Amore Elderly Care Limited

Dalton Court Care Home

Inspection report

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Date of inspection visit:
20 June 2016

Date of publication:
07 September 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 20 June 2016 and was unannounced.

We had previously carried out an unannounced comprehensive inspection of this service between 14 December 2015 and 07 January 2016. Nine breaches of legal requirements were found. We judged that this service was "Inadequate" and Dalton Court was placed in special measures. We issued seven requirement actions and two Warning Notices.

Requirement actions were issued as people who used this service did not receive respectful and dignified care or appropriate treatment that met their needs and reflected their preferences. People were at risk from the risks of infections and contamination, of having unlawful restrictions placed on their liberty and at risk as their nutritional and hydration needs were not met. People who used this service did not receive their care and support from people who had the skills, competence and experience to do so safely. The management of the service was not open and transparent, with no clear lines of accountability in place. The registered provider sent us an action plan to show how they would ensure compliance with these parts of the regulation.

We issued two Warning Notices because the registered provider was not complying with Regulation 17 – Good Governance and Regulation 18 – Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A Warning Notice tells a registered provider or a registered manager that they are not complying with a regulation.

We undertook an unannounced focused inspection on 4 May 2016 to check that the requirements of the two Warning Notices had been met. We found that the registered provider had complied with the requirements of the Warning Notices.

Our unannounced inspection on 20 June 2016 was a full comprehensive inspection. We found improvements had been made. Some breaches in the regulations identified in December 2015 had been addressed but some still remained.

We have made the following recommendations:

We have made a recommendation in relation to risk assessing whether staff were safe to work with vulnerable people.

We have made a recommendation about the management of complaints.

We found breaches of the following Regulations:

Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who

used this service did not have care or treatment that had been personalised specifically for them. This placed people at risk of receiving care or treatment that did not meeting their individual needs or expectations.

Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Procedures for obtaining consent to care and treatment did not always follow current legislation and guidance. This meant that people who used this service were placed at risk of receiving care or treatment that they had not agreed or consented to.

Regulation 12 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014 because people were not protected from the risks of receiving unsafe care, treatment and avoidable harm. Additionally, medicines were not managed safely and people were placed at risk of receiving their medicines not as their doctor intended.

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

Dalton Court Care Home (the home) is operated by Amore Elderly Care Limited, a unit of the Priory Group. Dalton Court is registered to provide accommodation for people who require personal and/or nursing care. The home can accommodate up to 60 older people and people with complex health care needs. Accommodation is provided in single, en-suite rooms over two floors, with the upper floor accessible via stairs or passenger lift. There is a separate unit at the home that provides accommodation for people living with dementia.

The home does not currently have a registered manager. 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 manager in post has made an application to register with CQC.

The provider had made improvements to ensure the home had sufficient numbers of suitably qualified staff on duty at all times. Everyone that we spoke to commented on the improvements made in this area. People who used this service confirmed that staff attended quickly when they "pushed the buzzer" and felt that there was enough staff around to meet their needs in a timely manner.

We found that staff training and development had improved and that staff felt "better supported" with their roles and responsibilities. However, there remained some gaps in staff skills and knowledge but the manager was aware of most of these and had started to address them. The manager had identified that the standard induction period was not always sufficient for some staff and arrangements had been put in place to help monitor and support new staff with their work. We have made a recommendation about induction training for new staff.

The accuracy, quality and detail recorded in people's risk assessments was inconsistent. Gaps in information meant that people who used this service were placed at risk of receiving unsafe care and treatment that did not meet their needs.

Most people received their medicines at the times they needed them. However, people were not always fully protected against the risks associated with the use and management of medicines because there was not enough personalised information available to enable staff to support people to take their medicines correctly and consistently.

We found that staff had received some training with regards to the Mental Capacity Act 2005. However, we found that staff did not have a working knowledge of this legislation. We found examples where decisions had been made about the care and support people would receive without mental capacity or best interest assessments being carried out .

Where people had needed to be deprived of their liberty. We found that the manager had acted appropriately and obtained lawful authorisations.

We observed the service of the lunchtime meal and looked at a sample of the records relating to the support people received with eating and drinking. We found that when necessary people were referred to the dietician and/or speech and language therapist. The kitchen staff were aware of any special dietary needs of people who used this service.

