Amore Elderly Care Limited

Dalton Court Care Home

Inspection report

Europe Way
Cockermouth
Cumbria
CA13 0RJ

Tel: 01900898640
Website: www.priorygroup.com

Date of inspection visit:
22 November 2017
24 November 2017
21 December 2017
02 January 2018

Date of publication:
29 January 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook a focused inspection of Dalton Court Care Home on 22 & 24 November and 21 December 2017 and 2 January 2018. The first visit to the service on 22 November 2017 was unannounced. We told the provider that we would return to the service for the other days so that we could check on progress and well-being of people in the home.

At our previous comprehensive inspection of this service on 18 & 21 July 2017 breaches of legal requirements were found. One of these breaches Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Person centred care, had been made at a previous inspection in March 2016, and was a continued breach.

We issued a warning notice for the service to meet this regulation by 30 September 2017. This was because people who used this service did not have care or treatment that had been personalised specifically for them; important information was missing from the care plans; and people's medicines were not being managed safely.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met the legal requirements as set out in the requirements of the warning notice. This report covers our findings in relation to those requirements, and other concerns found during this focused inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Dalton Court Care Home on our website at www.cqc.org.uk.

The service had a registered manager in post and they had been in post since September 2016. 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.

On the first day of the focused inspection, 22 November 2017, we found that the warning notice had not been met and there was a continued breach of Regulation 9 Person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that little progress had been made to meet the warning notice and there were new areas of concern identified. We immediately notified the provider

who took swift action, and across the other subsequent visits we saw how the provider's actions were leading to improvements in the service.

We found assessments of people's needs were still not being carried out to cover all areas of the person's support needs. There was little evidence of person centred care planning. This included end of life care planning and care plans. Some people living with dementia had not had a life story history undertaken. This is essential in the delivery of recognised national best practice for people living with dementia.

The registered manager had not been effectively managing new admissions of people to the home. Pre-admission assessments carried out lacked detail and were not always accurate. As a result we judged the service was accepting people with complex health needs without sufficient numbers of skilled and trained staff to meet people's needs.

At our last inspection in July 2017, we had found the provider had failed to protect people against the risks associated with the unsafe use and management of medicines. At this inspection, while there had been some improvements we found that medicines were still not managed safely.

Risks to people were not being well managed. We identified that risk assessments were not being carried out when a person's needs changed so that care plans were still relevant and people received person centred care and safe treatment.

The management of falls within the service was poorly managed and not in line with current nationally recognised good practice. We found a similar lack of action and recording for people at risk of developing pressure sores.

Staff also lacked the required skills and expertise to manage some of these more complex conditions and associated risks. For example there was inadequate guidance and training for staff to safely support people whose behaviour could challenge the service.

This is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014: Safe care and treatment.

There were insufficient staff to consistently meet people's needs. We found there was a shortage of trained nurses, senior staff and care staff on some shifts. There had been occasions when only one nurse had been on duty when a minimum of two was necessary to meet the needs of people in the service.

This is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Staffing.

The registered manager and the provider had not ensured that the warning notice had been met. Some care plans highlighted in the warning notice had not been changed, updated or amended. The audit mechanisms in place were not carried out effectively and staff were not held to account for tasks not completed to ensure practices were improved on.

Key information for safe and effective care was not available to all staff. Documentation was disorganised, incomplete and ineffective in communicating clear plans of how individuals should be supported.

The service did not always work effectively with key external health and care practitioners, for example there are a number of people who are at high risk of falls who have not had recent assessments by either a

physiotherapist or occupational therapist. This was compounded by a lack of falls management plan for individuals.

This is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Good governance.

The service was now reporting incidents and events as required by law into CQC. On the inspection of 18 & 21 July 2017 we found this was not the case and we prosecuted the service and issued a fixed penalty fine for this offence.

Staff and the service did not always recognise incidents that required making a safeguarding alert to adult social care. We asked the service to make a number of referrals on the first day of the inspection.

We observed that staff continued to be respectful, kind and considerate with people in the home. Relatives we spoke to and who contacted us continued to be happy with the care provided. One relative wrote to us tell us, "We are constantly relieved and heartened by the positive, affectionate atmosphere of Daffodil unit."

