ARMSCARE Limited

Docking House

Inspection report

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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

This inspection took place on 9 July 2018 and was unannounced. Our last full comprehensive inspection of this service was in November 2017. At that inspection we rated the home overall as Requires Improvement, with the key question of is the service Well Led rated as Inadequate. At that inspection there were seven breaches of legal requirements within the Safe, Effective and Well Led areas.

Following the last inspection in November 2017, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of Safe, Effective, Caring, Responsive and Well Led to at least Good. We also met with the provider in March 2018 to discuss the progress of this.

During this latest inspection the registered manager and provider demonstrated to us that improvements had been made and the home is no longer rated as Inadequate in any of the key questions. The provider is no longer in breach of five of the regulations that we found at our inspection in November 2017. However, the provider remains in breach of Regulations 12 and 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Further improvements are needed in some areas as detailed below.

Docking House 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. Docking House provides personal care for up to 39 people in one adapted building. At the time of our inspection, there were 38 people living there. Docking House provides personal care to people living with a range of health conditions, including physical disabilities and people living with dementia.

The service had a registered manager in place. 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.

There were inconsistencies in people's care records. Risks to people's safety were assessed but information was sometimes conflicting and lacking in detail about the action staff should take to minimise them. The way in which staff were deployed, did not always ensure people that people were kept safe in line with the provider's requirements.

People felt safe living at Docking House. Staff understood how to safeguard people from risk of abuse and were confident the registered manager would ensure any allegations of abuse were appropriately managed. Staff were trained in relevant areas, including health and safety and moving and handling. People's medicines were managed safely. New staff working at the home had been subject to the appropriate checks before their employment began designed to check they were safe to work within care.

Staff had received training in a number of different areas to provide them with the skills and knowledge to

support people. Their competency to do this effectively had been assessed however, we saw that on some occasions staff used poor practice that placed people at risk of harm and was not caring.

Further training was to be provided to staff regarding dementia care to help them develop their skills further and gain confidence on how to assist people who may regularly become upset or distressed. Staff also received adequate support and guidance in their roles.

Improvements had been made to the monitoring of people's nutrition and hydration needs, but oversight of this did not always identify when people had not met their daily fluid intake target in a timely way.

Improvements had been made to the provision of activities to enhance people's wellbeing and stimulation but was not yet delivered consistently. The provision of staffing resources to provide this had not yet been implemented due to difficulties in recruitment.

Complaints to the service had been managed in line with the provider's stated procedure. People were supported to maintain their relationships with people who mattered to them. Relatives and visitors were welcomed at the service at any reasonable time.

People's healthcare was monitored. Healthcare professionals who visited the home regularly were confident that people's needs were met and that expert advice was sought without delay when required.

Governance and quality monitoring had improved, but still required further amendments to ensure it was robust. Audits and checks in place to monitor the quality of the service had not found some of issues that were present during our inspection. The registered manager and provider were open to suggestions for improvement and had a plan and resources in place to drive up the quality of the service provided.

The staff were happy working at the service, felt very supported by the registered manager and provider and worked well as a team to deliver care to people.

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.

Improvements had been made to the assessments of risks to people, however guidance to staff in the management of this needed to be clearer in some records.

The way in which staff were deployed meant that communal areas were left unsupervised which posed a risk to people that need constant monitoring.

Some staff were observed to use poor moving and handling practice which placed people at risk of injury.

People received their medicines as the prescriber intended, the audits of people's medicines were robust.

Safe practices were undertaken in the recruitment of staff.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were provided with training and supervision to develop and maintain their skills. However, we saw mixed practice from staff during the inspection in relation to their competency.

People's rights were respected and care was provided with consent or in people's best interests. Staff understood the principles of the Mental Capacity Act 2005.

Improvements had been made to the recording of people's food and fluid intakes but the monitoring of this was not yet robust enough.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People confirmed staff were caring and kind.

Staff did not always respond to people when they were upset or

distressed.

People were actively involved in making decisions about their own care where they were able to do this.

Is the service responsive?

Requires Improvement

The service is not always responsive.

The provision of activities was improving but required further staffing resources to ensure this could be delivered regularly.

Some people's care records still lacked important information about how staff were to support them, which may lead to some people not receiving the right care and support.

A complaints policy and procedure was in place. Issues raised were acted upon to improve the service.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Governance and quality monitoring had improved, but still required further amendments to ensure it was robust. Audits and checks in place to monitor the quality of the service had not found some of issues that were present during our inspection.

People using the service, relatives and staff had their views asked for and their feedback was acted upon.

