people on the staff rota who were not accounted for on the training matrix. We were unable to verify that these members of staff had been provided with appropriate training and had the skills and knowledge required to carry out their role safely.

We found that there were gaps in the staff training records. There were staff who required training or updates in the protection of vulnerable adults (safeguarding) and moving and handling skills. We noted from the staff rotas that there were staff designated as 'fire marshals' and 'first aiders' for their shift at the home. When we checked the training matrix we found that three of these people were required to update their basic life support training and one of them needed to update their knowledge with regards to fire safety too. A further three people who had been designated as a first aider or fire marshal were not included in the training document and their skills and knowledge could not be accounted for.

The operations director visit report in September 2015 had identified the shortfalls in staff training. These included safer people handling, basic life support and first aid. In October their report noted that basic life support and first aid training was still required and in November 2015, concerns remained about training and access to training.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were placed at risk of receiving unsafe care and support because staff did not have up to date skills and knowledge.

We checked whether the service was working within the principles of the MCA.

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 looked at the way in which the service protected the rights of people who may lack the capacity to make particular decisions.

The provider had policies and procedures in place with regards to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLs). There was a system in place to help the provider monitor and keep track of any applications that had been made with regards depriving someone of their liberty.

We looked at the staff training records to check whether staff were up to date with their training with regards to the Mental Capacity Act 2005 and DoLs. We found that there were significant numbers of staff who had not updated their skills and knowledge in these subjects.

One person's care records showed that an application to deprive them of their liberty was in progress. There was no clear reason as to why this request was being made and when we asked the registered manager about this, they were unable to provide further information and an explanation.

The operations director monthly visit report for December 2015, recorded that 10 DoLs applications had been submitted and that most were awaiting an outcome decision from the supervisory body. We checked the information we held about this service. We found that the provider had failed to notify us of the granting or refusal of any application as required by the Regulations.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were placed at risk of unlawful restrictions of their liberty. The provider had not properly trained and prepared their staff in understanding the requirements of the Mental Capacity Act and of the Deprivation of Liberty Safeguards.

We looked at the way in which people who used this service were supported with eating and drinking.

One person who we spoke to told us that they were, "very hungry and very thirsty" and had not had anything to eat or drink since teatime the previous evening.

Another person told us; " I'll have to be honest, we get a drink sometimes, when they (staff) can. The food is OK, that's alright but drinks, they are a bit hit and miss." Someone else said; "You get a drink when they (staff) think of it and you get food eventually."

One of the people who used this service were in bed and called out to us as we passed the door. They asked us for help as a member of staff had brought them tea and toast but had not put their teeth in for them. We had to go and find a member of staff to assist this person.

We received other comments about the food during our visit, including; "the food is a bit rough", "the meals come up cold" and "the food is best not talked about."

One person described their meal as "splodge on the plate with gravy poured on it." They also told us that they used to have a tray with a jug of water, but not anymore, "I get so thirsty" they said.

We observed that there were jugs of water, juice and snacks available around the home, but these were not accessible to most people because they needed the assistance of staff. People sat in communal rooms did not have access to a call bell to help them summon assistance from staff when they wanted a drink or a snack.

We observed the service of the lunchtime meal. There was a marked difference in the standard of presentation between 'normal' diet and 'soft' diet. We saw the chef preparing the soft diets. They took great care in ensuring the meal was well presented and looked appetising. The 'normal' diet, which was exactly the same meal, was served in a heap on the plate with vegetables and gravy.

We spoke to a speech and language therapist who was visiting the home at the time of our visit. They told us that the provider "usually" acted appropriately on advice and instructions given with regards to people's dietary needs. However, we noted one person with a bottle of water who should have been receiving thickened fluids and food to help reduce the risks of choking and we were told of another person who had been placed on a pureed diet without consultation with the speech and language therapist. This resulted in this person not eating properly for three days.

We looked at the nutritional assessments and records of some of the people who used this service and had been identified as needing extra support and monitoring with their nutritional needs.

One person had a detailed plan of their nutritional needs, including the need to fortify their diet. Instructions were recorded in the care plan that staff were to monitor food intake and inform the nurse if meals were not eaten. We looked at the nutritional diary for this person. The records showed when food had been refused or when the person was sleeping at a mealtime, but there was no evidence to confirm that alternatives had been offered in order to tempt them to eat, or that meals had been offered once the person was awake again. There were no records to confirm that fortified drinks had been offered and taken as detailed in their care plan and prescribed by the dietician. We noted from the monthly body weight records that this person's weight fluctuated. There was no way of confirming the nutritional intake of this person or whether this had impacted on their fluctuating body weight.

