Mr Pan Danquah & Mrs Kate Danquah

Dorcas House

Inspection report

56 Fountain Road
Edgbaston
Birmingham
West Midlands
B17 8NR

Tel: 01214294643

Date of inspection visit:
13 December 2018
17 December 2018

Date of publication:
18 March 2019

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?	**Inadequate**

Summary of findings

Overall summary

We undertook this unannounced inspection on the 13 and 17 December 2018. Dorcas 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. Dorcas House provides care to people living with dementia or mental health needs. Dorcas House can accommodate up to eleven people in one adapted building. At the time of the inspection six people were living at the home.

The service has been in breach of regulations relating to the governance of the service since February 2017. We have carried out two subsequent inspections since this time and at out last inspection in November 2017 we found the home had continued to not meet regulations around the governance systems in place and we placed conditions on the providers registration. These conditions instructed the provider to send us regular updates on checks that had been carried out at the service to ensure the quality and safety of the service. The provider has submitted these updates as per the conditions in place. This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our inspection in November 2017 had been made. We found that whilst improvements had been made to the governance systems they had not been sufficient or sustained and the breach of regulation continued to not be met. The conditions will remain on the providers registration.

We found notifications had not been submitted as required to the Commission on three separate occasions. This is a breach of Regulation 18 Notification of other incidents. You can see what action we told the provider to take at the back of the full report.

The home has a registered manager who was present throughout the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The risks associated with peoples' care had not always been identified or well managed. Where incidents had occurred, there were no robust systems in place to analyse the cause or put steps in place to reduce the chance of reoccurrence. The risks around managing peoples' diabetes had not been managed well and we saw people had been provided with foods that were not in line with a diabetic diet. We found the provider had breached the regulations in relation to safe care and treatment. You can see what action we told the provider to take at the back of the full version of the report.

People received their medicines safely although we found improvements were needed in the identification of medicines. Staff understood safeguarding procedures and action to take should they have concerns.

People had their privacy respected although we found some practice where supporting people in a dignified

manner could be improved.

People were supported by staff who had the skills and knowledge to meet their needs. Staff training had been provided around people's individual needs. However, we found the support people living with mental health conditions received needed improving. People had their healthcare needs met and were assisted to have foods and drinks they enjoyed.

People's care had been reviewed to ensure it continued to meet their needs, although these reviews did not involve the person themselves.

Not all people had been involved in activities of interest to them.

Staff felt supported in their roles and felt able to provide feedback to the registered manager should they have any.

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 always safe.

The risks associated with people's care were not always well managed.

People received support from sufficient staff.

People received their medicines safely although we found improvements were needed in being able to identify medications

People were supported by staff who were aware of the signs of abuse and action to take should they be concerned.

Is the service effective?

Requires Improvement

The service was not always effective.

People were offered daily choices although some aspects of the Mental Capacity Act 2005 were not fully embedded into practice.

The support for people living with mental health needs needed improving.

People enjoyed meal times. However, people had not always been provided with appropriate meals

Training was provided to staff to enable them to gain the knowledge required for their roles.

Is the service caring?

Requires Improvement

The service was not always caring.

Some aspects of care provided was not always person centred.

People felt cared for by the staff who supported them

People had their privacy respected. Some practice we saw did not support peoples dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Not all people were involved in activities of interest to them.

Peoples care had been reviewed to ensure it reflected their current needs. These reviews had not routinely involved people.

There were systems in place to respond to complaints

Is the service well-led?

Inadequate

The service was not well-led.

Quality monitoring systems were not consistently robust and had failed to identify issues that we found at the inspection.

Staff felt supported in their roles.

There were some processes in place to seek people's feedback.

Dorcas House

Detailed findings

Background to this inspection

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

This inspection visit took place on 13 and 17 December 2018 and was unannounced.

As part of the inspection we looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care. We refer to these as notifications. Before the inspection, the provider had completed a Provider Information Return (PIR) and returned this to us within the timescale requested. 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 reviewed the information from notifications and the PIR to plan the areas we wanted to focus our inspection on. We requested feedback from the local authority about the provider. The local authorities are responsible for funding people receiving care and for monitoring the quality of care provided.

We reviewed the audits the provider was required to send us in line with the conditions we had imposed following the last inspection. We used information from these audits to help us plan our inspection.

We spoke with three people who lived at the home. We spent time in communal areas observing how care was delivered. We 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 to us.