The service had not been well-led but the provider took immediate action after our inspection visit, 22 November 2017, to strengthen the management of the home. We saw on our return visits, to check on progress, that the provider had put in place a recovery programme 'Older people accelerated plan for quality improvement' with tools and support made available to the service to this end.

Since the inspection in November 2017 the provider had worked collaboratively with stakeholders, such as NHS health teams and adult social care leads to jointly drive up standards in the home.

While we found this progress promising we also took the service's inspection history into account. The service had been rated as 'Requires Improvement' for the last two inspections and 'Inadequate' for two inspections prior to that.

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

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

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

You can see what action we told the provider to take at the back of the full version of the report. Further information is in the detailed findings below.

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.

People not always fully protected against the risks associated with the use and management of medicines. We found some people were not receiving their medicines as prescribed.

Staffing levels were not meeting the needs of people in the home.

Not all safe recruitment practices were adhered to.

Risk assessments were not being carried out effectively to reduce risk to people in the home.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Pre-admissions assessment were of a variable quality and many did not cover all the individual support needs of each person.

We found gaps in person centred care planning. The plans for people at the end of life were not in enough detail to ensure that their wishes and end of life treatment was being met. Staff lacked training and confidence in this area.

Complaints were being better managed in the home and people where confident about raising concerns and these being dealt with.

People were being offered more choice and activities.

Is the service well-led?

Inadequate

The service was not well-led.

Systems in place to monitor the quality and safety of the service were ineffective.

Warning notices issued after the last inspection had not been

met.

Previously identified risks had not been addressed by the provider.

The provider was taking action to address these shortfalls.

Dalton Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

Dalton Court Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Dalton Court Care Home accommodates 60 people in one adapted building. The upper floor, Daffodil unit specialises in providing care to people living with dementia. There were 55 people living at the home when we inspected.

We undertook an unannounced focused inspection of Dalton Court Care Home on 22 & 24 November, 21 December 2017 and 2 January 2018. The visit to the service on 22 November 2017 was unannounced. We told the provider that we would return to the service for the other days so that we could check on progress and to see that people were safe.

This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection 18 & 21 July 2017 had been made. The team inspected the service against three of the five questions we ask about services: is the service safe, is the service responsive and: is the service well led. This was because the service was not meeting some legal requirements in these Key Questions.

No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

The inspection on 22 November 2017 was carried out by two adult social care inspectors, a pharmacist inspector and specialist advisor with expertise in occupational therapy. The following visits were carried out by the lead adult social care inspector for the service.

During the course of our inspection we spoke with 18 people and with four relatives of people living in the home. We spoke with six registered nurses, seven care staff, and four ancillary staff that included a domestic and a house keeper, a maintenance person, and activities staff. We spoke with the registered manager, the operations manager, Priory Quality Improvement Lead Support (QIL) and the Priory's Director of Performance and Regulation.

We looked at the care plans files and medicines records for the people living in the home and at 12 people's care records in greater detail. We observed the care and support staff provided to people in the communal areas of the home and at meal times. We observed medicines being handled and discussed medicines handling with the staff involved.

We reviewed seven recruitment files, three belonging to staff members who had been recruited since the last inspection. We checked documentation that was relevant to the management of the service including quality assurance and monitoring systems.

Before the inspection we reviewed the information we held about the service. We contacted health and social services commissioners who contracted people's care. We also contacted the local safeguarding and adult social services teams. We spoke with health care professionals who supported people who lived in the home.

We checked the information we held about statutory notifications sent to us about incidents and accidents affecting the service and people living there. A statutory notification is information about important events that the provider is required to send to us by law. We used a planning tool to collate all this evidence prior to visiting the home.

Inadequate

Our findings

At a previous inspection in March 2017 we found the provider had failed to protect people against the risks associated with the unsafe use and management of medicines. This was a breach of Regulation 12 (2)(g): Safe care and treatment of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At the inspection of 18 & 21 July 2017 there had been significant improvements in how medicines were managed but we also saw there was inconsistency in the level of improvement between the two units within the home. At this inspection beginning 22 November 2017, again there had been some improvements but we found that medicines were still not managed safely.

