Care South

Dorset 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

We carried out an unannounced comprehensive inspection of this service on 24 and 25 August 2015. In June 2016 we received information from the registered manager and a professional that someone had fallen on the stairs and had passed away shortly after. As a result we undertook an unannounced focused inspection to look into how people were kept safe from falls. This report only addresses the key question "Is the service safe?". The report from our last comprehensive inspection, can be found by selecting the 'all reports' link for Dorset House on our website at www.cqc.org.uk.

Dorset House is a care home without nursing for up to 52 people. There were 38 people living there during our inspection, many of whom were older people who were living with dementia. Accommodation is located on the ground and first floors. The two floors are connected by a passenger lift as well as stairs. There is a large enclosed garden at the rear, with lawns, paved areas, seating, flower and vegetable beds and trees. Sizeable parking areas are situated to the front and side of the building.

The service has an established registered manager, who has been in post for several years. 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.

People were able to access the stairs. A range of environmental risk assessments had been undertaken in relation to the premises. However the risks posed generally by unguarded staircases had not been assessed and managed. At the time of the inspection the provider had started an investigation into the incident and begun to review the risks posed by unguarded staircases at Dorset House, and the other homes run by their organisation. The provider informed us after the inspection about measures they had taken to improve safety by restricting resident access to the stairs.

People's individual risks were assessed and reviewed, with care plans in place to address identified risks. However, one person's individual risk assessments and care plans did not accurately reflect how the person would remain safe on unguarded stairways.

Some people's risk assessments identified that they needed well-fitting footwear to help prevent the risk of falls. Most people's footwear was well fitting with intact soles. Staff had identified that one person required new footwear and were arranging for their slippers to be replaced. Following the inspection, the management team informed us staff had checked everyone's slippers and new slippers had been purchased for four people.

There were two instances of people not receiving pain relief when they might have needed this.
One person had often missed doses of some of their regular medicines because they were asleep or refused the medicine. Staff had not flagged the missed medicines to the GP so they could consider whether the

person might benefit from changes to their treatment. Recognised pain scales to help staff recognise when people living with dementia might be in pain were available but not in regular use.

You can see what action we told the provider to take in relation to risk assessment and management, and medicines and pain management at the back of the full version of the report.

A further person who was at risk of falling and needed spectacles to see clearly was not always wearing them. We saw that their spectacles were very dirty. The management team confirmed that staff handovers would include a reminder to staff about the cleaning and wearing of spectacles. This person's spectacle care, foot care and nail care were not always recorded. The maintenance of complete care records is an area for improvement.

People were protected against the risk of abuse. Staff understood their responsibilities for reporting accidents, incidents or concerns. When people had accidents, incidents or near misses these were routinely recorded and monitored by the registered manager to look for developing trends to reduce the risk of re-occurrence.

Staff had first aid awareness training and more senior care staff had more in depth first aid training.

Lifting equipment was maintained and serviced at the required intervals.

Most areas of the premises were clean. The downstairs lounges had been refurbished and the carpet had been replaced. Floor coverings elsewhere were intact. Whilst most bathroom and toilet areas were in reasonable decorative order, there were a few cracked tiles that would be difficult to clean effectively and could harbour germs. This is an area for improvement.

People were supported by sufficient staff with the right skills and knowledge to meet their individual care needs.

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

Some aspects of the service were not wholly safe but action was under way to address this.

The risks presented by access to unguarded staircases had not been fully assessed and managed. The provider was investigating a recent event and was implementing measures to reduce the risk stairs posed at Dorset House.

People did not always receive their medicines, because they chose not to have these or were asleep. Missed medicines had not been followed up with a person's doctor to consider whether this person would benefit from changes to their treatment.

The premises were clean and mostly in good repair. Lifting equipment was maintained.

There were sufficient suitably competent staff on duty to provide people's care.

Dorset House

Detailed findings

Background to this inspection

We carried out this focused inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to follow up information of concern, to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 20, 22 and 23 June 2016 and was unannounced. It was undertaken by two inspectors.

Before the inspection we reviewed the information we held about the service, including notifications of incidents since our last inspection in August 2015. As we were inspecting in response to information of concern we did not request the provider to complete a Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what it does well and the improvements they plan to make.