The care plans of another person recorded that they had "diminished swallowing" and we could see that the speech and language therapist had been involved with their nutritional assessments. Their nutritional plan instructed staff to ensure this person was sat appropriately when eating and drinking. The plan also referred staff to another part of this person's care plan for further guidance about positioning. When we checked this we found that there was nothing recorded about this. We noted that this person was recorded as needing fortified meals and that they had lost 6.5kgs since their admission to the home six months ago. Their records showed progressive weight loss but their food intake had not been monitored in order to help address this concern.

When we visited the home on 7 January 2016, the provider's divisional catering manager was at Dalton Court. They told us of the changes they were planning to put in place with regards to meals and nutrition and described these as "a work in progress."

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were not provided with adequate nutrition and hydration. This meant that their health and welfare were placed at risk of harm.

Dalton Court is a purpose built, modern care home. All of the bedrooms were well appointed with en-suite facilities. Additionally, there are communal areas such as pleasant lounges, dining rooms, quiet areas,

bathrooms and family rooms. The home was generally well maintained with good quality furnishings and décor.

We noted that people had access to equipment to help them mobilise and help keep them safe, although some of this equipment was not maintained to a clean and hygienic standard. Where people had been identified as needing specialist equipment and adaptations, we found evidence to confirm health and social care professionals, such as the occupational therapist, had visited to carry out assessments.

The registered manager told us about the staff induction process and showed us examples of the recently reviewed and up dated induction training package that would be provided to new staff. We looked at a sample of five staff personnel records and noted that these staff had received supervision from their line manager. We noted that one of these staff had recently started working at the home and were currently working through their probationary period. Supervision sessions included face to face meetings and direct observations of working practices.

Requires Improvement

Is the service caring?

Our findings

We spoke to people who used this service and some of their visitors. We also spoke to members of the staff team and observed them working with people during our visit to Dalton Court.

One person told us; "Oh it's alright. They (staff) look after me. They are alright the care staff but not some of the new ones. They are a bit hoity toity and that doesn't do for me." Another person said; "The girls are OK. They are very busy but they are very nice."

However, not everyone was so positive about their experiences. One person told us; "The staff are mostly good but there are one or two not so good. The girls are always in a rush, I didn't even get my teeth in this morning."

The visitors we spoke to also had differing views. One person told us that their relative had not been at the home long, but "seemed to have settled in". They said their relative referred to some of the staff as, "Friends, which is a great improvement on their previous experience of living in a care home." Another visitor told us that staff looked after their relative "really well." They added; "They (staff) ring me if my relative is poorly and they discuss the care plans with me."

The relative of another person who used this service commented that there wasn't enough staff available. They said; "They (staff) don't shower my relative properly and dress them anyhow. Their hair is quite often like a hayrick."

One of the members of staff we spoke to during our visit described all the tasks they were responsible for during their shift, including administration of medicines, managing the special nutritional needs of seven people and helping induct new staff into their role. The staff member was distressed and told us; "There was one particular time recently when I could not give the care that two people at the end of their life needed."

Another staff member said; "I love my job but all this wears you down." They were referring to the staffing levels in relation to care tasks that needed to be provided.

During our visits to the home we observed that staff were extremely busy but were trying their best to attend to everyone who needed their help. During our inspection visits to the home we noted that call bells were going off constantly. We observed that people remained in bed or were sitting in communal areas for long periods of time without any staff appearances or interventions. One person kept trying to get out of their chair and was at risk of falling and people were calling out from their rooms for staff assistance. We had to go and find staff to come and assist.

We saw one person being taken from their room to have breakfast. This person looked very unkempt. Their clothing was ruffled and their hair had not been brushed. We looked at the care plan for this person and it stated that they liked their, "clothing to be smooth and neat." We noted that this person also had an injury and when we checked their records two further injuries had been recorded. There was no indication as to

how the injuries had occurred or what had been done to in response to them. We asked the registered manager about these but they could not provide us with an explanation.

