Mr Pan Danquah & Mrs Kate Danquah

Dorcas House

Inspection report

56 Fountain Road
Edgbaston
Birmingham
West Midlands
B17 8NR

Tel: 01214294643

Date of inspection visit:
14 February 2017
17 February 2017

Date of publication:
12 April 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this home on 14 and 17 February 2017. This was an unannounced Inspection. The home was registered to provide personal care and accommodation for up to eleven people who suffer from mental health related conditions or physical disabilities. At the time of our inspection nine people were living at the home. The service was last inspected in October 2014 and was meeting all the regulations at that time.

The registered manager was present during our inspection. 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 told us they felt safe living at the home. Staff knew what action to take in the event of a fire; however the fire risk assessment was not current. Staff knew how to report any concerns so that people were kept safe from abuse. Risk associated with people's health conditions had been assessed. People and their relatives told us there were sufficient numbers of staff to meet their individual needs. The management of medicines was not always safe and did not always follow good practice guidelines. We recommend that the service consider current guidance and take advice on safe storage of medication and take action to update their practice accordingly.

People were supported by staff who had been provided with most of the key training they needed to safely meet people's needs. Not all the staff who we spoke with were confident about how to comply with the principles of the Mental Capacity Act. People had a choice of nutritious meals and drinks but the dining experience needed improvement. People told us that they had regular access to a range of health care professionals which included general practitioners, diabetic nurses, dentists, options and chiropodists.

The majority of people we spoke with told us they were happy at the home and were happy with the care provided. Generally people made decisions about their daily lives. People's privacy and dignity had not always been protected.

People's preferences and choices about their care and support needs were sought and were known. However, people and their relatives told us they had not consistently contributed to the routine review process. Some people told us some activities of particular interest to
them were provided for them to participate in. However the activities offered on occasions were not engaging enough for all people in the home. People knew how to make complaints and the registered provider had arrangements in place so that people were listened to.

We found that whilst there were some systems in place to monitor and improve the quality and safety of the service provided, these were not always effective and did not identify if the service was consistently compliant with the regulations and failed to identify concerns raised in our inspection. People and their relatives considered the home to be well-led and the registered manager was consistently described as kind,

supportive and approachable.

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

Requires Improvement

The service was not consistently safe.

People received their prescribed medicines; however the storage and management of medicines was not robust.

There was a process in place to protect people from risks however fire risk assessments needed improvement.

There were sufficient numbers of staff available to meet people's individual needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff sought people's consent before providing care and support but some lacked enough knowledge and understanding of the Mental Capacity Act (2005) to protect people's rights.

People told us they were offered choices of meals. However the dining experience was not always pleasant for everyone.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We observed some positive interactions with staff and people. However, we saw some occasions when staff did not engage with people for a period of time.

People's privacy and dignity was not always maintained.

People and their relatives told us staff were kind and caring.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Some care plans were person-centred but people and their relatives had not always been involved or had contributed to the review process.

People had limited support to follow their identified interests and hobbies.

People know how to raise complaints and were confident that complaints would be listened to and resolved in a timely manner.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality checks had not reliably identified and resolved shortfalls in the quality and safety of the service provided.

People, their relatives and staff spoke positively about the approachable and supportive nature of the registered manager.

Dorcas House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 and 17 February 2017 and was unannounced. The visits were undertaken by one inspector and an expert by experience on the first day and the inspector on the second. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

As part of the inspection we asked the local authority and Health Watch if they had any information to share with us about the care provided by the service. We also checked if the provider had sent us any notifications since our last visit. These are reports of events and incidents the provider is required to notify us about by law, including unexpected deaths and injuries occurring to people receiving care. We used this information to plan what areas we were going to focus on during our inspection visit.

During our inspection we met and spoke with six of the people who lived at the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us. We also spent time observing day to day life and the support people were offered. We spoke with five relatives of people and one health care professional during the inspection to get their views. In addition we spoke at length with the registered manager, the registered provider, and three care staff.

We sampled some records including four people's care plans and medication administration records to see if people were receiving their care as planned. We sampled two staff files including the provider's recruitment process. We sampled records maintained by the service about training and quality assurance.

Requires Improvement

Is the service safe?