Docking 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 unannounced inspection took place on 9 July 2018 and was carried out by three inspectors.

Before our inspection, we looked at information we held about the service including notifications. A notification is information about important events, which the provider is required to tell us about by law.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also gained feedback from professionals from the local authority and clinical commissioning groups who had regular contact with the service.

During the inspection, we spoke with two people living in the service and three relatives. Not everyone who used the service was able to verbally communicate with us due to their health care needs. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with the registered manager, two senior carers, a carer, and the provider's operations manager and managing director. As well as speaking to staff employed to work at the service, we also spoke with a consultant employed by the provider to improve the quality of care people received.

We looked at five people's care records, quality assurance surveys completed by staff and people who used the service, staff meeting minutes and medication administration records and audits. We checked records in relation to the management of the service such as health and safety audits and staff recruitment and training records.

Requires Improvement

Is the service safe?

Our findings

At our previous comprehensive inspection on 20 and 22 November 2017, we found shortfalls in the provision of good and safe care. The provider was in breach of four regulations relating to this key question. These breaches related to safe care and treatment, safeguarding people from the risk of abuse and avoidable harm, sufficient numbers of staff employed and the safe recruitment of staff. We rated this key question as 'Requires Improvement'. At this inspection, we found that some improvements had been made however further improvements are still required in respect of managing risks to people. Therefore, we have again rated this key question as, Requires Improvement.

At our last inspection in November 2017, we found that the provider was in continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had not taken appropriate action to manage risks to people's safety. At this inspection we found improvements had been made but these were not sufficient and the provider remains in breach of this regulation.

Care plans contained assessments of risks to people's safety. This included for example, risks associated with mobility, poor dietary intake and to their skin integrity. However, we found that information within these care plans was sometimes conflicting which could confuse staff about what they needed to do to mitigate any identified risks. Also, staff were not always deployed in a way that was consistent with what was stated in care plans about managing risk. Also in one instance, we were concerned that the action they took following a fall, placed a person and the staff themselves at risk.

During our tour of the building, we observed a person standing in the lounge and having difficulties holding a cup of tea. When we returned to the area, the person was on the floor having fallen and spilled the tea around them. Staff attended and asked the person if they were all right, before lifting them to their feet. There were no robust checks of their limbs to see if they were injured and no mobility aids were used to return them to a standing position or to a nearby chair. This is unsafe moving and handling practise. Staff lifted the person while the tea was on the floor presenting a risk to their safety and to the person concerned.

We asked the operations manager and consultant how staff were expected to assist a person from the floor safely. They told us that they expected staff to check the person's limbs before moving them and to use the hoist if people were on the floor. This did not happen placing people and staff at risk of injury.

We checked the person's care records regarding their mobility and risk of falls and found that staff had reviewed these during the weekend before our inspection visit. The records stated, "[Person] cannot walk now." The records also showed that the person had a two-wheeled walking frame but that they were not using it now due to their lack of mobility. Elsewhere the records showed, "[Person] can walk with two carers assistance at times and sometimes [person] walks without assistance." The records stated this depended on the person's mood and that they required frequent reminding to use the walking aid. We observed that there was no walking frame near to the person for them to use. The information in the persons plan was conflicting and inaccurate.

We spoke with the registered manager about the person's mobility. She told us that the person could mobilise themselves and would go from the lounge to the dining room on occasion. We were concerned that the information did not provide clarity for staff about supporting the person with their mobility.

To minimise the risk of falls, the information stated that the person needed to remain "…in communal areas where [person] can be observed at all times." Their tissue viability records referred to poor mobility and again stated that they were to be observed "…at all times." We noted that staff were not present when we first found the person had fallen and was on the floor. Accident records showed two further incidents where the person was found on the floor having fallen unobserved. The person was noted as having a pressure mat by their bed to alert staff if they attempted to move independently during the night. However, there was no such equipment in use for them in the lounge area that could alert staff to the person's movements when there were no staff present.

There was conflicting information about the condition of the same person's skin and therefore their risk of developing pressure ulcers. For example, their tissue viability records stated that their skin condition was good. However, their Waterlow assessment (a recognised tool for assessing the risk of pressure ulcers) indicated that their skin condition was tissue paper, dry, oedematous, or discoloured. This should have increased the score indicating the level of risk and presented concerns that risks to their skin integrity were under-estimated.

For another person we found similar concerns that intervention and monitoring of their skin condition may not be at the right level. This was because of conflicting information in their care records about the level of risk. The person's care needs summary indicated that risks to their skin integrity were low, but the Waterlow assessment itself showed they were at medium risk.