We also spoke with three care staff, the registered manager and the registered provider. We spoke with a visiting health professional. We looked at three care records and medication administration records. We looked at two staff files to review the provider's recruitment process. We sampled records from staff training plans, incident and accident reports and quality assurance records to see how the provider monitored the quality and safety of the service.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection in February 2017 we rated the service as requires improvement in this key question because medicine management was not robust and not all required information around fire safety was in place. At this inspection the rating remains unchanged because the risks associated with peoples' care had not been identified or managed well.

We found that risks to people's care had not always been clearly identified and managed well. Initial assessments of people's care were not comprehensive or detailed enough to identify potential risks and this had resulted in one person been inappropriately placed at the service. In one case there were no detailed risk assessments of the persons behaviour or risk management strategies around past history that posed a risk to the person and other people. A lack of robust risk management processes had put people and staff at risk of harm. Where people used behaviour as a means of communicating we saw there were no detailed plans in place that stated strategies to support the person or de-escalation techniques to be used. This meant staff may have an inconsistent approach in supporting the person.

Where incidents had occurred, we saw that records had been made detailing the incident. Some of the incident records we reviewed were not completed in sufficient detail and whilst the registered manager was able to provide some information about what had happened, a clear record of the incident had not always been made. Whilst some monitoring of these incidents had occurred we found that further detail and analysis was needed in order to identify possible triggers for behaviours and to put plans in place to reduce the chance of re-occurrence. Care plans and risk assessments were not reviewed after these incidents.

Some of the people living at the home had diabetes. Diabetes is a life long condition that affects a persons' blood sugar levels. Specialist healthcare had been sought for one person to support them with maintaining their diabetes. Some people who had diabetes had lived at the home for a while but no attempts had been made to seek training for staff on this condition. There was no clear detail in peoples care plans or risk assessments about their diabetes. We saw that foods offered were not always appropriate in supporting people to manage their diabetes. Inappropriate foods may increase the chance of the persons' diabetes not been controlled. We raised our concerns with the registered manager. Following the inspection the registered manager advised that diabetes training would be occurring in the next couple of months and that they had secured a meeting with healthcare professionals to gain further information about how to support people with their diet.

A failure to ensure all peoples risks were identified and managed well is a breach of Regulation 12(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 Safe care and treatment.

People were supported by staff who understood the signs of abuse and appropriate action to take should they have concerns. Staff we spoke with were able to describe the action they would take to report any concerns. Staff told us and records confirmed that training had taken place to aid staffs' knowledge of up to date safeguarding procedures.

People were happy with the support they received with medicines and one person told us, "I do get medicines when I need them." People were supported to take their medicines safely although we found improvements were needed in being able to identify medications. All staff responsible for administering medicines were required to undertake training in safe medication administration and had their competency tested before they were allowed to administer medicines. We saw that there was information available to staff about when people may need their medicine on an as required basis. There were systems in place to check that medicines had been given safely. However, we found that improvements were required in the identification of medicines. All prescribed medicines were supplied in a blister pack. There was no way of identifying what each medicine was. Whilst there had been no medicine errors, if there was an error or if the person refused or spat out their medicine there would be no way of identifying which medicine the person had not taken. We brought this to the registered managers attention and they had contacted their pharmacy by the second day of the inspection. As a result staff could not easily identify the individual medicines they were administering

We saw staff were always available in communal areas to provide support to people and that there were sufficient staffing levels in place. We looked at the checks the provider had carried out to satisfy themselves of staff's suitability of working at the home. From records we sampled we saw that the providers recruitment process included obtaining a Disclosure and Barring Service Check (DBS) to check whether staff were safe to work with people. Whilst most checks had been carried out we found that the provider had not followed up gaps in one person's employment history and had not validated references to ensure they were credible.

We saw that general day to day practice supported good infection control. We saw staff wearing aprons and there were hand washing sinks and hand sanitiser available. However, we noted a number of areas around the premises that needed improving. There was mould on one bath seat and the bath panel was loose. The light switch cord in the bathrooms and toilets were dirty and there was a stain on the ceiling in the dining room. We noted wallpaper was peeling away in some areas of the building. The monitoring checks carried out a month prior to our inspection had not noted that these areas needed to be improved. We raised this with the registered manager who told us that these areas would be improved.

Requires Improvement

Is the service effective?