Our findings

People confirmed that they received their prescribed medicines on time. We observed staff supporting people with their medicines during the day. Staff spoke with people about their medicines and offered appropriate drinks.

The systems to ensure the safe administration of medicines in the home were not sufficiently robust to ensure people who used the service were adequately protected. We saw that medicines were not stored safely. The medicines trolley was locked but it was not secured safely to a wall when not in use. The temperature recording for the medicines trolley was not completed. A failure to store medicines at the correct temperature could mean that they would not be effective to treat the conditions they were prescribed for. Medicine that had a short expiry date once opened was not always dated to ensure that staff knew how long the medicine could be used for. We noted that the refrigerated storage of people's medicines did not follow good practice guidelines. Medicines were stored in a fridge with food and they were not secured. We recommend that the service consider current guidance and take advice on safe storage of medication and take action to update their practice accordingly.

Some people that were prescribed medicine only when required did not have protocols in place to provide staff with enough information to know when the medicine was to be given. Whilst staff we spoke with knew when to administer medicines there was a risk that people might not always be given their medicine consistently, and at the times they needed them. The MAR's (Medicines Administration Records) chart should be clear and permanent. We found that this was not always the practice. We found one MAR's chart had been handwritten and the record had not been checked for accuracy and signed by a second trained and skilled member of staff. People did not have an information sheet alongside their MARs. This meant that there was a risk that staff could not easily identify each person; know what allergies they had or any other key information regarding the management of their medicines.

Staff that were handling and administering medicines had received training. The registered manager advised us that they did not have a system in place to check that staff were competent to administer medicines.

We looked at the systems in place to deal with emergencies. Staff we spoke with told us they were aware of the importance of reporting and recording accidents and incidents and had received first aid training. The registered provider advised us that there was on on-call system in place which ensured staff had access to advice and assistance when the registered manager was not there. Staff confirmed that they had not had any difficulties in getting assistance in an emergency. We spoke with care staff about the procedures they needed to follow in the event of the fire alarms sounding. Staff were confident in the procedures they needed to follow. We noted that the fire risk assessment was not current and no consideration had been given to the need for personal emergency evacuation plans being available for any people living at the home. The registered manager told us this would be addressed following our inspection.

People who lived at the home told us that they felt safe living there. Comments from people included, "I feel

safe day and night." and "I feel protected." Relatives of people who lived at the home told us that they thought their loved ones were safe. One relative said, "My mum needs to be kept safe and she is."

Staff told us and records confirmed that they received training in recognising the possible signs of abuse and how to report any suspicions. Staff we spoke with knew the different types of abuse people were at risk of. Staff knew the different agencies that they could report concerns to in order to protect people. One member of staff said, "Any bruises or concerns I would report to my manager and then to CQC [Care Quality Commission] if necessary."

We saw that risks to individual people were managed so that people were protected. The registered provider had completed assessments to mitigate any risks to people. These were reviewed monthly or sooner if there were identified changes in people's needs. Staff we spoke with were knowledgeable about the risks presented by people's specific health conditions and described how they would manage these risks. Staff informed us how they worked to keep people safe. One member of staff told us, "[name of person] is at risk of choking so we have to prepare foods and drink in a particular way."

People and their relatives told us that there were enough staff on duty to safely provide the level of care, supervision and support that people needed. People described staffing levels as, "Enough staff at all times." Relatives we spoke with generally said they were happy with staffing levels. One relative said, "Always enough staff when I visit." The registered manager told us that staffing levels were determined by dependency needs of the people living at the home. Staff we spoke with told us there were enough staff to meet people's individual needs and that the same group of staff were employed to support people who lived at the home. Staff rotas we sampled reflected this. On the day of the inspection we observed enough staff were on duty to meet people's individual needs.

People were cared for by suitable staff because the provider followed safe recruitment procedures. Staff told us they had been interviewed and checks had been made before they started to work at the home. We looked at the recruitment process for two staff. We saw that appropriate pre-employment checks had been completed. This meant that only people with the appropriate skills, experience and character were employed.

Requires Improvement

Is the service effective?

Our findings

People confirmed that the staff who were supporting them knew how to look after them and that they received the care and support they needed. One relative we spoke with told us, "Staff have a good knowledge about mums needs."