A third person spent the day of our inspection visit sitting in a recliner armchair. During lunchtime and the afternoon, we observed that the chair was in an upright position and their feet were dangling. They had their legs crossed in the same direction at lunchtime and during our observations up to 4pm. This presented concerns that, as their feet were unsupported, undue pressure on the knee of one leg increased the risk of a pressure area developing.

We also observed that, during the morning, a staff member attempted to assist this person to drink. However, their chair remained in the reclining position. The person attempted to hold their head up but was not able to sustain this. We were concerned that the position they were in made it difficult for them to drink and presented a risk of choking.

We concluded that identifying risks to people and the monitoring and management of their safety, was not always completed consistently, accurately and in accordance with their care plan. This meant that people living at the home did not always receive safe care in relation to the risks posed to their health.

This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's safety associated with the premises were kept under review. Systems for detecting and extinguishing fires were tested regularly and staff had guidance about how to ensure the safety of individuals should a fire break out. We also noted regular checks on equipment used for assisting people with their mobility and on electrical appliances. There were programmes of audits and checks on safety of individuals and associated with the premises or activities people and staff might undertake.

At our last inspection, we found that a number of incidents relating to safeguarding concerns had not been reported to the local authority safeguarding team as is required. Not all staff had completed training in safeguarding people from the risk of abuse, and staff did not have the skills and experience to intervene to prevent a potential safeguarding incident. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made and the provider was no longer in breach of this regulation.

The registered manager had reported any incidents of alleged abuse to the local authority safeguarding team, and had notified the Care Quality Commission (CQC). Staff we spoke with knew how to keep people safe and were aware of their roles and responsibilities in reporting any concerns or incidents. They told us this could be to their manager or to external safeguarding agencies such as the police or the local safeguarding authority. Staff had undertaken training in the safeguarding of adults, and could tell us how to recognise indicators of abuse. We were therefore satisfied that the provider had systems in place to help protect people from the risk of abuse.

At our last inspection we found shortfalls in the checks made on potential new workers in the home. This included not obtaining all the required information from the Disclosure and Barring Service, and fully exploring applicants full working history prior to them commencing employment. These checks help to reduce the risks of unsuitable staff being employed. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made and the provider was no longer in breach of this regulation.

Staff only commenced working in the service when all the required recruitment checks had been satisfactorily completed. Staff we spoke with told us that their recruitment had been dealt with effectively and that they had supplied all requested recruitment documents. These documents included completing an application form, a criminal records check and references. This meant that only staff that were checked as being suitable were employed to work at the service.

At our last inspection we found that not enough suitable staff were employed to meet people's needs and keep them safe. Staff had been deployed to work unsupervised before carrying out the necessary training and having their competency assessed. Staff had been working excessive amounts of hours because the provider had not recruited enough staff. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made and the provider was no longer in breach of this regulation.

The registered manager told us that they had recruited a number of new staff, and that they had all completed the required training and had their competency to fulfil the role assessed before being deployed to work unsupervised. The number of hours staff were working had also reduced and they no longer worked an excessive amount whereby they became fatigued and less effective. Records we reviewed confirmed this to be the case. The amount of agency staff the provider used had also decreased as a result, meaning people were supported by a consistent team that knew them well.

People's relatives told us that they felt there was enough staff to keep them safe and meet their needs in a timely way. They also told us that their relative felt safe living at Docking House. However, at certain points of the day, such as during the morning where staff were supporting people with personal care in bedroom areas, we saw that communal areas were left unsupervised. This meant that should an incident occur, or if a person required support, there was a delay in staff being available to support them. We spoke to the registered manager and the providers managing director about this. They told us that they planned to increase the staffing numbers on duty by one member, and that this was currently being recruited to. On the

first day of our inspection interviews were due to take place. They felt that this additional post would take the pressure off the staff team and allow them to spend more time talking and interacting with people when providing them with care. The registered manager explained that the deployment of the existing level of staffing currently included monitoring the communal areas, but agreed that this deployment had not been effective. They agreed that instruction to staff on their deployment needed to be more explicit and that they would action this.

Relatives told us their family member received their medicines on time and were able to take them how they wanted to. We observed staff did not rush people to take their medicines, and explained to them what they were before administering. Staff had access to up to date guidance on the safe management of medication, including the registered provider's policy and procedure. Medication was administered only by staff who had completed the relevant training and checks on their competency. The rooms where medicines were stored were clean, well-organised and well ventilated. Records showed the temperature of the rooms and medication refrigerators had been monitored daily to ensure they were within the required range so that medicines remained effective. Safe systems were in place for the ordering, receipt, disposal and administration of medication and records showed these were correctly followed.