We observed another person in the dining room eating their breakfast. They had vomited or coughed and there was porridge all down the front of their clothing. We observed that this situation remained for at least 15 minutes, after which, a member of staff sat down with them and started to feed them, with the spilled food still in situ. This was not a very dignified experience for this person and we spoke to the manager about this matter.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were not treated with respect and dignity at all times while they were receiving care and treatment.

We observed and heard some positive interactions between staff and people who used the service. We heard a member of staff giving one person their breakfast. The staff member made sure the person was comfortable in their bed and in the correct position to enable them to eat and drink safely. The member of staff was very helpful, pleasant and provided reassurance to the person they were supporting.

We observed another member of staff singing to a person who used this service, who had become distressed. This approach seemed to calm the person and had a positive outcome.

We spoke to a member of staff about one of the people they were caring for. This person had, at times, been distressed. The member of staff had put together a good plan of care in order to try to meet their needs and keep them safe. The staff member had escalated their concerns to senior members of staff so that the right level of safe care and support could be sourced.

Although we saw some good interactions between staff and people who used this service, we noted that staff were very "task" focused and had little time to spend with the people who lived at Dalton Court.

Some of the people we spoke to told us that they had been consulted and assisted in the development of their relative's care plans. One of the people that lived at Dalton Court told us that they had access to advocacy services. There was some general information available on the notice board about advocacy services but the positioning of this information meant that it was not accessible to most of the people who used this service.

We spoke to the registered manager about the ways in which people could comment and be involved with the service. We saw that relatives and residents meetings had been held, but these were not held on a regular basis. We asked about the use of satisfaction surveys and questionnaires . The manager told us that there had been no recent surveys carried out and added that they were "putting one together" for use in the near future.

We recommended that service seek advice and guidance from a reputable source about supporting people to express their views and involving them in decisions about their care, treatment and support.

The end of life care plans that we saw, referred only to whether someone wished to be resuscitated or not in the event of a cardiac or respiratory arrest. There was little information recorded about people's wishes when they came to the end of their life.

We recommended that service seek advice and guidance from a reputable source about supporting people

with their end of life care needs and wishes.

Requires Improvement

Is the service responsive?

Our findings

Everyone we spoke to told us that their family and friends could visit "anytime" and that they were able to receive their visitors in private, if they wished.

We asked people about the social and leisure activities that were available at the home. One person told us; "There is nothing to do." Another person told us that they had enjoyed the singer who had visited the home the previous day; and another person commented "We get stuff to do sometimes", but did not elaborate on what "stuff" was provided.

We observed many people were in bed for most of the time, particularly on the ground floor units. We saw one person lay in their bed with the TV on. They were in such a position that they could not see the TV. We saw this person again later in the day. They were sat up in bed, the housekeeper had got more pillows to prop them up in bed.

People who used this service had a written plan of their care and support needs. The staff we spoke to were able to give us an account of people's care and support needs. However, we observed and people told us, that staff were not always able to respond to people's needs in a timely manner because there were not enough staff on duty.

The sample of care records we looked at showed that the provider had started to collect information about people's lives and interests before they came to live at Dalton Court but this information had not yet filtered down into their care plans in order to make them more personal.

We found inconsistencies when people who used this service needed to access other health and social care professionals. For example:

The care plans of one of the people we looked at stated that they were "very chatty", enjoyed music and the TV. However, we observed this person socially isolated in one of the communal lounge areas. This person had also been recorded as having some behavioural issues and whilst we saw other people had been referred to the mental health team, this person had not.

We looked at the care plans of another service user. They had been referred to the mental health team and a care plan had been devised to help staff manage this person appropriately and safely in times of distress. There was conflicting information in their personal profile and social care plan that could have resulted in this person becoming upset and agitated.

The registered manager told us of a person who had been admitted to the home recently. There was some confusion with regards to the admission and the person's transfers between services during their stay at Dalton Court. This person did not experience a smooth transition, although the nurse in charge on the unit did their best to manage this situation within the allocated resources available at the home.

During our visits to the home, we noted that there were many people cared for in bed. Interaction from staff only occurred when a care task was needed, for example help with meals or personal care. We noted other people had been taken to communal sitting rooms and again were left alone. These actions potentially placed people who used this service at risk from social isolation.