Staff we spoke with told us that they had completed training to make sure they had the skills and knowledge to provide the support people needed. One member of staff said, "Training is done here. I'm being supported to do my NVQ. You can ask for anything." We looked at the records around staff training which showed that not all staff had completed a range of training relevant to their roles and responsibilities. There was no evidence of any competency assessments being carried out to ensure that the knowledge and skills gained by the staff were being put into practice and continually developed.

Staff told us they felt supported and received regular supervision. A member of staff we spoke with said, "The manager is knowledgeable. [During] my supervision we talk about my development, my training and how to improve." Staff confirmed that they had been given an induction prior to starting work. They advised us that this included training and working alongside more experienced staff before they worked on their own.

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. The registered provider understood their role and responsibilities in relation to assessing people's capacity to make decisions about their care. However, the staff that we spoke with had limited knowledge and understanding of the principles of the MCA and what it meant for people who lived at the home. We found by speaking with staff and records confirmed that they had not received training in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, we saw that staff gained people's consent before providing them with care and support. For example, we saw and heard staff asking people if they had finished eating and if they could remove their plates. A relative we spoke with told us, "Mum still makes her own decisions about what she wants to eat and what she wants to wear."

One person's end of life plans recorded that they did not want to be resuscitated if they were unresponsive to immediate lifesaving treatment. We noted that the appropriate documentation had been completed and was available in the person's care plan. However, all the staff we spoke with were not aware of the person's expressed instructions. This meant that the person's wishes may not be respected. The registered provider advised that this concern would be rectified immediately and all staff would be informed.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Discussions with the registered provider and a review of people's care plans confirmed no DoLS applications were necessary.

We observed a variety of meals being provided to people. A person we spoke with told us, "Food is okay and I'm offered choices." A relative said, "Mum tells me she likes the food. Friday is a favourite…. fish and chips." We observed lunch being served in the dining room. There was a menu on display which was presented in different formats to meet people's communication needs. People seemed to enjoy their meals and had enough time to eat at their own pace; we noted that condiments were not supplied. We found that there was limited interaction between people and staff in the dining room, the atmosphere was subdued and support offered was very task focused. Some people remained in the lounge in armchairs for their meals. We did not see people being offered a choice to go to the dining room and some care plans did not evidence people's preferences. One person told us, "I don't mind sitting here; it's a bit of a squash in the dining room." Tables to eat from in the lounges were seen to be low which resulted in people not being able to maintain their position to eat their meals comfortably. The registered provider advised us that they would look into options to improve the dining experience and comfort of people during meal times.

We saw that meal choices reflected people's cultural preferences and staff we spoke with could describe people's individual eating and drinking preferences. They knew who had risks associated with eating and drinking and how they needed to have their foods prepared so people could enjoy their meals safely. We observed snacks and drinks were provided between meals throughout the day to prevent people from becoming hungry or thirsty. We saw people were able to makes drinks independently. One person told us, "I make a drink when I want one."

Arrangements were in place to ensure that the healthcare needs of people were addressed. We saw that people received regular visits from a variety of health professionals. People confirmed that they had access to their doctor and opticians. One relative we spoke with told us that their relative gets very distressed and said, "[name of registered manager] goes with [name of person] to all their medical appointments. [name of registered manager] is fantastic." Another relative said, "The home are very good. They organise the doctor and chiropodist and involvement with the diabetic nurse. I'm always kept informed." A health professional we spoke with told us that staff knew what they are doing and followed any advice given.

Requires Improvement

Is the service caring?

Our findings

We saw that privacy and dignity of people using the service was not consistently promoted and protected. We asked members of staff what they did to protect people's dignity and privacy. All of the staff we spoke with were able to describe how they did this in practice when they provided personal care and support. However, we saw occasions were staff failed to approach people discreetly when necessary to discuss aspects of personal care such as the need to go to the toilet. We saw staff speaking about people's dietary and personal care needs in front of other people who lived in the home. We also saw people's individual weights and planned health appointments displayed on a notice board in the communal lounge. We brought our findings to the attention of the registered manager. They advised us that this was not normal practice and the confidential information had been removed whilst the inspection was being conducted. In addition we saw people used plastic beakers which were not age appropriate. Whilst we did not see anyone distressed by this, some people living at the home may find this failed to treat them with respect.