During the inspection we talked with four people who lived at the service. We also spoke with three care staff, the deputy manager, two operations managers and the provider's clinical lead. We observed staff supporting people in communal areas. We looked at eight people's care records, including risk assessments for six people, assessments, care plans, daily records and medicines administration records. We also reviewed some records relating to how the home was managed, including three staff files, records of complaints, accidents and incidents, premises and equipment maintenance, staff training records and the staff rota.

Requires Improvement

Is the service safe?

Our findings

This inspection was carried out in response to information received that a person had fallen on a flight of stairs and had passed away shortly afterwards. As many of the people at the service are living with dementia and are able to walk around the home without constant supervision or support, we carried out this inspection to look at how people were kept safe from falls.

People felt safe living at the service. They told us they liked the staff; for example, a person described staff as "very kind" and someone else said they were "as happy as I've ever been". People looked comfortable in the presence of staff.

Most people were living with dementia and 26 out of 38 of them made their way around the building by walking, many using walking aids and some with staff support. The building had two interior staircases, both of which were accessible to people. The rear staircase had a gate with a simple bolt at the top and the main staircase had no restrictions in place to prevent people from accessing the stairs. Staff were available throughout the home, but neither staircase was under constant supervision. Therefore, people who might not be safe on the stairs may have been able to access the stairs without staff knowing and being able to support them to stay safe.

The property risk assessments in place at the time of the inspection did not refer to people having access to the stairs. An index for risk assessments, which had been reviewed in March 2016, did not include a separate risk assessment for stairs, although a risk assessment for slips, trips and falls referred to non-slip edgings being fitted to stairs, which we saw were in place. The property risk assessments had made no reference to restricting people's access to stairways.

In response to the person falling on the stairs, the provider was undertaking an investigation and this was ongoing at the time of the inspection. The provider had taken action to ensure that the risk posed by unguarded stairs was assessed and measures put in place to ensure people's access to staircases was safe. The management team informed us that at Dorset House consideration was being given to the installation of coded doors or gates to restrict access to stairs, with due regard to fire safety. Following the inspection, the nominated individual confirmed the measures that were to be installed on 19 and 20 July 2016 reduce the risk to people.

The provider acknowledged the importance of people being able to maintain their mobility and independence, which meant there was a risk of some people falling. Risks associated with individual people's mobility, including their risk of falls and fractures, were assessed, with management plans in place to address these risks. People's 'Moving Around' risk assessments included whether people were able to use stairs and steps independently and any assistance needed. Their 'Staying Safe' risk assessments considered whether the person had a history of falls, whether there was a potential risk of falls and fractures and whether there was a risk that a person would walk into unsafe areas and be unaware of the risk.

Six people's individual risk assessments accurately reflected risks to their health and safety, However, one

person's individual risk assessments and care plans did not. This person lived with dementia and often walked around the building. They were assessed as being at high risk of falls, with a history of falling, a visual impairment and often not using their walking aid. Their assessments also stated they could become unsteady on their feet. However, their 'Moving Around' assessment stated they were independent on stairs and neither this or their other assessments and care plans identified measures they needed to use stairs safely. The provider confirmed that this person had only been known to access the stairs on two occasions and that they were normally supported by staff to use the passenger lift.

Care staff told us they looked out for people on the staircase while they were passing, but that most people used the passenger lift. However, as a member of staff noted, it was difficult to see the top flight of the main staircase from the main corridors. We observed two people using stairs independently and confidently. Staff confirmed that these people had been assessed as being able to use the stairs. Other people were assisted by staff to use the lift.

These shortcomings in risk assessment and management were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was an electronic medicines management system, where each medicine was provided by the pharmacy in a sealed blister and staff recorded electronically when the medicine had been given or their reason for not giving it. The electronic system prompted staff to attempt to administer medicines three times within a certain timeframe before they were recorded as not given, although it did not show the time when separate attempts made. However, one person had regularly missed doses of medicines, such as a particular daily medicine on 14 days and a twice-daily medicine on 27 occasions in the most recent complete medicines cycle (28 days). The provider's management team confirmed following the inspection that there was no evidence the person's doctor had been contacted regarding the missed medicines. They subsequently took action to reinforce the procedure whereby staff would request the GP to review medicines for any person who consistently refused or missed medication for three consecutive days.

