Dorrington House

Dorrington House (Dereham)

Inspection report

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Ratings

Is the service safe?	Inadequate

Overall summary

We carried out an unannounced comprehensive inspection of this service on 22 and 24 April and 01 May 2015. Breaches of five legal requirements were found in how the service supported people with specific nutritional needs. The breaches we identified related to ensuring the safety of people with specific nutritional requirements, meeting their nutritional needs, application of the Mental Capacity Act 2005, how people's specific nutritional requirements were planned for and management oversight of this area of care. After the comprehensive inspection the provider wrote to us to say what they would do to meet the legal requirements in relation to the breaches we found.

A warning notice was issued on 29 May 2015 requiring the provider to provide care and treatment of people with specific nutritional requirements in a safe way by 24 June 2015.

We undertook this focused inspection on 14 July 2015 to check that the provider had met the legal requirements of the warning notice. This report only covers our findings in relation to this regulation. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Dorrington House (Dereham) on our website at www.cqc.org.uk.

This July 2015 inspection found that significant improvements had been made and that the provider had ensured the safety of people with specific nutritional requirements.

People were receiving food in consistencies that were in accordance with the guidance provided by healthcare professionals. Staff were following the guidance by ensuring that people were positioned in a safe way during meal times. Specialised training had been provided and staff were positive about the changes that had been implemented. Staff were able to clearly describe what type of diets people required and what they needed to do to ensure people were safely assisted at mealtimes. The provider had taken the necessary action to mitigate the risks to people's safety and welfare that we had identified at our previous inspection.

As a result of our April and May 2015 inspection this service was placed into 'special measures'. A further

Summary of findings

comprehensive inspection will be carried out by November 2015 to ensure that the provider has met the legal requirements in relation to the remaining four breaches and to re-evaluate all ratings for this service.

Summary of findings

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 

We found that action had been taken to improve the safety of the service in relation to people's nutritional requirements.

The risks to people with swallowing difficulties had been minimised because guidance from healthcare professionals was being followed.

People were given foods appropriate for their individual needs and were positioned in a safe way during meals so the risks of choking or aspiration had been reduced.

We could not improve the rating for safe from inadequate because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

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Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Dorrington House (Dereham) on 14 July 2015. This inspection was carried out to check that the provider had met the legal requirements set out in a warning notice we issued on 29 May 2015. The team inspected the service against one of the five questions we ask about services: Is the service safe? This was because the service was not meeting some legal requirements.

The inspection was undertaken by two inspectors.

During our inspection we checked the information that we held about the service and the service provider. We also reviewed action plans the provider had sent us since our last inspection.

During this inspection we spoke with the provider, a manager from one of the provider's other homes who was supporting this service, the cook and two staff members who were supporting people with their meals. We carried out general observations and reviewed records held by the service in relation to people's care and support.

Inadequate

Is the service safe?

Our findings

At our inspection of April and May 2015 we found that people were not protected from avoidable harm or the risk of harm resulting from their specific nutritional needs not being safely met. People who were at risk of choking or aspiration due to swallowing difficulties did not receive safe care. Staff were not following professional guidance to position people in a way that reduced the risks of choking or aspiration during and after meals. Food records had shown that people who required a pre-mashed diet were not always being provided with food in a texture that was safe for them to eat. The provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice in relation to this failure.

Since our inspection in April and May 2015 the provider had written to us on several occasions to inform and update us of the steps they were taking to ensure people's nutritional needs would be met in a safe manner. They told us that staff would receive training in respect of the importance of ensuring people received their specialist diets and how to position people who took their meals in bed to reduce the risk of choking or aspiration. They also told us that the management team would oversee the day to day practice at meal times to ensure people were correctly supported with their nutrition.

During this inspection on 14 July 2015 we spoke with the cook, who told us how informative and helpful their recent training had been. They were knowledgable about people's specific dietary requirements and told us how they were now making a variety of high protein and high calorie drinks as recommended by a dietician. We saw records to show that staff had engaged with healthcare professionals to ask questions about how they could best meet people's dietary requirements safely whilst ensuring people's preferences were taken into account. For example, one person liked bread but it was not safe for them to eat. This had been brought to the attention of the speech and language therapist (SALT) team which had advised that the person could have bread with the crusts removed. Similarly where the person was unable to have crisps, some maize based snacks had been advised as suitable by the SALT team which the person was very happy about.

We reviewed the food diaries for people who had specific nutritional requirements. We found that they were receiving a good range of food that was prepared in accordance with the guidance given by health care professionals. The risks to people who were at risk of choking or aspiration had been mitigated as far as was possible because people were receiving food in a texture that was safe for them to eat.

Improvements had been made to ensure that records regarding people's nutritional needs were up to date, accurate and consistent. Detailed records of people's individual dietary requirements and the textures people needed to have their food prepared in were held in the kitchen. This information was also correctly recorded in people's care records. The accurate and consistent information for people using the service ensured that staff had clear guidance about people's nutritional needs to reduce the risk of people receiving food that was unsafe for them.

Over the lunchtime period we observed the support being given to the four people who were taking meals in their rooms. All four people were sitting up at a safe angle to eat and remained upright for a period thereafter in accordance with professional guidance. One person had regained some independence because they were better positioned and were able to feed themselves on occasions. The risks to people who were at risk of choking or aspiration had been mitigated as far as was possible because people requiring assistance were positioned in a safe way during meals.

We spoke with staff members who had assisted people who took their meals in bed. They were clear about the types of diet people required and why and how people needed to be positioned during meals.

The provider had met the requirements of the warning notice and was no longer in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.