We observed staff supporting people who used this service in some of the communal areas. People were treated with care, respect and dignity. Staff knocked on doors and announced themselves before walking into people's private bedrooms. People who used the service told us that staff were "very nice", "marvellous" and "look after me beautifully."

Seven of the people who used this service, who we spoke with told us that there were plenty of social and leisure activities available if they wished to join in or attend them . During our inspection of the service we observed that there were plenty of interesting and appropriate activities available if people wanted to join in. We noted that people all had polling cards so that they could participate in the EU referendum if they wished.

We found that some improvements and additions had been made to people's care and support plans. One really useful addition were "pen pictures" on the front of each care file. This provided information at a glance of the things that were important to people. However, the main body of the care plans had important information missing such as individual management strategies to help ensure people were supported safely and with dignity during periods of anxiety or distress.

We found that the registered provider had taken the situation of Dalton Court being in special measures very seriously. A new manager had been appointed and frequent quality audits continued to take place to help measure improvements and the successful implementation of the recovery action plan.

Even though we found areas where further work was still needed, everyone we spoke to about Dalton Court was very positive about the improvements to the service and the current situation at the home.

We have judged that the overall rating for the service is Requires Improvement. Although some breaches in the regulations have been addressed some still remain. We need to be confident that the registered provider can demonstrate consistent good practice over time. We will check this again during our next planned comprehensive inspection .

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.

Risk assessments were not always reviewed and updated as people's needs changed. Important information to help staff support people safely was not always included in risk assessments. This meant that people were placed at risk of receiving unsafe care.

We found that whilst most people received their medicines at the times they needed them, people were not always fully protected against the risks associated with the use and management of medicines.

Sufficient numbers of skilled and experienced staff were employed at the home. There was a plan in place to help ensure staffing levels are reviewed and adapted to meet the changing needs of people who use this service.

Is the service effective?

Requires Improvement

The service was not always effective.

People who used this service were not always involved in the decisions being made about their care and support. When people potentially lacked capacity to make such decisions, they had not always received mental capacity or best interest assessments.

A staff training and development plan was in place and staff received support and supervision from their line manager on a regular basis. This helped to ensure that staff were competent to carry out their roles and responsibilities.

People who used this service were supported with their nutritional needs and had access to health care professionals and specialist nutritional advice when necessary.

Is the service caring?

Good

The service was caring.

Staff supported people with their personal care needs in a sensitive and dignified way. The privacy and dignity of people who used this service were promoted and protected.

Staff were familiar with the needs of the people they supported. They demonstrated concern for people's wellbeing and understood the need to spend quality time with the people who used this service.

People's personal choices and preferences about the support they would like at the end of their life were clearly documented.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People who used this service did not have care and treatment plans that had been designed specifically for them. This meant that people were placed at risk of receiving care or treatment that did not meet their needs or expectations.

The registered provider had a policy and procedure with regards to complaints. The people we spoke to were confident any concerns they raised would be listened to. However, we found that the process for effectively dealing with complaints had not been followed appropriately.

People who used this service were supported to be actively involved with activities within the home and in the wider community.

Is the service well-led?

Requires Improvement

The service was not always well led.

Improvements to the quality and standard of service provided had been made but there were still some areas where the registered provider was not meeting the regulations.

A manager had been appointed at the service, but had not progressed through the CQC registration process at the time of our inspection.

People told us and we saw evidence to confirm that the registered provider had been open, honest and transparent about the standard of service provided at Dalton Court and about the action they were going to take to make improvements.

Dalton Court Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 20 June 2016 and was unannounced.

The inspection was carried out by two adult social care inspectors, a pharmacist inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we looked at the information we held about the service for example notifications, comments from relatives of people who used the service and from health and social care professionals.

Information was gathered from a variety of sources throughout the inspection process. We spoke with ten people who used this service and eleven of their relatives, friends or visitors. We spoke to ten members of staff, including the manager at the home and the operations manager.

To gather information, we looked at a variety of records. This included care plan files relating to six people who used the service and 12 medication records. We reviewed recruitment files belonging to three staff members. We also viewed other documentation which was relevant to the management of the service including quality and monitoring systems and training records.