Each person had a medication administration record (MAR) listing each item of their prescribed medicines and instructions for use. MARs were accompanied by a personal profile which displayed a recent photograph of the person along with details of any allergies and any special instructions for administering medicines. MARs were signed to show when a person had taken their medicines and identifiable codes were used where a person had not taken their medication, for example if they refused or where in hospital. Staff followed appropriate guidance by contacting a person's GP in circumstances when they had continuously refused to take their medicines. A body map was in place for people who were prescribed topical creams and pain relief patches. These clearly identified the area on the body where the medication was to be applied. Details of these medications and times of use were recorded onto the persons MAR.

Some people were prescribed medication to be given 'as and when required', (PRN medication), for example for pain or anxiety. Protocols were in place for the use of PRN medication and they provided guidance for staff on the reason for giving it, the dose to be given and minimum intervals between doses. The use of PRN medication was clearly recorded and kept under review. These records showed that people were administered PRN medication in line with the prescriber's instructions.

We checked the process for preventing the spread of infection in the service. Staff were aware of infection control procedures and had access to personal protective equipment to reduce the risk of cross contamination and the spread of infection. Training records showed staff had received training in infection control. The service was odour free, clean and pleasant. Sluice rooms were kept locked when not in use and staff wore personal protective equipment (PPE) such as aprons and gloves when supporting people with personal care. One visitor to the home told us that they felt that cleanliness of the floors of the homes communal areas could be improved. On the day of our inspection we observed the floor to be clean.

The registered manager carried out audits of accidents and incidents in the service to assess if actions could be taken to prevent future occurrences. For example, staff had referred people to the falls team when required.

Requires Improvement

Is the service effective?

Our findings

At our previous comprehensive inspection on 20 and 22 November 2017, we found shortfalls in the provision of effective care. The provider was in breach of three regulations relating to this key question. These breaches related to staff training, eating and drinking and consent to care and treatment. We rated this key question as 'requires improvement'. At this inspection, we found that improvements had been made however further improvements still need to be made in one area. Therefore, we have again rated this key question as, 'Requires Improvement'.

At our previous inspection, we found the provider had not provided sufficient oversight and monitoring of people who were at risk of not eating and drinking enough. This had resulted in a continued breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. At this inspection, we found that some improvements had been made, and that the provider is no longer in breach of this regulation. However, further improvements still need to be made in regard to the accurate recording and monitoring of people's intake of fluids.

People's records identified where there were risks of people not eating or drinking enough. However, we found that records did not consistently show how the risks were managed and our observations showed that this would sometimes be difficult to monitor accurately.

For example, one person's records showed they needed to drink between 1600 and 2000mls of fluid each day. We reviewed records of their fluid intake from 5 July to the day of our inspection visit, and found that the minimum level had not been reached on any of those days. On 5 July, they had only drunk 1050mls. The registered manager indicated that the fluids they had taken with their medicines had not been included in the record and so it was likely their intake was higher. However, they were 550mls short of the minimum target risking dehydration, particularly in the recent hot weather leading up to our inspection visit. Staff we spoke with told us that they had enough time to ensure people received enough to drink. Relatives we spoke to did not have any concerns regarding the amount people received to drink.

For another person there was a similar risk and conflicting amounts. We found that, on the day before our inspection visit, their electronic records showed they were 300ml short of the minimum target. However, the paper records staff kept, showed they were 500mls short of what was intended as the minimum desirable amount. The notes showed they had thrown two of the drinks on the floor but there was no indication they had been offered an alternative at times between the "drinks rounds" to increase their fluid intake.

We observed that one person had taken another's drink from the table before spilling it and had also taken and eaten some of their toast. This compromised how accurately people's intake of food or drink could be monitored because staff were not available to see this happen.

People did not always receive the supervision or support they needed to eat properly or easily and the mealtime experience for some people needed improving. For example, we noted that one person was eating

breakfast in their armchair without the benefit of having an appropriate table to sit at and on which to place their cereal bowl. There was only a small round 'occasional' table next to them where their tea and toast was. When we first observed, the person was holding the bowl and eating with a spoon. However, later on, they had given up and were trying to eat the cereal and milk with their fingers.

We also observed that there was a considerable delay in serving lunch, which caused some people to become restless, and in one case, to fall asleep so they did not eat their meal. Staff told us that lunch should be at 12.30pm but for some people, they did not get their food until approximately 1.15pm, despite having staff assistance to sit at tables much earlier.