Our findings

At our last comprehensive inspection in February 2017 we rated the service as requires improvement in this key question because not all staff had completed required training and improvements were needed in the application of the Mental Capacity Act (2005). At this inspection the rating remains unchanged because information was not always available about peoples specific conditions.

All of the people living at the home were living with mental health conditions. There was no specific information in care plans about how to support people with their individual conditions. This meant that staff may not recognise a deterioration in a persons' mental health and in turn appropriate support may be delayed. We spoke with the registered manager and they informed us that most people's mental health was stable and that they had contact numbers of healthcare professionals should they have concerns.

Staff informed us they had received training and that it had equipped them with the skills they needed to support people. One staff member told us that, "Training helps staff a lot." We saw that a training plan had been developed to ensure that staff kept up to date with their training needs. Where staff had not attended training there were on-line courses available. We saw that one member of staff had not completed a number of training sessions. There were no systems in place to see if this staff member was competent or to check if previous training had been effective in providing the staff member with the knowledge they required. Whilst improvements had been made in checking staffs competencies following training, these needed to be more specific to allow the registered manager to determine if the individual training session had been successful in providing the staff with the knowledge they required.

People told us they were happy with the meals they received. One person told us that they were asked what they would like to eat and said, "The food's nice." People were supported to eat and drink sufficient amounts. We saw that menus were devised based on people's preferences and that people were offered a choice of two meals at dinner time. However, we saw that people were not always offered a choice in what they wanted to drink. The registered provider assured us that staff would be reminded to offer people choices.

People were supported to maintain their health. One person told us, "I see the nurse and see the doctor if I need to." The home had ensured people had access to regular healthcare. We observed during the inspection that the registered manager took prompt action on two occasions to seek healthcare support for people when they had requested it.

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. 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 had the appropriate legal authority and were being met. We saw that people were offered choices in most aspects of their care. Staff had an

understanding of the principles of the MCA and told us how they offered people choices and one staff member told us, "We have to serve them [people] in their best interests." We found that one family member had consented to a person's care without having the legal authority to do so. We spoke with the registered manager about this and have advised them to update their knowledge around consent.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). Staff could tell us how they supported people in the least restrictive way and knew who had a DoLS in place. One person had a DoLs in place with associated specific conditions.

Requires Improvement

Is the service caring?

Our findings

At our last comprehensive inspection in February 2017 we rated the service as requires improvement in this key question because people's privacy and dignity was not always upheld and people were not consistently involved in making decisions. At this inspection the rating remains unchanged because people did not consistently receive person centred care.

People we spoke with felt cared for and were happy living at the home. One person told us "I do like it here. People care for you," and another person told us, "It's lovely. You're well looked after." Staff knew people well and could tell us about people's likes and dislikes. One staff member told us, "They [people] make you happy."

We saw familiar and kind interactions between people and staff. We saw people responding positively and joking with staff. However, we noted that there were periods of time where staff and people were in the lounge together without any interaction. Whilst people did not seem to be affected by the lack of interaction it may not have supported peoples well being.

The home had made efforts to find out people's life histories and their wishes for care. Whilst this was important information to find out, little had been done with the information to support people. For example, one person said they wanted to attend a specific church. The person had not been supported to access this church despite living at the home for several months.

Most of the people living at the home did not have any relatives or other important people that they stayed in contact with. The home had tried to access advocacy services for one person but the assessment resulted in the person not meeting the criteria for advocacy support. For the one person who did have family contact we saw that this was encouraged and that the relative's views of care had been sought.

People were supported to maintain their privacy. We saw staff knocking on people's bedroom door before entering and seeking peoples consent prior to supporting them. Staff respected people's choices and any refusals to be supported were respected by staff to ensure people felt listened to.

Whilst much of the practice we saw showed us that staff supported people's dignity there was some staff practice that did not. For example, we noted that one person was referred to by three different names and not their preferred name. We brought this to the attention of the registered provider who stated they would address this with staff immediately. We saw staff using mobile phones for short periods on two different occasions whilst on shift with people. Whilst this did not place any person at risk this did not show us that the service was consistently caring.

We saw that people's independence was promoted with mobility and personal care tasks. One person was able to access the community independently and did so on a near daily basis.

Requires Improvement

Is the service responsive?

Our findings

At our last comprehensive inspection in February 2017 we rated the service as requires improvement in this key question because people had not always been involved in reviewing their care and information about peoples interests was not always current. At this inspection the rating remains unchanged because people were not involved in reviewing their care and did not consistently have the opportunity for activities of interest to them.