Requires Improvement

Is the service safe?

Our findings

One of the people who used this service told us; "I'm so glad you people come and check, it's very reassuring, but I have no complaints, they have been marvellous, I feel very safe."

A relative told us; "It is much better here now. These are the best lot of nurses we have ever had."

Another visitor to the home said; "Things have improved no end, there is enough staff. A lot of them are young and inexperienced, and they could do with two more seniors up here, but they are coming on. My relative always appears clean, tidy and safe."

People who used the service told us that they thought there were "enough staff on duty" to meet their needs. People confirmed that staff attended quickly when they "pushed the buzzer."

People told us that the home was "clean" and that the domestic staff did a "marvellous job." Two people said; "The home is always clean and there are never any unpleasant smells."

We checked the information we held about this service. We noted that there had been a significant reduction in the number of potential safeguarding incidents reported to us. The local authority also reported that they had not received any new complaints. We were told that safeguarding referrals were being made appropriately.

We looked at a sample of staff training records. These showed that staff had been provided with updated training with regards to safeguarding adults and keeping people safe. When we spoke with staff, they confirmed that they had undertaken this type of training recently.

We noted from the sample of care records we looked at that risk assessments had been completed, including falls risk assessments and bed rail assessments. Accidents and incidents had been recorded and where people had fallen frequently we saw that they had been referred to the falls clinic to help establish the cause and what could be done to minimise future risks.

However, the level of information and detail recorded within risk assessments varied. For example the records of two of the people we looked at identified that they could, at times, present with behaviours that could place them or others at risk of harm. Although there was a wealth of information available, there were no strategies documented to help ensure people were supported safely and appropriately at these times.

This is a breach of Regulation 12 (1)(2)(a)(b) of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014 because people were not protected from the risks of receiving unsafe care, treatment and avoidable harm.

People who used this service, their relatives and staff working at the home all told us that the staffing levels were very good. Night staff and day staff all commented on the "team work" aspect at the home and of the

positive staff morale. A visitor told us: "It's so much better, more staff and so much better organised." Another person thought that the staffing levels were the "Best they had ever been in the last four years."

We looked at the tools that the home manager used in order to determine the correct level of staff needed to support people safely and in a timely manner. We saw that there were a sufficient number of staff on duty at the time of our visit and planned work rotas reflected that these levels were planned for. The home manager told us about the plans in place for reviewing staffing levels as the service started to accept new service users into Dalton Court.

The manager identified that there were still some staff vacancies to fill. She told us that staff recruitment had been going well and described the processes that were in place to help ensure the right people were recruited.

We looked at the recruitment files of three people who had recently been employed at Dalton Court. With the exception of one person, all of the necessary checks had been undertaken, with the results appropriately recorded. The results of checks on one person had revealed some negative issues and there was no evidence to support that their training qualifications had been verified. There was little information recorded as to how the manager would monitor and manage the performance of this person.

We recommend that the service considers current advice and guidance in relation to risk assessing whether staff were safe to work with vulnerable people.

We spoke with the manager and four registered nurses about the safe management of medicines, including creams and nutritional supplements. We looked in detail at the medicines; medication administration records (MARs) and other records for 12 of the people who lived at the home.

We looked at the records for three people who were given their medicines covertly. Best Interests decisions had been taken to support giving medicines in this way but details of the people involved in making those decisions had not been recorded. There was no evidence showing that a pharmacist had been consulted to ensure that the medicines were safe to be given this way and details of how the medicines should be offered were poor. In one example staff were instructed to mix the medicines into the person's food supplement drinks, but they were not prescribed any supplements. This showed that staff did not always have enough information to administer covert medication safely.

At our last inspection of this service we had found that "when required medicines" and "covert" medication were not always safely managed. We made a recommendation at that time that the provider considered current guidance about the management of medicines but we found that little improvement had been made in this area.

This is a breach of Regulation 12(1)(2)(g) of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014 because medicines were not managed safely and people were placed at risk of receiving their medicines not as prescribed.