There were instances of people not receiving pain relief when they might have needed this. Two people had fallen and bumped their heads yet neither was given pain relief, either at the time of the incident or during the period following the injury. Staff had recorded in one of the people's notes in the hours following the accident that they were saying they were in pain and holding their stomach, yet there was no record that pain relief had then been offered. A member of staff told us that although the service had access to recognised pain scales these were not often used. Pain scales help staff recognise when people living with dementia are in pain but are unable to verbalise this.

The shortcomings in following up missed doses of medicines with the person's doctor and assessing and managing pain were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most of the people whose care we reviewed used walking aids such as zimmer frames to help them walk safely. Many people were living with dementia and might not always remember to use their walking aids. Risk assessments and care plans specified that staff should prompt people to use these. Staff reported they frequently reunited people with their walking aids and we observed them doing so. We saw people seated with walking aids to hand. Some people had pressure mats to alert staff when the person got out of their bed or chair and was starting to walk around.

One person was at risk of falling needed spectacles to see clearly. On the first day we found two pairs of dirty spectacles in the person's room. On the second day we saw them in the dining room without glasses on.

Their care plan stated they wore spectacles but were inclined to take them off and put them down. The same person had no foot care, nail care or spectacle care recorded in the morning during June 2016 and foot care had been recorded only three times during May 2016. The management team said that staff handovers would include a reminder to staff about the cleaning and wearing of spectacles and confirmed following the inspection that this had been done. The maintenance of complete care records was an area for improvement.

Staff understood their responsibilities for reporting accidents, incidents or concerns. When people had accidents, incidents or near misses these were routinely recorded and monitored by the registered manager to look for developing trends. Two people whose records we reviewed had fallen bumping their head, and medical advice had been that staff should keep them under observation, monitoring for adverse symptoms. Staff were able to tell us how they checked on people who had injured their head who appeared to be asleep in bed, such as feeling whether they were breathing and responded to touch or speech. Staff had first aid awareness training at induction and every two years thereafter. Senior care staff had additional first aid training every three years.

Lifting equipment was maintained and serviced at the required intervals. On the second day of the inspection the passenger lift had broken down. Maintenance records showed the lift had been inspected six monthly by a contractor to ensure that it was safe for people to use, as had hoists and stand-aids for moving and handling people. We saw a mat in a person's bedroom with rucked and broken edges, which posed a trip hazard. We drew this to the attention of the management team and they immediately arranged a replacement.

Most areas of the premises were clean and well maintained. The downstairs lounges had been refurbished and the carpet had been replaced. Floor coverings elsewhere were intact, apart from the door mat at the bottom of the back stairs, which was uneven and had frayed edges. This posed a trip hazard. Following the inspection the management team confirmed the mat had been replaced and the surface levelled. Whilst most bathroom and toilet areas were in reasonable decorative order, there were a few cracked tiles that would be difficult to clean effectively and could harbour germs. This is an area for improvement.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. The provider assessed staffing levels based on people's dependency, and senior management confirmed the home was adequately staffed based on their dependence calculations. Staff confirmed there were enough of them on duty to meet people's basic care needs, although they expressed frustration that staffing levels did not allow for them to simply spend time with people outside of care tasks. They reported that staff absences, for example due to sick leave and holidays, were usually covered and that where agency staff were used, these were generally staff who were familiar with the service and understood people's care needs.

People were protected against the risks of potential abuse. Staff had a good understanding of their responsibilities in relation to safeguarding and knew how to report any concerns that people might be at risk of abuse or unsafe care. Staff had training about safeguarding and whistle blowing at induction and every two years thereafter. The staff we spoke with were confident that the manager and senior staff would listen to and act on any concerns they had.

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 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users because risks to the health and safety of service users had not all been fully assessed and, as far as reasonably practicable, mitigated. Medicines had not been managed properly so as to ensure that people always received pain relief when they needed it and that the regular omission or refusal of medicines was referred to a person's doctor. Regulation 12 (1) (2)(a)(b)(g)