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Dormie House Residential Care Home

Inspection report

Dormie House
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Tel: 01263823353

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18 August 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 28 June 2016. After that inspection we received concerns in relation to people's emotional and psychological wellbeing. We were told that people had restrictions imposed on them regarding their food and drink and that the provider frequently shouted at them if they did not adhere to the provider's 'house rules'. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those specific concerns. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Dormie House on our website at www.cqc.org.uk"

This focused inspection took place on 18 August 2016 and was unannounced.

Dormie House provides residential care and support for up to eight older people. At the time of our inspection, six people were living in the home.

As the provider is an individual, the service is not required to have a separate registered manager. The provider is the 'registered person' and manages the day to day running of the service. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People could not be assured of their safety in the home because neither the provider nor staff working in the home demonstrated a full understanding of safeguarding or what constituted abuse. This was because they did not recognise the signs of abuse, including emotional and psychological abuse, or report any issues of concern appropriately.

The provider did not respect people's individual preferences or choices with regard to what they were able to eat and drink or how, where and when they spent their time. People were unhappy with the way they were treated and spoken to and the strict house rules. People were also afraid of 'upsetting' the provider.

The provider did not demonstrate good governance because people living in the home, their relatives and staff were not empowered to make decisions nor be involved in the development or improvement of the service. Concerns or complaints were not responded to appropriately and steps were not taken to ensure sufficient improvements were made for people's quality of life.

Our findings from this focused inspection were that the provider was in breach of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Neither the provider nor staff working in the home demonstrated a full understanding of safeguarding or what constituted abuse.

The provider and staff did not recognise the signs of abuse, including emotional and psychological abuse, or report any issues of concern appropriately.

No regard was given to the negative impact on people's emotional and psychological wellbeing, caused by not being able to make their own choices or decisions.

Is the service well-led?

Inadequate

The service was not well-led.

People living in the home, their relatives and staff were not empowered to make their own decisions nor be involved in the development or improvement of the service.

The provider did not enable open communication with people who lived in the home, their relatives or staff.

Concerns or complaints were not responded to appropriately and steps were not taken to ensure improvements were made for people's quality of life.

The provider did not ensure that a good quality service was provided and did not promote values that included involvement, compassion, dignity, independence, respect, equality or safety.

Dormie House Residential Care Home

Detailed findings

Background to this inspection

We carried out a comprehensive inspection on 28 June 2016 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 was 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.

The overall rating for Dormie House following our inspection on 28 June 2016 was 'Good'. However, shortly after our inspection on 28 June 2016 we received information of concern regarding restrictions that were being placed on people living in the home. In order to follow up the concerns, we carried out a focused inspection on 18 August 2016. This inspection was carried out by two inspectors and was unannounced.

As part of this inspection we spoke with the provider and members of care staff. We also spoke with people who used the service, their relatives and friends. In addition, we looked at some records in respect of people's care, meal choices and activities and carried out observations of the support being provided.

We also sought feedback and held discussions with the local authority's quality assurance team and the safeguarding team.

Inadequate

Is the service safe?

Our findings

Our conclusion from this focused inspection was that neither the provider nor staff working in the home demonstrated a full understanding of safeguarding or what constituted abuse. This was because they did not recognise the signs of abuse, including emotional and psychological abuse, or report any issues of concern appropriately.

During our inspection on 28 June 2016 people living in the home told us they felt safe living in Dormie House. The provider also told us that they understood what constituted abuse and explained how they would follow the correct reporting procedure if and when necessary. They also told us that all the staff were equally as confident and would report anything they were concerned about straight away.

However, after that inspection, we received information that told us this was not in fact the case.

During this focused inspection people told us that the provider frequently shouted at people living in the home and the care staff, although they did not always know why. People said they had to adhere to the provider's rules and that he often told them they could leave if they did not like it. We were told that staff, as well as people living in the home were afraid of the provider.