Medicines were stored safely and securely and stock was managed effectively to prevent overstocks. Records showed that two people had missed some of their medicines because supplies had run out. We saw evidence that these had been ordered in plenty of time, but not received due to delays in the prescriptions being issued. The manager told us how she was trying to work with local surgeries to prevent this from happening again.

Most medication records were clear, complete and accurate and it was easy to determine that most people had been given their medicines correctly by checking the current stock against those records. However we found minor discrepancies in three people's records where some medicines had been signed for, but not actually given.

We saw that nurses were polite and supportive when offering people their medicines and the management had recently undertaken checks to ensure that nurses were competent to manage medicines safely.

We found that improvements had been made to the cleaning and housekeeping arrangements at the home. On the day of our visit the home was clean and tidy. Equipment, bathrooms and wheelchairs were clean and free from debris.

Two members of staff had been identified as the infection control and prevention leads, with responsibility for the management and oversight of infection control and prevention at the home. We saw evidence to confirm that infection control and prevention training had been arranged for all staff to attend in the next few weeks.

The deputy manager told us; "It's improved (the home) so much now it's made working here a pleasure. I have responsibility to check the housekeeping. It looks clean and fresh and smells nice, It's nice to work and live in and it's a lovely home, we want to be proud of it"

Requires Improvement

Is the service effective?

Our findings

A visitor to the home told us; "My relative is putting on weight now and maintaining this. They have been seen by the speech and language therapist and there have been big improvements with their eating and drinking all round."

Another relative said; "The nursing team they have at the moment are great, they do everything for my relative. They (staff) are on top of their medical care and get the doctor when needed. They are quick on things like that."

All of the staff we spoke to during our inspection told us of the improvements to staff morale, support from senior staff and management. One member of staff said; "The manager has an open door policy, I can go and talk to her whenever I want. She listens and takes notice of what I have to say." Another person said; "We are still developing our staff teams, but we're getting somewhere now. It's a much nicer place to work these days and the manager has time to listen."

We spoke to staff about the training and support they received from the provider and the manager. Nursing staff told us of the training they had received to help ensure they administered medications safely. This type of training also included having their competence checked and practices observed. One member of the nursing team told us of some gaps in their skills and knowledge. The manager was in the process of organising training to help ensure the nurse was able to update their skills.

New staff had been provided with induction training over two days. However, the manager at the home recognised that this may not always be a sufficient amount of time for everyone to become confident and competent with their roles and responsibilities. Arrangements had been put in place to help ensure new staff were supported to deliver the care expected.

Staff told us and we saw evidence to confirm their statements, that they met regularly with their line managers both individually and as a staff team. We looked at a sample of staff supervision records and found that these meetings had been used to identify training needs, check competencies and address any shortfalls in staff performance. The information from these meetings was also being used to plan further improvements to the service.

We checked whether the service was working within the principles of the Mental Capacity Act (2005).

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We looked at the records of two people who had been legally deprived of their liberty. We found, in the sample we looked at, that the provider had followed the requirements of the DoLS and obtained appropriate and lawful authorisations. The conditions of the authorisations were being followed.

The registered provider had ensured that most of the staff had completed training with regards to the MCA 2005 and DoLS. However, the registered provider had also carried out an internal check on the way in which Dalton Court managed MCA, DoLS and consent. They found that mental capacity assessments had not always been completed in line with the company policy and there was some confusion around mental capacity assessments and best interest decisions. This corresponded with our findings and meant that staff did not have a working knowledge of these important pieces of legislation.

We found evidence of some decisions being made about the care and support people would receive, without mental capacity or best interest assessments being properly and lawfully undertaken.

We noted conflicting information about mental capacity, choice and consent recorded in the care plans of two of the people that used this service. We found that people who could display behaviours that challenged were not always supported and managed as well as they could be and we observed that this had resulted in one person not being able to move around the home as they would normally have done. We found that staff had made decisions about this person without proper consultation and lawful consent.

We spoke to the manager and the operations manager about these matters at the time of our inspection as this needed to be addressed quickly.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Procedures for obtaining consent to care and treatment did not always follow current legislation and guidance. This meant that people who used this service were placed at risk of receiving care or treatment that they had not agreed or consented to.

We looked at the ways in which people were supported with eating and drinking.