We saw several examples of good practice where staff were kind and caring in their approach. However staff did not consistently support and encourage people to make their own decisions. For example, we observed staff members turn over television channels with no discussion with the people who were sitting in the lounge at the time. We carried out a SOFI [Short Observational Framework for Inspection] observation to capture and reflect the experiences of people who couldn't verbally tell us their experience of care. During the observation we saw that despite staff being present in the lounge there were long periods of time where staff did not interact or engage with people. This lack of interaction failed to benefit people's well-being. Our discussions with the registered provider indicated they were not up to date with best practice in regards to responding to the needs of people living with dementia. For example, all doors did not display dementia friendly signage indicating where bathrooms and personal rooms were.

We spoke with people and their relatives about the standards of care being delivered and the kindness shown by the staff who were supporting them. Comments from people included, "Staff are kind and compassionate" and "Staff are approachable and listen." Relatives we spoke with were complimentary about the staff. One relative told us, "It's not a 5 star hotel, but it is clean, food is good and the care is good." Another relative said, "Staff are kind and respectful, they stop and have a chat with us."

Some people told us they were involved in their care planning and had been asked how they would like to be supported. " One person told us how they liked to go out walking independently on a daily basis and that they preferred their own space. We saw that this was respected. We saw that people's individual routines, preferences and support needs were met by staff who knew them well. The staff spoke positively and with affection about the people they were supporting and knew people's likes and dislikes. One member of staff said, "People have the rights to choose what they want to." A relative we spoke with told us that their loved one was unable to verbally communicate and said, "[name of person] demeanour suggests that they are happy and well-cared for."

People had been encouraged to personalise their environment to make them feel at home and comfortable. A relative we spoke with said, "We were told we could bring items of interest for [name of person] room."

Some people had mobile phones so that they could keep in contact with family and friends.
Relatives we spoke with told us they could visit at any time. One relative told us, "There are no restrictions to visiting [name of person]." Another relative said, "We can go to mums room if we want some privacy when we visit but she also likes us to chat with her friends."

Requires Improvement

Is the service responsive?

Our findings

Some people told us that they were involved in the initial planning of their care. One person said, "I am involved with my care plan and I have signed to agree with it." Most care plans we sampled were person-centred and contained information that was pertinent and relevant to the individual. For example, one person's care plan we reviewed contained a map of their life. This included information in respect of their birthplace, school, employment, childhood memories, dreams and interests. We saw that care plans had been regularly reviewed and updated in support of people's changing needs. However, people and those that matter to them where appropriate had not always been involved or had contributed to the routine review process.

People who lived at the home told us they felt that staff knew their care needs. People confirmed that the staff who supported them asked them for their views about the things that are important in their lives. We spoke to staff about the people they were supporting and found they had a good knowledge and understanding of people's individual needs; which included their preferences and personal histories.

People did not always receive personalised care that was responsive to their needs. We asked people how they were supported to follow their interests and take part in social activities. One person told us, "I spend most of my day in my room listening to my music. I'm often bored." We were advised by the registered manager that this person did go out from the home on a regular basis and had declined to be involved in activities that had been organised. We saw an activity schedule was displayed and available in different formats to meet people's needs. Staff shared responsibilities for providing most of the activities. During our visit we saw staff encouraging people to take part in group activities in the lounge. We saw some people playing ball games, participating in exercise activities and one person playing dominoes and a board game. However, most people were seen chatting to each other and preferred watching television or singing along to music. We did note that a person who lived at the home requested an item that they wanted. This request was not acknowledged by the staff and staff did not respond to the person's needs. This resulted in other people becoming quite agitated. We discussed this with the registered provider who advised us of their intentions to reassess the person's care and support needs.

We were told that information about activities people enjoyed had been sought from people to help inform planning of activities to be provided. Records relating to individual interests were not current. The registered manager advised us that they would update the care records to reflect people's current needs and interests. Some people were supported to engage with their local communities which prevented the risk of social isolation. For example some people had participated in trips to the cinemas and pub lunches.