People were not routinely involved in having the opportunity to review their care. Some people had been living in the home for a long time and as their needs had changed the home had ensured that care records were reviewed to ensure they accurately reflected people's current needs. Whilst individual care records were reviewed and updated it was not consistently the case that people were involved in these reviews. The registered manager advised that they had spoken to people but they were not interested in reviewing their care. Involving people in reviews of their care would enable people to state any changes they wanted to make to care delivery and would enable the registered provider to further monitor how effective care delivery had been.

Whilst there was an activity timetable in place at the home we saw that there was little everyday activity occurring in the home and people spent time watching TV. We spoke with one person who said they enjoyed watching the programme that was on the TV at that time. We spoke with the registered manager about activities and they explained although people were offered different activities people often refused preferring to watch TV. One person we spoke with said they would like to go out into the community more often which we fed back to the registered manager. One person took part in the same activity both days of the inspection visit and we were informed that this was the persons favourite hobby which the person confirmed. Whilst this was important to the person more could be done to engage all people living at the home in activities of interest to them.

The Accessible Information Standard of 2017 defines a way of identifying, recording, and sharing people's communication needs. The standard aims to improve the health, care and wellbeing people receive by making sure they are communicated with in a way that suits them. This helps make sure that people can take part in decisions as much as possible. We spoke with the registered manager about how they supported people in line with this standard but the registered manager was unaware it had been introduced and had not kept up to date with changes in the care sector. This meant people may not have had the opportunity to receive information in an accessible way to help them in making decisions.

We saw there were effective systems in place for people to raise any concerns they may have. We saw there was a complaints procedure on display in the entrance hall to the home and people had been asked if they had any concerns during meetings. One complaint had been received in the last year and prompt action had been taken to resolve this complaint.

Whilst no one was currently receiving end of life care some people had stated their wishes for care at the end of their lives. This ensured people were involved in planning and making decisions about their care as they

neared the end of their life.

Inadequate

Is the service well-led?

Our findings

At our last comprehensive inspection in February 2017 we rated the service as requires improvement in this key question because governance systems were not effective. At this inspection the rating has deteriorated to inadequate because sufficient improvements to the governance of the service had not been made or sustained.

The service has been rated as requires improvement for the last three inspections in the key question 'well led'. At our last focussed inspection in November 2017 we imposed conditions on the providers registration instructing them to provide us with details of the quality and monitoring checks they had carried out. The service had designated the task of completing these quality and monitoring checks to one staff member. Whilst we found that improvements had been made in designing and carrying out monitoring checks they had not been fully effective and had not identified the concerns we raised at this inspection. Audits did not clearly say what had been checked to determine compliance. The processes in place to monitor, audit and assess the quality of the service being delivered were not always effective.

Audits had not effectively identified that recruitment checks were not completely robust and had not identified that incidents of behaviour were not been monitored or analysed. Checks of records had not identified that inappropriate foods were being given to people living with diabetes. Audits had not identified that medicines could not easily be identified. The monitoring checks carried out had not noted the areas around the premises that needed to be improved. Competency checks needed to be improved to allow the registered manager to determine if staff were skilled and competent in their work. People had not contributed or been involved with the reviewing of their care and support needs. The registered provider and registered manager had not consistently ensured people received person-centred care which meant that people were not always given choice and control over how they preferred to spend their days.

At this inspection we found sufficient action had not been taken to make or sustain improvements and the provider remained in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 Good Governance.

We found that the registered manager had failed to inform the Commission of all specific events that had occurred at the home. They had failed to inform us about three separate incidents that had involved the police. This is a breach of Regulation 18 (2)(f) of the Care Quality Commission (Registration) Regulations 2009

The registered manager was able to monitor the culture of the service as they were working on shift most days. However, this had not afforded the registered manager time to monitor the service fully or to fully complete their responsibilities to the commission. The registered manager had not kept up to date with some changes in legislation. The registered manager was not clear on what the care certificate was or that the accessible information standard had been introduced. We did note that the registered manager had ensured the latest inspection rating had been displayed.

At our last inspection the provider had informed us they had a clear plan for improving the décor and completing maintenance of the building. We asked for an update at this inspection and were informed that due to financial constraints this had not been possible and as such no work had taken place.

We saw that a survey had taken place with the people living at the home. Where people had suggested things that could be improved action had been taken to ensure this happened. For example, one person had suggested a change to the menus and we saw that this was occurring in practice.