Staff assured one person who became anxious that, "Dinner is on its way, I promise you." They called out, "Why have I got to sit down?" Staff told them their lunch was coming and the person shouted, "Well, I haven't got any down" and then, "I haven't got anything." Another person was provided with their meal while this person waited for a further ten minutes.

We saw that, when their meal did arrive, they immediately took a potato in both hands and ate it rapidly, then tried to eat their meat and sauce with their fingers. We noted that their records showed they were likely to throw their food onto the floor and this happened. They also tried to eat their lemon meringue pie with their fingers and then became anxious and angry that, "There's white stuff [meringue] everywhere." They were not offered an alternative and there was no "finger food" provided that might have encouraged them to eat more easily.

One person was awake when staff put their cutlery on their table at just after 12.45pm and they smiled at the staff member. However, their meal did not arrive until nearly 1.30pm and, by then, the person had become very drowsy. A staff member commented that the person was very sleepy so was not eating. They took the lunch away to label and use later, "… when [person] is more awake." However, the opportunity to encourage the person to eat more had been missed.

We observed that staff brought a tray of cold drinks into the lounge and placed them for each person. However, they did not offer any choice and had only one selection on the tray. During the afternoon, we saw that staff offered people a choice of drinks and "ice pop" or choc-ice.

We concluded that although improvements to the monitoring of people's nutrition and hydration needs had been made, as well as to the overall dining experience, there were still shortfalls which presented a risk to people's wellbeing and enjoyment.

People and their relatives told us that they enjoyed the food and that they had a choice of meal. One relatives told us, "[Relative] gets a lot to eat and drink, we know what they have as well." People were assisted with eating their meal by staff where required and suitable equipment was available to aid this, such as plate guards and adapted cutlery. People who needed support to eat their meal were supported discreetly. Staff gave people time to eat at their own pace, and chatted to them during the meal.

Weekly menus were planned and rotated every four weeks. The daily menu was displayed on a menu board in the entrance to the dining area. We observed lunch and saw that the dining tables were set with place settings and condiments. The meals looked appetising, and all meals were prepared daily from fresh ingredients. We observed that refreshments and snacks were offered throughout the day.

Records showed that staff monitored people's weights regularly to establish whether there was any unintended weight change. The electronic system flagged up alerts if the percentage of weight loss was a

concern. We noted that this had happened for one person whose records we reviewed. However, this followed a period of weight gain and their weight was predominantly stable.

At our previous inspection, we found the provider had not ensured that staff had completed the necessary training to provide effective care and support to people. This had resulted in a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. At this inspection, we found that sufficient improvements had been made, and that the provider was no longer in breach of this regulation.

All staff we spoke with told us they received regular training and records we saw confirmed this. Recently recruited staff shadowed staff that were more experienced so that they could confidently carry out care tasks. There was an induction programme in place, which included completion of the care certificate. The care certificate is a nationally recognised qualification for staff new to working in care.

We saw that training sessions had been arranged for staff to update their skills. Examples of training included; manual handling, infection control, safeguarding adults, fire safety and health and safety. Identification of their training needs and the provision of effective training meant that they remained knowledgeable and skilled in the areas they required for their work. The provider had recently engaged the additional resource of an external social care consultant to aid driving up the quality of care provision in the home. This included delivering face to face training sessions for staff rather than just training delivered on line. Staff told us that they preferred this format of training for certain topics as it facilitated discussion and sharing experiences.

Staff's competency to perform their role had also been checked. Staff told us that they had regular supervision and an annual appraisal. They said that these sessions were supportive and helpful in developing their skills. However, we observed that on occasions, staffs practice in relation to moving and handling and ensuring people had mobility aids to hand was poor. We also observed that staff did not ensure people were sitting in a safe position to drink, or had support when struggling to use cutlery. We concluded that although the providers approach to staff training and development had improved, the skill of staff in some areas required further improvement.

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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

At our previous inspection, we found the provider had not ensured that staff obtained people's consent before supporting them. Staff had not completed training in the MCA and could not demonstrate an understanding of its principles. This had resulted in a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. At this inspection, we found that sufficient improvements had been made, and that the provider was no longer in breach of this regulation. However, some people's records relating to this lacked clarity.

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.

We saw that the capacity of people to make decisions about their care was taken into account within the care plan process. However, there was some confusion about the information and conclusions drawn, which needed review. For example, one person had an initial assessment saying that they may lack the capacity to make decisions about their care. However, the information also noted that they had not agreed to share information with health care professionals and their social work team. Given the information that they lacked capacity to make such a decision, clarity was needed about what was in their best interests to ensure they received appropriate care.