People told us that the provider had thrown a bag at a person living in the home and shouted at them to "Get out." People said this happened because the person had gone against the provider's rules and had been drinking coffee. We were told that this had really upset and frightened the person, because they did not know where else they would go to live. We were also told us that the provider could be, "A bit over strict" with people living in the home.

We were told that on occasions some people living in the home asked staff not to call the provider for assistance, for fear of getting into trouble. In addition, we were told that some people were not allowed to sleep during the day, to ensure they slept at night and did not disturb the provider. We were also told that regular observations were not always carried out at night, so as not to disturb the provider.

People told us that the provider shouting at people was a common occurrence. They said that nobody was allowed to touch the television or the remote control in the lounge and that things had to be done how the provider wanted. They also told us that the provider did not like it if people did not do what he said or went against him.

We were told that people living in the home were exposed to attitudes and treatment which were unkind and inappropriate. Examples we were given included how people were not allowed to have the television on in the communal lounge in the mornings. We were told that if people wanted to watch TV or go and rest in their room at any time, they were then not allowed to come downstairs any more that day and were isolated in their room. People told us that they were told that if they were not happy, they could find somewhere else to live.

We told the provider that we had received allegations of him shouting at people and asked why this was. The provider replied, "I don't shout, but when emotion kicks in then your voice raises; I raise my hand to that. Because of my accent, that might be the way I come across."

During this focused inspection we identified that people living in the home had restrictions placed upon them regarding their food and drink, which had a detrimental impact on people's wellbeing.

For example, people told us they were not allowed to have certain items of food or drink in the home such as coffee, sugar or salt. People also said that the provider would sometimes take food items away from people living in the home, such as chocolate and sweets. There was no clear justification as to the reason for these restrictions.

We were told that people could only have one hot meal a day and had no choices other than sandwiches for tea every evening. We were told there were no alternatives for people living in the home and that they had to have what was given to them, regardless of whether they liked it or not. In addition, we were told that the provider would not allow people living in the home to have coffee or sugar and that cups of tea could not be served after 7pm. We were also told that no food was allowed to be taken into the home and, if relatives brought any in, it was often taken away by the provider. We were told that some people had lost weight whilst living in the home because were not allowed to eat many of the foods they liked, with no alternatives being given.

When we raised these issues with the provider, he told us that he liked to promote good health and advised people on things that weren't good for them. When we asked about people not being allowed things such as coffee, salt and sugar the provider said, "People don't take salt or sugar. We've had these discussions and people here have never had these." This meant the provider did not demonstrate an understanding of people being able to have an informed choice.

We discussed people's choices around what they had for their evening meal and asked the provider if people could have something other than sandwiches. The provider did not understand the fact that people may like to be offered something different. We suggested that people may like a choice for their evening meal, such as salad, fruit or beans on toast for example. The provider told us, that people did not like salad and that he did not provide fruit, other than strawberries on a Sunday. The provider told us, "I don't think their generation is too much into salad. They are not the sort of salad people." However, people told us they did like fruit and salad and would like to have these on occasions.

People told us that the food was terrible in Dormie House and that there was never enough to eat. People said, "We don't get a choice of tea or coffee, they just serve us tea." When we asked about the food in general, people responded, that the food was always set and that they were not given a choice. People said they did not know what they were going to have for dinner or who chose the menus.

The provider told us that people could relax after their evening meal and had a cup of tea at 7pm, before they went to bed. When we asked whether people could have a hot drink after 7pm, the provider did not confirm whether they could or not and said, "None of them have ever asked for a cup of tea after 7pm." He also added that everybody had access to water and everyone had a glass of water in their rooms.

During this inspection we observed that care staff automatically brought a cup of tea, with milk and no sugar, plus a plain biscuit for everyone at approximately 3pm. We were also given a cup of tea, which was with milk and no sugar. We were not asked whether we wanted a drink, whether we liked tea or whether we took sugar.