Medicines had not been administered as prescribed. A number of people were prescribed medicines to be taken before food and usually given by night staff, before breakfast. We observed a nurse administering medicines on Daffodil unit and saw that none of the early medicines had been given by late morning. Staff gave medicine to people that had not eaten but a number of medicines were missed. We saw other early morning medicines in the trolley that had not been given from the months' supply. Medicines may not be effective if not taken at the optimum time.

One person was prescribed a medicine to treat symptoms of Parkinsons that was required at specific times to be effective. There was no stock of this medicine on the day of the inspection and according to the medication administration records (MAR), the person had missed sixteen doses in the last three weeks. Furthermore, the MAR record had been signed on more occasions than the number of tablets provided by the pharmacy, which meant the medicine was not given as recorded. There were discrepancies with other medicines we checked. This meant records did not reflect the treatment that people had received. We saw how this had impacted on this person's health on the day of the inspection making mobility more difficult for them.

We looked at the records for two people that received their medicines covertly, hidden in food or drink. One person had additional information in their MAR file guiding staff how to prepare the medicine. However, we did not see any advice from a pharmacist explaining how to disguise each medicine without reducing its effectiveness. The other person had no information that explained how to administer their medicines. We also found no record that the person had been assessed for capacity to make decisions and that covert administration was in the person's best interest. This did not follow the provider medicines policy.

A chart had been introduced to record the administration of medicines with a variable dosage. Staff had

been trained to record when medicine had been given and count the remaining stock each day. According to records and remaining stock, one person had received too many tablets on one day in November. The regular blood test required for this person was overdue by seven days at the time of the inspection. This was escalated to the registered manager and actions taken.

People were at risk of not receiving medicines to meet their needs. One person who had recently been admitted to the home for palliative care had no plans in place for pain management. This person was described, in information from their hospital discharge notes, as being non-compliant with pain medications but a pain assessment was not completed for eight days and there was a further delay a before an appropriate method of pain relief was put in place. Daily notes stated on numerous occasions that this person was displaying signs of being in a high degree of pain.

This was a breach of Regulation 12 (2)(g): Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to the safe management of medicines.

At the last inspection 18 July 2017 we made a recommendation to continuously review staffing levels in line with changes in dependency. We found this had not been put in place and there were still insufficient staff to consistently meet people's assessed needs.

We found there was a shortage of trained nurses, senior staff and care staff on some shifts. There had been occasions when only one nurse had been on duty when there should be a minimum of two, according to the provider's dependency staffing tool. The registered manager had sent in statutory notification to CQC on 13 November 2017 to report significant staff shortages that had the potential to prevent the proper running of the service. We were informed that the required staffing level should be a minimum of two qualified nurses per shift and six care staff. The notification reported that there had been one nurse and only three care staff on a number of shifts for that week. During this period the home had admitted one person with very complex health and behaviours that challenged the service. We found that this persons needs were not being met and the introduction to the home had been very poorly managed.

Staff reported to us that they were very short staff at times and that they had little time to carry out risk assessment or update people's files. Two relatives we spoke with told us that at times the home was short staffed.

We looked at the staffing rotas for the previous four weeks and saw that these shortages were a regular occurrence. The home had an on-going recruitment to employ more staff but high sickness levels were hampering this process.

We also noted that some people spent significant amounts of time alone in their rooms or sitting in wheelchairs for prolonged periods. For these people we observed that there was little staff interaction or inventions, such as position changes to promote good skin integrity to reduce the risk of pressure sores.

This was a breach of Regulation 18: Staffing of the Health and Social Care Act (Regulated Activities) Regulations 2014 as the provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet people's care and treatment needs.

At follow up visits on 21 December 2017 and 2 January 2018 the provider gave assurances that staffing levels were now sufficient to meet people's current needs. The provider had assigned a dedicated HR person from the company to support the recruitment drive. Qualified nurses both from the company and from an agency had been drafted in to make up the numbers until permanent nurses could be recruited. On the 2 January

2017 we saw that six care staff had been offered posts and were awaiting references and police clearance. Staff reported an improvement in staffing levels and the staff rotas confirmed that these were now sufficient for the number of people in the home. We observed people receiving increased staff support and interaction in the home.