Two people's information indicated that there was a relative or other person with legal authority to make decisions about their health and welfare. However, their records also showed that confirmation of this was not available. This is needed to ensure that decisions taken on behalf of people who lack capacity, are taken legally.

We saw that the registered manager had submitted applications in accordance with DoLS where they considered this was required. However, care plans contained some ambiguous information about whether they were needed or had already been granted. We found that care records asked whether each person required an application to be submitted under DoLS. They also asked what were the details of any existing DoLS authorisation. For one person, their records said that they did not require an application to be made. However, the section about details said an application had been made and that the service was awaiting the outcome. This was contradictory. We discussed this with the management team and the need for clarity to properly show whether an authorisation had been granted and if there were any conditions attached.

Staff were able to demonstrate good understanding of the principals of the MCA and give examples of how they applied this to their daily work. We observed that staff asked for people's consent before they offered support. For example, they asked people if they could help them put on an apron to eat their meals, and whether they needed help to cut up their food. We also saw that the staff member administering medicines explained to people what the medicines were for.

People's needs and choices were assessed prior to moving into the service. This helped ensure people's needs and expectations could be met. Staff were knowledgeable about the people living at the service and were confident they could meet their needs. Relatives of people told us they were confident that staff knew their family member well and understood how to support them.

People's records showed that staff supported them to get advice about their health and welfare. This included referrals to the GP or community matron. Staff assured one person they would ask the matron to see the person when they came in. They also told us that they had asked the matron to test a urine sample for another person to establish whether there was any infection present. We spoke to a community professional who told us that staff contacted them for support in a timely way. They went on to tell us that when they visited the home to provide clinical care, that staff were knowledgeable about the person and could provide them with up to date information about any changes in their needs.

We found that people also accessed advice from the dietitian and in one case that a mental health nurse had been involved in the person's welfare. We also noted that staff made prompt contact with a GP to seek a referral for occupational therapy advice about a person's mobility.

We noted that some aspects of the décor of the service could present difficulties for people who were living with dementia and their perception. For example, there was a sudden change in colour from laminate

flooring in one area to a dark carpet. People who are living with dementia can perceive this as a hole in the floor, making them anxious about moving around.

We saw that one person's care records recognised how the presence of mirrors might present them with difficulties and increase their anxiety. The records showed that staff should consider removing them from the person's room if this happened. This indicated that staff had guidance about minor adaptations they could consider that would enhance people's wellbeing. Signage around the home had been provided in a way that could aid people living with dementia to better understand. Door colours had been painted in distinct colours which aided people in their navigation around the service.

Requires Improvement

Is the service caring?

Our findings

At our previous comprehensive inspection on 20 and 22 November 2017, we found that not all people living at Docking House were treated with dignity and respect. Staff did not always ensure they maintained people's confidentiality, and promote people's independence. We rated this key question as 'Requires Improvement'. At this inspection, we found that the required improvements have not been made, we have continued to rate this question as 'Requires Improvement.'

During our inspection, we saw mainly positive interactions between the staff and the people using the service. We did however see some incidences whereby staff did not respond to people when they sought interaction.

We found variable practice in how staff respected people by offering emotional support and comfort when they needed it. For example, we observed that one person, who was anxious and distressed, asked staff, "Will you put your arms around me?" The staff member did not approach and did not offer the comfort that the person had asked for. The same person called out to another staff member who walked through the lounge area and the person received no acknowledgement or response.

We observed that staff were often very busy in ensuring people's personal care needs were met, which impacted on their time to be able to stop and talk to people. We spoke to the registered manager and the providers managing director about this. They agreed with us and said they had also identified that staff were often short of time to do this, which was why they were in the process of increasing the numbers of staff on duty.

We observed staff respond to people in a calm and reassuring manner. For example, one staff member intervened promptly when a person became upset having spilled a drink. They offered reassurance and mopped up the spill, talking to the person in a gentle manner. Other interactions between staff and one person increased their wellbeing. We saw a staff member get down beside a person's chair, hold their hand, and chat to them quietly. They became calmer and responded by smiling and singing. Another staff member also offered reassurance and stroked the person's hair.

Relatives we spoke with all told us their family member was well cared for and that staff were kind and caring. One told us, "The care is really, really good. The staff are wonderful, I only have good things to say. [Relative] is really happy and the staff are so friendly." Another relative also said that staff were kind and friendly, and that they always had a, "laugh and a joke."

