Lancashire County Council

Dolphinlee House Home for Older People

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Dolphinlee House is a residential care home providing accommodation and personal care for up to 46 adults. Care is provided across four units with two units providing support to people who may be living with dementia and the other two units support people who require a short period of reablement. At the time of the inspection 42 people were living at the home.

People's experience of using this service and what we found
People told us they felt safe living at the home and were supported by staff who knew how to raise safeguarding concerns. Risks to people were assessed and, in some cases, actions had been taken to reduce the risks. However, this was not always consistent because risk assessments for people's medical conditions, equipment and the environment were not always carried out or robust. People's medicines were not always managed safely. Infection prevention protocols were not robustly followed, and we were not assured by measures in place including measures to reduce the risks associated with COVID-19. We made a recommendation about infection prevention practices. The provider had not ensured all staff received training they deemed necessary for the role.

While premises and equipment had been serviced and maintained, improvements were required to ensure professional guidance on fire safety was acted on in a timely manner.

Staff were recruited safely and there were adequate numbers deployed to support people.

The registered provider and their staff used a variety of methods to assess and monitor the quality of the service. However, the systems and processes needed to be robust to ensure shortfalls were identified and acted on in a timely manner; including recommendations from fire services. Medicines audits, environmental and care plan audits were not effective in monitoring quality.

Staff worked in partnership with a variety of agencies to ensure people's health and social needs were met. The provider needed to improve systems for seeking authorisation to protect people from unlawful restriction under Deprivation of Liberties (DoLS). We found people who had been in the service for a while who had no authorisation applications. We received positive feedback from staff regarding management.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update:
The last rating for this service was requires improvement (published 29 March 2019) and there were

breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We undertook a focused inspection to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Dolphinlee House Home for Older People on our website at www.cqc.org.uk

Enforcement and Recommendations
We have identified breaches in relation to medicines management, risk management, staff training and good governance. Please see the safe and well-led sections of this full report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Dolphinlee House Home for Older People

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
One inspector carried out the inspection.

Service and service type
Dolphinlee House Home for Older People is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was no registered manager in post. They had recently left to work in another part of the provider's business, and an interim manager was in charge. This means the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service, including information from the provider about important events that had taken place at the service, which they are required to send us. We sought feedback from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used information gathered as part of monitoring activity that took place on 27 April 2022 to help plan the inspection and inform our judgements.

During the inspection
We spoke with eight people who lived at the home about their experiences of the care provided. We spoke with eight members of staff including the interim manager, three senior managers, activities coordinator and housekeeping staff on the inspection. We reviewed a range of records. This included eight people's care records, multiple medicine records, accident and incident records, three staff recruitment records, rotas and staffing records and we looked at a variety of records relating to the management of the service. We walked around the home and observed the environment and interactions between staff and people.

We continued to seek clarification from the senior managers to validate evidence found. We looked at training data and quality assurance records and sought feedback from health and social care professionals.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management;

At our last inspection the provider had failed to ensure care records accurately reflected people's needs and risks associated with equipment. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance).

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17 and further new breach of regulation 12 in this area.

- The provider had not assessed risks associated with the use of equipment such as bed levers. This includes risks of entrapment and injury. A bed lever is a piece of equipment to support safe mobility and independence. These were similar concerns at our last inspection.
- The provider had not adequately carried out risk assessments for receiving care and around people's care needs. This included risks associated with conditions such as diabetes, skin conditions, constipation and specific unstable health conditions. We could not be assured people would be adequately supported by staff who had a good awareness of risk monitoring and risk reduction measures. We found concerns of poor risk monitoring in relation to people receiving short term care or intermediate care.
- People's nutritional care plans and risk assessments were not always up to date including guidance on monitoring deterioration for people living with diabetes. Risks associated with these conditions were not included in nutritional care plans or risk assessments.
- The provider had a system for monitoring environmental risks, however we found some door handles that had not been listed for repairs. Fire safety equipment had been serviced, staff were trained in fire safety and evacuation however there had been a delay in responding and rectifying some of the shortfalls raised by the local Fire Safety Authorities in September 2021.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We found the service was not consistently working within the principles of the MCA. Whist authorisations had been sought for some people, we found appropriate legal authorisations had not been sought for people whose care included restrictive practices to ensure their safety.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a continued breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance). Records were not an accurate reflection of people's needs and risk controls were not recorded within individual care records.

● The provider responded immediately during and after the inspection. They confirmed all the actions from the fire risk assessment were now completed and suitable checks of the environment and equipment were in place.

Using medicines safely

● People's medicines were not managed safely. Staff did not always follow best practice guidance in medicines management. We found medicines were not always given safely in line with best practice guidance. Staff did not share concerns regarding people who constantly refused their prescribed medicines to health professionals. In addition, they had not monitored if people's health conditions had been impacted by the frequent refusal of medicines. There was a risk of deterioration of medical conditions.