At the last comprehensive inspection 18 July 2017 we made a recommendation with regard to the recruitment procedures to obtain references from previous employers. When we looked at the recruitment files of staff who had been employed at Dalton Court since our last inspection we continued to find that it was not clear that all checks had been carried out. We also found that three of the five files we checked did not have a reason stated for leaving the last employment, two had no employment history listed and one had gaps in employment history. This meant that the provider had not ensured that people employed in the home were suitable to work with vulnerable people.

We had considered that this to be a breach of Regulation 19: Fit and proper person employed of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However the provider took immediate action and on our follow up visit of 21 December 2017 we saw this had been resolved and appropriate checks and references were now in place.

We identified a new concern on this inspection regarding risk management. We found risks, both for individuals and for the environment, were not always assessed effectively to enable risk reduction measures to be implemented. The environment was not always risk assessed to ensure it was safely maintained. For example, on the specialist unit for people living with dementia a storage room for chemicals and cleaning products had a broken lock and was left ajar. The combination lock had been taped over to prevent the door from shutting and this had been like this for some time as the tape was worn and discoloured. The sign on the door read 'to be kept locked at all times'. This placed vulnerable people at risk of harm. We told the registered manager and the door was fixed straight away.

Risk assessments that had been completed were not always accurate or up to date when people's needs changed. For example, personal emergency evacuation plans (PEEPs) did not contain sufficient detail and many were out of date.

We observed one person sitting in the lounge on a sling. We asked why this was and the carer replied they didn't know. The nurse in charge told us this person was left sitting on the sling because it was too difficult getting the sling on and off. The sling was not a specially lined sling made of fabric designed to be left under a person. We checked who made this decision and where the risk assessment was associated with this. The nurse stated that a risk assessment had been completed but was unable to provide written evidence of this. There was no care plan in place for skin integrity care. This placed this person at risk of developing pressure areas and receiving unsafe care and treatment.

Risk assessments were not up to date, not filled in, or incorrectly filled in. The tools used for scoring risk were also incorrectly used and scored. The correct scoring of risk assessment tools triggered certain interventions. Such as whether to use a fluid balance chart to check food and fluid intake; or to check weights more frequently to monitor weight loss; or more frequent turning in bed to reduce risks of developing pressure sores; or to make referrals for more specialist support, such as dieticians or tissue viability nurses.

This meant that the wrong scores were being used to calculate the service's staffing levels. These scores were used to determine people's dependency levels. People's needs should have scored much higher if the tools had been used correctly. This meant that the level of monitoring required and staff interventions were

not as high as they should have been to offer the support they needed. We saw one person had numerous falls resulting in injuries, including a broken hip. The care plan held no details on falls prevention, neither was there a review after each of the falls. Staff reported that this person would benefit from more staff supervision but was yet to be referred back to the commissioning body for further funding as they hadn't up dated the paperwork for this.

One person's notes stated they were at high risk of falls but the falls risk assessment and care plan were not up to date. A risk assessment stated this person was fully continent and independently mobile. However, daily notes and a senior handover night shift hand over form stated that they had frequently been incontinence of urine, soaking themselves, chair and the floor and a sensor mat was in place due to being at high risk of falls. And on two occasions it was recorded that they had slipped in the urine. On the first occasion causing a fractured foot (CQC notification in August 2017). A Falls Risk Assessment was scored at 11 when it should have been at least 21 very high risk taking into account all these risk factors but was rated at 11 moderate. This meant that measures to reduce risk where not identified by these tools and this score did not accurately feed into the calculations for the amount of staff support required for this person.

There were no measures in the falls risk assessment or falls care plan to ensure that they did not slip again. There were no instructions for staff on how to use the sensor mat and any associated risk, such as slipping on the mat when wet. There was no reference to seeking outside support for continent management. We would have expected that a toileting regime would be set up to try and re-establish continence.

This was a breach of Regulation 12: Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) 2014 relating to assessing the risks to the health and safety of service users and doing all that is reasonably practicable to mitigate any such risks.

Staff and the service did not always recognise incidents that required a safeguarding alert to adult social care. We asked the service to make a number of referrals on the first day of the inspection. The provider made arrangements for the local safeguarding lead to carry out training for staff in the home.