We could see that care plans involved discussions with people where possible, and included their family members and care home staff who knew the person well. While we were present, we heard the registered manager making arrangements for friends to visit and support the person with reviewing their plan of care.

A visitor to the service told us how they were able to support their family member with decisions about their care. They said that they were consulted about changes in their family member's care plan if any were

necessary. The registered manager had taken steps to support and involve people in planning and making decisions about their care. We saw that where they were able to, people and their relatives had been involved in the development of their care plans.

Staff we spoke with could describe how they would ensure people's privacy. We observed staff knock before entering people's bedrooms. When providing personal care, staff told us that they ensured curtains were pulled and doors closed.

Staff could tell us how they supported people to maintain their independence and knew about people's individual preferences. This included knowing about people's back grounds, life histories and experiences. We observed during the lunchtime meal that staff encouraged people to be independent with gentle prompts and reminders. People and their relatives said they were able to visit the service without any restrictions.

Requires Improvement

Is the service responsive?

Our findings

At our previous comprehensive inspection on 20 and 22 November 2017, we found that people living at Docking House received care that was task based and did not meet people's individual needs. People did not receive enough activity and stimulation to enhance their daily living. We rated this key question as 'requires improvement'. At this inspection, we found that some improvements have been made however, further improvements still need to be made. Therefore, we have again rated this key question as, 'Requires Improvement'.

The electronic system used for assessing, planning and recording care, notified the registered manager when people's needs were due for review. The registered manager showed us how they had allocated senior staff small groups of people for whom they were expected to review care plans. From the sample we reviewed, we saw that this had happened to see if any changes were needed. The registered manager showed us how she checked what updates had been made and printed off copies of the changes for staff reference when needed.

There were examples of people's preferences being recorded. This included for example, that one person liked a medium/soft mattress and two pillows, as well as their preferred times for getting up or going to bed. However, we noted that there was a "choice" section within care records for recording people's likes, dislikes, interests, and preferred routine. For one person for whom we checked this, the information was blank.

We observed that staff did not consistently respond to people's needs taking into account their individual health histories. One person repeatedly expressed anxiety about their health and their stomach, shouting out, "I haven't eaten anything. Why would it do that?" A staff member did stop what they were doing to ask if they were in pain or all right. They offered to ask the community matron to see the person when they visited later in the day. However, when the person was later holding their stomach, and remaining anxious, their concerns were not acknowledged and validated. A staff member responded, "We've all got tummies. Don't you worry." We checked the person's care records and these showed that they had a history of abdominal pain. We discussed with the management team that this should have been taken into account and more efforts made to establish whether the person needed pain relief.

People's backgrounds, histories, and interests were included within their care records where information was available. Staff were aware of one person's origins and how and why they had moved to the area, confirming what the person explained to us.

We noted that one person's records showed they had an interest in painting. However, there was a lack of detail and guidance about how staff could facilitate this. For example, the support information said, "Due to the effect of [person's] dementia, [person] is not able to engage with [person's] interest." It went on to say that, "With the assistance of the care provider, sometimes [person] might engage such as talking with [person's] family member." There was no exploration of how the person's reported interest in painting could be encouraged. Another person living with dementia, behaved in a way that reflected their life time

occupation and staff were able to tell us about this. However, they were not provided with any opportunities or equipment that they could use safely to facilitate their behaviour into a meaningful activity for them.

At our last inspection, we found that staff did not have the time to provide people with activities or stimulation. The provider employed one member of staff to provide activities in the home for approximately half a day a week. There was no schedule of activities in place, and people were not aware what day the activities person was due to visit because this was not at a fixed time. The registered manager told us that they and the provider had agreed that more resources needed to be made available. Recruitment for a permanent member of staff to work at the home to provide activities was underway, with interviews scheduled for the day of our inspection. We saw that a notice board had been installed since our last inspection that detailed activities to be provided for people to look forward too. We observed people participating in card games, dancing to music and singing with staff. The registered manager showed us how records provided information about which people had participated in activities. However, this was not analysed in such a way that it showed what had gone well, or whether everyone had the opportunity to engage in something they might enjoy. People were not yet surveyed as to what activities they would like to see offered, however the registered manager told us that this piece of work would be completed once the new co-ordinator started in post.

People's care records showed whether they were able to understand and retain information about how to make a complaint. Where it was felt they would not be able to speak up for themselves, there was an indication that they would need support from staff or family members. We reviewed records that showed complaints were responded to and managed within the provider's stated timeframes. Relatives of people told us that they felt comfortable with making a complaint should the need arise. We also saw a number of letters and cards from relatives thanking the registered manager and staff for care received at Docking House.