People were supported to maintain relationships with people that mattered to them. A relative we spoke with told us how their relative valued the friendship of other people who lived at the home. One relative said, "The home celebrates people's birthdays and everyone had a lovely time at Christmas."

The registered provider had a formal procedure for receiving and handling complaints. People told us that they had not experienced any reasons to complain but would speak to the registered manager if they

needed to. Where complaints and concerns had been raised by visitors or other professionals we saw these had been responded to in a timely manner. A copy of the complaints procedure was clearly displayed in the home for people and their relatives to access. People were confident their concerns would be listened to, acted upon and resolved to their satisfaction. One relative told us, "Any complaints I could speak to [name of registered manager]. They would listen and respond."

Requires Improvement

Is the service well-led?

Our findings

The registered provider told us there was a programme of audit and monitoring in place to look at the quality and safety of the service being provided for people. However, the audits had not been consistently effective and in some instances had failed to identify issues that we found during the inspection. For example; the medicine audit had failed to identify that the storage of medication did not comply with accepted standards in line with recognised guidance from the Royal Pharmaceutical Society of Great Britain about the Handling of Medicines in Social Care. The absence of individual protocols for the management of non-routine or 'as required' medication had not been addressed. Whilst we saw that accidents and complaints had been recorded; overviews and analysis had not been completed to identify common themes or to prevent reoccurrence of negative experiences for people living at the home. The fire risk assessment had not been updated and no consideration had been given to the need for personal emergency evacuation plans being available for any people living at the home. There were no systems in place to check that staff competency had been assessed to provide some assurance that people were safely supported. There had been some improvements in the programme of activities provided for people. However, more were needed to ensure all people were offered appropriate stimulation. In addition feedback was not being used effectively to support with the continual drive of improvement.

Our inspection visit and discussions with the registered manager identified that they were not keeping themselves up to date with changes, developments and requirements in the care sector. For example, the registered manager was unaware of responsibilities that had been introduced in March 2015 relating to the regulation regarding the duty of candour or the requirement that any new staff recruited had to complete the Care Certificate standards, which is a key part of the induction process for new staff to make sure they are supported, skilled and assessed as competent. Organisations registered with the Care Quality Commission have a legal obligation to notify us about certain events. However we found a potential safeguarding incident on one person's care records. Whilst we saw action had been taken to safeguard the person, the concern had not been reported in line with requirements. The registered manager acknowledged this shortfall. They gave us assurance that the correct procedure would be adhered to for any future concerns.

These issues regarding governance of the service were a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014, Regulation 17.

People and their relatives told us that in their view the service was well-run. People we spoke with told us that they were happy with the care they received. People told us that they liked the registered manager and knew them by name. One person told us, "[name of registered manager] is a kind person and looks after us." Relatives we spoke with were very complimentary about the knowledge and skills of the registered manager. One relative told us, "[name of registered manager] communication is excellent." Another relative said, "[name of registered manager] is lovely and knows what she is talking about." We spoke with a health professional who described the registered manager as a 'good manager'. Throughout the day we saw that the registered manager interacted with people and staff and were seen to be responsive and supportive in meeting people's needs.

People who lived in the home confirmed that they were asked to share their experience of living at the home. We saw that resident meetings were held and people were encouraged to share their opinions. For example, what the food was like, if people were happy with the staff and if people had any suggestions to improve their care. We noted that feedback from meetings had not been analysed or used to drive improvement within the service.

Communication between people, their families and friends and the home was encouraged in an open way. Staff we spoke with were knowledgeable about how to raise concerns and told us that the registered manager encouraged them to tell the truth and own up to any mistakes.

Staff we spoke with told us that they felt supported in their job role. They were clear about the leadership structure within the home and were able to describe their roles and responsibilities and what was expected from them. Staff told us and we saw that they attended regular staff meetings and were asked for their views about the home. This gave them the opportunity to contribute to the development and improvement of the service. One member of staff told us, "The manager asks for my opinion how the home can improve. I wouldn't change anything."

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 17 HSCA RA Regulations 2014 Good governance The provider did not have robust systems in place to monitor the quality of the service. Regulation 17 (1) 17(2)(a)