● The provider had not provided staff with guidance on how to support people whose medicines required to be administered 'when required' or intermittently. Without guides to administer 'when required' medicines also known as PRN protocols; people could not be assured they would receive their medicines when they needed them. People did not always have medicines care plans in particular where they may be concerns with their ability to take the medicines.

● The provider and their staff needed to ensure details of people's allergies were accurately recorded in all medicine administration records. We found eight records did not reference people's allergies where they had one. This exposes people to the risk of being prescribed medicines they are allergic to. In addition, there was a lack of consistency on the use of codes that were used to show when people had declined their medicines, or they were not required.

● Medicines audits were carried out however they were not robust because they had failed to identify shortfalls in medicines management and where practices were not meetings best practice standards.

Systems had not been adequately established to ensure the safe use of medicines. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment;

At our last inspection we recommended the provider seeks and implements best practice guidance on the deployment of staff.

Enough improvement had been made at this inspection and the provider had met the recommendation in this area, however we found new concerns in respect of staff training.

● The provider had failed to adequately ensure that staff were suitably qualified for their role. We found staff had not completed training that the provider deemed necessary for the role and linked to the specific needs of people in the service.

Systems had not been established to ensure staff were suitably qualified for the roles they were undertaking. This placed people at risk of harm. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were protected against the employment of unsuitable staff because robust recruitment procedures were followed.
● The provider had a system for assessing staffing requirements in the service. Rotas and our observations showed that there were adequate numbers for staff to support people in a timely manner. We observed staff responding to people's requests for support promptly.

Preventing and controlling infection
● There was a system to monitor the risks of infection however on the first day of the inspection we observed not all staff were wearing masks as recommended and visitors were not asked or checked for symptoms of COVID-19 on arrival.
● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider's infection prevention and control policy was up to date.

The home facilitated visits which aligned with the most recent government guidance. Visits from friends and family were actively encouraged to help maintain important relationships and aid people's emotional well-being.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● People were not adequately protected from the risk of abuse and their human rights were respected and upheld by staff who had received training on safeguarding adults. MCA/DoLS principles had not been met.
● People told us they were safe. Comments from people included, "It is not my own home, but I have nothing to worry about I am safe." And, "The care I receive is as safe as it can be, these staff are caring." Staff knew how to recognise potential abuse and report any concerns. Staff said they felt able to challenge poor practice and report their concerns.
● The manager had followed safeguarding procedures and reported concerns and shared relevant information to safeguard people from abuse and avoidable harm.
● The provider had systems to record and review and investigate accidents and incidents. Medical attention was had been sought where that was required. Lessons learnt from incidents were shared among the staff team to prevent re-occurrences.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated requires improvement. At this inspection this key question remains the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. There were continued breaches of regulations.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Staff and management understood their roles in relation to quality performance and regulatory requirements. The provider had a governance system to monitor and evaluate the quality of the care provided and to ensure compliance. However, this system had not been robustly implemented to monitor and identify areas of non-compliance and to promptly address shortfalls.
- The provider had failed to address shortfalls from the last inspection in line with the actions they proposed to us. This included the accuracy of care records and the availability of risk assessments in people's care records. This meant further improvements to the system for oversight and accountability were required.
- Leadership arrangements at the service needed to be strengthened to provide adequate oversight on staff and people. The registered manager had recently left, and an interim manager had been appointed. There were two further vacancies for assistant care managers.
- The provider audits to check quality and people's experiences were not robust and had not continued to support the service to continuously improve. Care plan audits, environmental audits and medicines audits were not effectively implemented. We identified shortfalls that had not been identified by the audit system before our inspection.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The manager and their staff engaged with people and considered their equality characteristics and they worked in partnership with other agencies including local health professionals and hospitals.
- People told us they were involved in the planning of their care. We saw people's rehabilitation goals had been discussed with them. Comments included, "The manager is very good; I can always raise issues with her"
- The manager had developed close links and working relationships with a variety of professionals within the local area.

Planning and promoting person-centred, high-quality care and support; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider needed to improve systems for promoting high quality and person-centred care. Care records did not always reflect people's preferences and opinions.

● The manager knew how to share information with relevant parties, when appropriate. They understood their role in terms of regulatory requirements. For example, the provider notified CQC of events, such as safeguarding concerns and serious incidents as required by law.

● People told us the staff team shared information with them when changes occurred, or incidents occurred.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy suitably qualified staff and support staff with ongoing training.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to protect people against the unsafe use of medicines. The provider had failed to assess people's risks to receiving care and the risks associated with equipment in the premises. Regulation 12(1)

The enforcement action we took:

A warning notice was served on the registered provider under Regulation 12(1)(2)(b)(g)

The provider had failed to establish systems to assess, monitor and mitigate risks to the health, safety and welfare of people using the service.

The provider had failed to establish systems to ensure the safe use of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure governance systems were robust and systems or processes were not established and operated effectively to ensure compliance. Regulation 17 (1) (2)(a)(c) HSCA RA Regulations 2014 Good governance

The enforcement action we took:

A warning notice was served on the registered provider under Regulation 17(2)(a)

The provider had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).