The provider employed an activities co-ordinator, but they were not at the home at the time of our visits. We noted that there was an activities notice board with dates and various activities. However, what happened at the home on the days of our visits did not correlate to this notice board. On one of the days we visited the home, a relative had organised for musical entertainment to come into the home. Many people attended this activity and enjoyed it very much but others were not keen on this type of activity. One person said; "It will be upstairs and too noisy."

We could not find any evidence to confirm that people who used this service had their spiritual needs met. There was no information about church services being held at the home and the staff we spoke with told us that they were not aware of any.

We saw that people who used this service had access to newspapers and books. People also had their own landline telephones or mobile phones to help them keep in contact with family and friends.

We observed and people told us, that their experience of care, treatment and support was task orientated rather than in response to their needs as individuals. Staff were aware of some of the individual needs and choices of the people they supported but they were unable to effectively and consistently respond to them due to the lack of staff at the home.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service did not receive appropriate treatment that met their needs and reflected their preferences.

Inadequate

Is the service well-led?

Our findings

One person who used this service commented that they "never" saw the manager.

Some of the staff we spoke with commented on the management of the service. One person said; "The manager just tells you what you want to hear. There is no confidentiality, everything gets out." They were referring to staff issues. Another person told us the "budgets were tight". We were told about items of essential kitchen equipment being broken or out of order for long periods of time without being replaced or repaired. The monthly operations director visit reports confirmed these matters to be correct, but there was little evidence to support the concerns had been addressed quickly and appropriately by the management team.

A member of staff from the community health care team told us that although the service, "more or less" followed their advice regarding the care needs of people who used this service, people were not always supported to attend appointments. This person also told us that the service doesn't tell them that people are not going to attend appointments, nor do they remake appointments for people when necessary.

Another person from the community health care team told us of the support they were giving to Dalton Court to help them effectively manage any on-going health problems and ensure appropriate referrals were made to the GP.

At the last comprehensive inspection of this service this provider was placed into special measures by CQC. Following that last inspection, we met with the provider and told them about our concerns with regards to the standard and quality of the service provided at Dalton Court. The provider had assured us that the concerns would be responded to and addressed. Action plans were put in place to help with this. We found at this, our most recent visit, that insufficient progress had been made in response to our concerns and that the provider had not kept CQC up to date with changes and improvements as they had assured us they would.

We looked at the Monthly Operations Director visit reports (internal monthly audits of the service) from September 2015 to January 2016 inclusive. We found that although issues had been identified as needing action, most of them had not been addressed throughout this period. For example, areas of staff development, cleaning records, relative's meetings and meetings for people who used this service.

The audits identified that accidents and incidents were not always accurately recorded and that the home development plan was not reviewed each month. The provider held Safety, Quality and Compliance meetings but these had not been held with any regularity and on occasion, rescheduled or postponed with no further dates for the meeting set. We noted that higher level management had oversight of these audits, but issues had continued for several months without any evidence of their involvement or of questioning practices.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014. The provider did not operate effective systems and processes to ensure compliance with the Regulations

We received conflicting information about various events that had occurred at the home. For example, we saw a record relating to whistle-blowers at the home. The record stated that "management" were dealing with these matters, but when we asked the registered manager about these they were unable to give us an explanation or details of the concerns that had been raised by staff.

We also received conflicting information regarding the admission of a person to the home and we found that people who used this service had been given inaccurate information during a meeting at the home.

This is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The management of the service is not open and transparent, with no clear lines of accountability in place.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People who used this service did not receive appropriate treatment that met their needs and reflected their preferences. Regulation 9

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People who used this service did not receive respectful and dignified care. Regulation 10

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used this service did not receive their care and support from people who had the skills, competence and experience to do so safely. Regulation 12 (1)(2)(c) People who used this service were not protected from the risks of infections and contamination. Regulation 12 (2)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People who used this service were placed at risk of having unlawful restrictions placed on their liberty. Regulation 13(5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The nutritional and hydration needs of people who used this service were not met. Regulation 14

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA RA Regulations 2014 Duty of candour The management of the service is not open and transparent, with no clear lines of accountability in place. Regulation 20(1)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There were no effective systems and processes in place to ensure compliance with the Regulations. Regulation 17

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to meet the needs of people who used this service and people were placed at risk of receiving unsafe care and support because staff did not have up to date skills and knowledge. Regulation 18

The enforcement action we took:

Warning Notice