We found that the service had not been applying the providers' policies and procedures to act on incidents and accidents to ensure that lesson were learnt to reduce the likelihood of any future recurrence. However, the provider's action plan to improve the service, following this inspection, included amongst other measures: a Clinical Risk Register; medicines competency checks for all nurses; and a standard operating procedure for updating risk assessments and care plans following visits to the home by external professionals.

Requires Improvement

Our findings

At the previous inspection in July 2017, we found a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and issued a warning notice. This was because care plans did not always provide sufficient detail regarding people's care needs and were not always updated when people's needs changed.

During this inspection we looked to see if improvements had been made. We found that not all care plans provided appropriate information to enable staff to support people effectively and were not always updated as people's needs changed. For example, one person's daily notes records indicated that their mobility had deteriorated recently and that they required support from two or three staff to mobilise. However, their mobility care plan indicted that they were able to mobilise short distances independently with the use of a walking aid. The plan had not been updated since the change in the person's need. We observed this person being supported to mobilise and staff were unsure of how to support this person and communication between them was poor. This resulted in unsafe care. This meant that staff did not have sufficient information to enable them to support the person safely and effectively.

Pre-admission assessment were of a variable quality with important information missing. For example sections incomplete included environment setting, physical health needs, mental health and wellbeing, personality profile, sleeping pattern, food and drink preferences and a miscellaneous section covering hearing aids, zimmer frame, glasses, bed rails, pressure cushions, specialist chairs, dentures, walking sticks, visitors, family members, pictures, pets etc. None of this was completed on admission for several of the files we looked at. For a number of people a care plan termed 'person-centred dementia care pathway assessment' was not completed and neither was a life history. This type of information is crucial for delivering effective person centred care, recognised by NICE as best practice, when supporting people living with dementia.

We looked at the end of life care for people living in the home. When we completed our previous inspection on 18 July 2017 we found concerns relating to the training for staff regarding the end of life care. At this time this topic area was included under the key question of Caring. We reviewed and refined our assessment framework and published the new assessment framework in October 2017. Under the new framework this topic area is included under the key question of Responsive.

We had made a recommendation at the inspection of 18 July 2017 that the service finds out more about training for staff, based on current best practice, in relation to the needs and management of people at the

end of their life.

On this inspection 22 November 2017 we found this recommendation had yet to be actioned. We found very similar findings to the other aspects of meeting people's needs. We found that the paperwork, assessments and records of people's end of life wishes were either missing or were incomplete. On our visit 3 December 2018 people at the end of life had been prioritised to have their end of life care plans reviewed to ensure they were up to date and accurate. As part of this process some staff had reported as not being confident in having end of life discussions with people and their relatives. The provider was actively sourcing training and support on our visit. Arrangements were in place for training to be given from a local hospice and NHS palliative care staff.

On the first day of the inspection we heard a number of people shouting out with frustration for assistance or in distress. Staff were working in a task orientated manner and had limited time to respond to individuals in a person-centred manner. We saw how one persons' care plan stated that they didn't like to join in noisy group activities, however we saw staff encouraging them to take part and they became agitated. For other people there was very little information in their care plans about how to respond to people when they did become distressed or agitated.

This is a continued breach of Regulation 9 Person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service did not have care or treatment that had been reviewed and personalised specifically for them.

On our return visits, 21 November 2017 and 3 December 2018 we found that there were more staff on duty, including a senior carer on each unit, and staff were better deployed and organised. The atmosphere was calmer and we saw people engaged in numerous activities. Staff had time for conversations and to engage with people. Some people were being supported to spend time in the sensory room; enjoying lights, music and hand massages. While in the lounge staff were using a parachute and balloons to aid exercise and people were obviously enjoying this becoming very animated, with lots of laughter and chatting.

We also saw how work had started in improving people's care plans to not only make them up to date but to also make them more person centred. A comprehensive review of care plans was underway and evaluation sheets were being used to audit and prioritise risk to ensure that care plans were now setting out clear instructions for staff to follow. We saw how one person's care plan for end of life care had been updated to include wishes and requests as well as appropriate treatment plans, such as end of life medicines. Staff reported that they had been given additional time to do this. One nurse said, "We are very focused now. The new care plans will be much better, more condensed, easier to use. We can see at a glance now, who's had changes, who's on increased 'obs' (observations), and when GPs and OTs have visited and what's been done about it."