Virtually everyone we spoke with made comments about accepting the limitations regarding people's choices around food. For example, one person said, "It may not be the ideal menu but I appreciate they can't cater for everyone." Another person told us, "It's not the greatest but I will eat anything that's put in front of me." A further person told us, "The food is terrible and I would call it starvation quantities."

We were unable to determine whether people were consistently provided with sufficient nutritious and wholesome food, because the provider did not keep records of the meals served and people could not always remember what they had eaten.

We saw a notice displayed in the home which referred to infection control and health and safety. This notice stated that it was the policy and good practice that Dormie House did not allow any meat or seafood brought in from outside to be consumed on the premises. It also stated that, "Biscuits, sweets, vegetables or fruits are allowed (if you are good). Please check with [provider] if unsure." This reference to people being allowed things 'if they were good' was patronising and further confirmed the restrictions that were being placed on people's freedom of choice.

This meant that inadequate regard was given to people's individual choices and preferences. In addition, no regard was given to the negative impact on people's emotional and psychological wellbeing, caused by not being able to make their own choices or decisions.

These concerns constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Our conclusion from this focused inspection was that the provider did not demonstrate good governance. This was because the provider did not enable open communication with people who lived in the home, their relatives or staff. People were not empowered to make decisions nor be involved in the development or improvement of the service. The provider did not ensure that a good quality service was provided and did not promote values that included involvement, compassion, dignity, independence, respect, equality or safety.

During our inspection on 28 June 2016 we were told that people living in the home, their family and friends, visitors and staff were considered to be an important factor in the way the home ran. The provider told us that any suggestions for improvements were listened to and action taken, where appropriate or necessary.

However, following that inspection, we received information that confirmed this was not the case.

Although the quality assurance survey carried out in July 2015 had contained some positive comments, we noted that one person's relative had commented about wanting certain food items for their family member. The provider told us during our June inspection that they had discussed and clarified the comments with the person living in the home and their relative and everyone had been happy with this. We spoke with the relative during this focused inspection and they told us the matter had not been rectified and that the provider was unapproachable.

Throughout this focused inspection we identified examples of decisions that were made by the provider, regardless of whether those decisions were in accordance with the preferences or choices that people were capable of making for themselves. For example, when, where and how people could spend their time in the home and choices of food and drink.

People told us they did not like the provider's rules but had to accept that this was how things were in the home. The provider's approach, attitude and lack of available choice meant that people were accepting situations that they were not happy with. We found that the culture of the home was not open and transparent and identified that some people were uncomfortable or afraid to complain or speak openly.

We were told that people living in the home were all woken up early in the mornings, regardless of whether this was what they wanted. People said they would prefer not to get up so early but that the provider got angry with them if they didn't. We also identified that mealtimes were set in accordance with the provider's requirements and that people could not choose when they ate.

People told us they were bored and didn't have anything to do, other than watch television, listen to music or read newspapers. We spoke to the provider about the activities schedule and they told us that some of the regularly listed events no longer happened. This meant that because meaningful activities and stimulation was very limited for people, their quality of life in the home was compromised.

We were told that concerns had been raised with the provider on occasions by people living in the home, as well as their families and care staff. However, we identified that the provider did not respond to these appropriately nor take steps to make sufficient improvements to enhance people's quality of life.

These concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider and care staff did not demonstrate a full understanding of safeguarding or what constituted abuse. They did not recognise signs of abuse, including emotional and psychological, or report any issues of concern appropriately. There was a negative impact on people's emotional and psychological wellbeing, caused by not being able to make their own choices or decisions. People were unhappy with the way they were treated and spoken to and the restrictions imposed on them in the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were not empowered to make their own decisions or be involved in the development or improvement of the service. The provider did not enable open communication with people. Concerns or complaints were not responded to appropriately and steps were not taken to ensure improvements were made for people's quality of life. The provider did not ensure that a good quality service was provided.