There was a list available for reference about those people who had Do Not Resuscitate decisions in place. This was also recorded in people's electronic care plans. The electronic record also provided for recording whether people had made any advance decisions about the care they wanted at the end of their lives. However, for those we reviewed the information was not available, because people were not known to have expressed a previous view. Staff received training in supporting people at the end of their lives during their induction period. They were able to describe to us the considerations needed when providing care at that time.

Requires Improvement

Is the service well-led?

Our findings

At our previous comprehensive inspection on 20 and 22 November 2017, we found that Docking House had not made the necessary improvements identified at a previous inspection. The quality of care provided had continued to decline. We rated this key question as 'Inadequate'. At this inspection, we found that improvements have been made in some areas, however further improvements are required to be made in others. We have now rated this key question as 'Requires Improvement'.

During our last inspection of this area in November 2017, we found that the provider had not ensured that there was a robust quality assurance in place to assess, monitor and improve the quality and safety of care that people received. This resulted in a breach of Regulation 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made with further changes being implemented. Most areas of care were monitored and therefore, the provider was no longer in breach of this regulation. However, some issues we found had not been identified by these current systems. Therefore, further improvements are required.

Since our last inspection, the provider had commissioned the support of an independent consultant in social care. This was to provide support to the management team of the home and design and implement new systems for monitoring the quality of the home. The provider had also appointed a new regional operations manager, who would be based at the service. They told us that their immediate focus would be to provide support to Docking House.

The independent consultant providing support had implemented an action and improvement plan in April 2018. This plan had identified actions to be taken in order to make the required improvements found at our last inspection. This had been updated with progress on a monthly basis so that progress could be measures. This plan had also been sent with updates to the Care Quality Commission so that we could be confident that the provider was making the necessary progress.

The registered manager told us that they worked closely with the independent consultant, and that they provided mentoring support to them as well as ideas for different systems and approaches. For example, at our last inspection we found that the mealtime experience for people was very poor, and that the oversight of monitoring people's food and fluid intake was not sufficient. At this inspection we saw that improvements for mealtimes had been made, and a new system to help staff record accurately implemented. However, staff had still made errors in recording peoples intake of fluid and assessments of skin integrity, these had not been identified quickly enough. We spoke to the registered manager about this, and they agreed that further improvements and changes still needed to be made to ensure that systems to keep people safe and healthy were robust.

At our last inspection, we found shortfalls in the skills, competency and quality of staff training. This had meant that staff did not always have the confidence to support people living with dementia. At this inspection we found that the registered manager and providers managing director had made improvements

in the recruitment, training and retention of staff. In order to improve the recruitment rates as the service is in a rural area, the provider had reviewed the rates of pay. They had also implemented a two-week induction and training period at the start of a worker's employment. This meant that staff had the confidence and competence to start working alongside experienced colleagues.

New staff undertook competency checks before providing support to people alone. Existing staff had also undergone retraining in a number of key areas, such as understanding the Mental Capacity Act (2005), and safeguarding adults. Some of this training had taken place in a face to face class room style setting, Staff told us that they preferred this approach, and felt that they learned more this was. Although this was a costlier and time-consuming method, the provider and registered manager told us that this was an essential part of their commitment to improve the quality of care in the home.

People's feedback and their relatives where appropriate had been sought to improve the quality of care they received. We reviewed the results of a recent satisfaction survey of relatives. All respondents stated that the quality of care had either improved or was satisfactory. No respondents had said the quality of care had declined. Relatives spoke highly of the registered manager and the quality of service provided at Docking House. One told us, "[Registered manager] is fantastic, always tells us what we need to know." Another relative said, "[Relative] is totally settled, the staff are wonderful, we are so grateful to them. The manager rings me all the time and keeps me up to date, any health stuff they get on and sort out."

All of the staff we spoke with told us the quality of care people received had improved since our last inspection. They told us that their morale was high and that they felt supported and valued. One staff member told us, "There's a good team spirit, you can always ask if you need help." Another staff member told us, "[Registered manager] and [Providers managing director] are approachable, the home is heading in the right direction."

The registered manager, independent consultant and provider's managing director were seen to be visible to staff and the people living in the home which demonstrated an open culture. Both interacted with people when they arrived at the home, and had a good understanding of their needs. Their conversations with staff were warm and positive, asking them how they were, and how their day was going.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems for managing and minimising risks and the monitoring of this did not properly contribute to people receiving safe care and treatment.