We saw the plan to update and review care plans. The interim manager said that this would 'go hand in hand' with training and introducing a scheme called 'resident of the day'. This would include a complete over view of a person's care, including risk assessment and care plans files and a meeting with the person and their relatives, a check of their room and a meeting with the cook to discuss any changes that might be needed or requested.

The interim manager shared with us plans to have a full dementia audit for the service in January 2018. This was to include an expert from the company delivering training for all the staff team and a review of the working practices and environment to ensure the home was dementia friendly and would meet the needs of people living with dementia. A review of technology used in the home would be part of this. The home

currently made use of some technology to support people, such as senor mats to alert staff when people were out of bed. However the interim manager spoke of introducing more 'high and low tech' aids and activities to promote people's independence and well-being.

People who used the service knew how to make a complaint or raise issues. Everyone we spoke to was aware of how to raise concerns or make a complaint if they needed to one person told us; "I know what I need to do. I would tell the staff and then someone higher if things were going wrong." Relatives we spoke with said that staff were approachable and most complaints were dealt with informally. One relative said, "I had a compliant about the food and mealtimes but it was dealt with very well by the manager and staff had additional training sessions." We were told by relatives that when a complaint had been raised about the standard of food the service had responded by carrying out a full review of the food and catering. This had included an audit of the mealtime experience for people. A relative now reported that the food was very good and the mealtimes were much better organised.

This showed us that the complaints procedure was embedded in the service and staff and visitors were confident to use it when needed. To support this information for people and their relatives in the home was available in different formats and easy read options were available.

Inadequate

Our findings

The service had a registered manager in post, as required by their registration with the CQC, at the time of this inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

When we completed our previous inspection on 21 July 2017 we found concerns relating to the running of the service and rated this key question of well-led as 'Requires Improvement'. We found that the registered provider had not ensured that we had been notified of the all the accidents and injuries that had occurred in the home as they were required to under the regulations. We prosecuted the service and issued a fine for this offence. This has been paid. The service was now reporting incidents and events as required by law to CQC.

On the first day of the focused inspection, 22 November 2017, we found that little progress had been made to meet the warning notice and there were new areas of concern and breaches identified. Care plans did not provide sufficient detail regarding people's care needs and were not always updated when people's needs changed. This meant people were not always receiving safe care and treatment specific to their individual needs.

There were systems in place to monitor the quality of the service at Dalton Court however these systems had failed to identify or to address in a timely way the areas of concern identified at this and previous inspections. These included concerns with risk management, insufficient staffing, poor medicine management and with the way in which care was provided to people who were vulnerable. We saw that the registered manager was not implementing the system the provider had in place to audit and check the quality of the service. There was a delay in the provider picking this up and therefore also taking action. This meant that people living in the service had been at risk of unsafe care and treatment.

Key information for safe and effective care was not available to all staff. Documentation was disorganised, incomplete and ineffective in communicating clear plans of how individuals should be supported. We were told that as a result of the previous inspection on 21 July that the registered manager and senior nurses were carrying out audits of medicines and care plans to ensure that these were accurate and up to date. We saw some evidence of these being recorded however simple errors and mistakes were being missed and we continued to identify risk. These included people not receiving their medicines at the times prescribed and

some medicines being out of stock. We identified at least two people that this had had a detrimental effect on their health.

At the last inspection we made a recommendation that staff recruitment procedures should include obtaining references from previous employers. At this inspection there had been no actions taken. This meant that new staff taken on from the last inspection had not had the necessary scrutiny to unsure they were suitable to work with vulnerable people.

The service did not always work effectively with key organisations, for example there were a number of people who are at high risk of falls who have not had recent assessments by either a physiotherapist or occupational therapist. When advice was sought it was not always communicated to other staff or transferred into care plans. This meant staff did not have up to date information on how to meet people's needs. This was not picked up by the auditing systems.

Some care plans highlighted in the warning notice had not been changed, updated or amended. The audit mechanisms in place were not carried out effectively and turned into action plans to ensure practices were improved on and staff were not held to account for tasks not completed.

This was a breach Regulation 17: Good governance as the service was not being well-led and the systems to monitor the quality of the service were not being applied effectively.

We immediately notified the provider who took swift action, and across the other visits we saw how the provider's actions had led to improvements in the service. The provider told us that they a responsive and responsible provider and took immediate actions as set out in an action plan sent to us the day after the 22 November inspection. The following is an extract from the action plan we received from the Priory's Director of Performance and Regulation: "We are keen and committed to ensure that the quality and safety at all our Older People's homes is to a high standard. The things you found fall short of this. As I stated, once we realised things were not as they should be, we started working on these immediately. This coincided with the CQC inspection. There were a number of things that were not escalated as per our procedure. ....such as making us aware of the whistle-blowers you mentioned, escalating up to the Operations Director breaches in staffing levels, and the complex end of life admission."

These were some of the immediate actions the provider took: ensured that safeguarding referrals had been made to the local authority on issues identified by CQC; admissions to the home were suspended; a review of recruitment and HR processes ensuring there was a dedicated HR resource link working with the home to find nurses. The issue regarding staff recruitment and obtaining references had been progressed. A senior manager within the organisation, with experience of supporting services to improve, was seconded full-time to the home.

The provider had put in place a recovery programme termed 'Older people accelerated plan for quality improvement' so that the service was placed under greater scrutiny and also offered support and additional resources. For example, a Priory Quality Improvement Lead Support (QIL) had been seconded to the service to focus on care plans and work with nursing staff to build competency and capability. We were also told by the provider that they were currently setting up Quality Hubs for the Priory Older People's homes so that homes do not become isolated and were encouraged to work together in geographical areas to share good practice.

At our follow up visits we saw that measures implemented had led to noticeable improvements to ensure safe and effective care was being delivered to people. For example, all nurses had completed medication

competencies and received refresher training for the safe management of medicines. There had been a review by the Priory Associate Director of Nursing of staffing based on dependency levels and need, and work with the nurses on nursing leadership. This had brought about additional nursing staff and a decision to recruit a deputy manager for the home to be responsible for clinical leadership. The service had also drafted in additional care staff from their bank and agency workers they had previously known and used.

The service has been placed in a process known locally as Quality Improving Measures by health and social care commissioners and the local authority to assist in ensuring that the care and support offered was to expected standards and that people were in receipt of safe care. Both health and adult social care commissioners had reported to us a willingness and openness from the provider to both identify failures and act on them, and were already finding an improvement in the standard of care being delivered.

While we found this progress promising we also took the service's inspection history into account. The service had been rated as 'Requires Improvement' for the last two inspections and 'Inadequate' for two inspections prior to that. We have placed the service into special measures to monitor that this progress both continues at this rate and is sustainable so that people consistently receive good quality safe care that meets their individual needs.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that assessments had been carried so that people's care and treatment were personalised specifically for them. Care plans did not provide sufficient detail regarding people's care needs and were not always updated when people's needs changed. 9(1)(3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that risk assessments relating to the health, safety and welfare of people using the service were carried out. Relevant health and safety concerns had not been included in people's care and treatment plans. The provider had not ensured the safe management of medicines.

The building was not being assessed effectively for risk.

Some staff were unclear on how to use equipment and to manage people's behaviours that posed a risk to themselves and others.

The provider had failed to do all that was reasonably practical to mitigate risk.

12(1)(2)(a-e)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to monitor the quality of the service were not effective. The provider's systems were not effective to minimise the likelihood of risk and to minimise the impact of risk on people who use the service. Risk to the health, safety and welfare of people who use the service had not been escalated within the organisation or to a relevant external body as appropriate. The provider had not ensured that records relating to the care and treatment of each person were accurate, complete and fit for purpose. Records relating to person employed at the home were not complete to ensure they were suitable to work with vulnerable people. The provider had not ensured that their audit and governance systems remained effective. Regulation 17(1)(2)(a)(b)(c)(d)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

Treatment of disease, disorder or injury

The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet people's care and treatment needs.

Regulation 18(1)