The sample of care records we looked at showed that people had received an assessment of their nutritional and hydration needs. Where people had been losing weight or experienced swallowing difficulties we saw that the manager had sought the advice of the dietician, doctor and speech and language therapist. We also noted that people identified at risk of poor nutrition were now closely monitored, including the keeping of food diaries and weekly body weight checks.

We observed the service of the lunchtime meal.

The dining room provided a pleasant and sociable environment. It was nicely set out with tablecloths, placemats, cutlery, condiments, cups, glasses and menus. There was a pictorial menu on the wall to help people who may have had some communication difficulties. There was quiet music playing in the background.

People were asked where they wanted to sit and people in wheelchairs were given the option of remaining

in their chair or moving into a dining chair. People were asked if they wanted to use an apron or napkin to help protect their clothing from accidental spills. Adapted plates and cutlery were available to encourage people to remain independent with eating and drinking. Where people needed support with their meals there were a sufficient number of staff to assist. We noted that staff provided people with support at mealtimes with care, dignity and respect.

Meals, including pureed diets were presented in an appetising manner. Trays with napkins, and plate covers were taken out to people who had their meals in their own rooms. The mealtime was calm and organised.

Throughout our visit to this service we observed people being supported to drink fluids at regular intervals and not just at meal times or when the tea trolley came round. There were containers of juice and water throughout the home and people were able to help themselves or ask staff to get them a drink when they wanted.

The people we spoke to all said that they had enough to eat and drink. However, when asked about the quality of the food we received a variety of opinions such as; "Good", "Moderate", "OK" and "So so."

We spoke to staff who worked in the kitchen. They confirmed that they received information about any special dietary needs and that they were involved with discussions with the dietician and speech and language therapist, when they visited the home. The kitchen staff were aware of the issues facing people with swallowing difficulties and unintended weight loss and of the expectations on kitchen staff to help support people with these matters.

Dalton Court was a purpose built care home. Accommodation is in single, en-suite bedrooms. Communal areas include comfortable lounges with panoramic views of the Lakeland fells, equipped with specialist seating where needed. There are specially adapted bathrooms and wet rooms and people who live at the home can access these facilities with the help of staff if necessary. One of the assisted bathrooms had been out of order for two weeks. A visitor to the home told us that an alternative bathroom was available and that their relative had been helped to use this, "But not as often as they would like."

We spoke to the manager about this matter. The manager was aware of the issues and had been trying to get the bathroom up and running again.

We observed that there were nice gardens with patio areas and garden furniture. There were raised vegetable beds at the back of the home. The weather on the day of our visit was very pleasant and people who used this service were able to access the gardens. Staff helped some of the people who lived on the first floor to go down and enjoy the outdoors too.

Good

Is the service caring?

Our findings

One of the people who used this service told us; "It's very nice here, the staff are very nice, they look after me. My family come in a lot, some live away, so when they come they stay a long time."

Another person said; "I have no complaints, they (staff) have been marvellous, they look after me so well. The girls are very nice to me, they look after me beautifully."

Two visitors to the home came to speak to us specifically during our inspection of this service. Their relatives had lived at Dalton Court for some time. Both visitors told us; "This is the best it has ever been. All of the staff here now are wonderful. The manager has time for us and she knows us and our relative very well."

Another visitor said; "They (staff) are very good at telling us what's going on, we can come in whenever we want." We observed that this visitor was in with a family party, which included a toddler.

We observed that there were information boards and leaflet holders round the home. These contained information for people who used the service and their visitors about, dementia, social care services, access to advocacy services and how to make a complaint.

We saw that people who used the service and their relatives had been kept up to date with the outcomes and actions following our previous inspections of the service. The provider and manager had met on several occasions with people who used this service, their relatives and staff to provide information and explanations about how they were going to make improvements to the service.

We observed staff working in communal areas with people who used this service and we observed staff knocking on doors before entering, even when the door was open. We heard staff engaging in meaningful conversations with people who used this service, throughout the day. They spoke about each other's families, where they were going later and a lot of discussions about the recent European football matches.

We observed that there were usually staff present in the communal areas. They chatted with people who used the service and one of them spent time providing hand massages to several people, this proved to be very popular. However, we also noticed one person asking for help to mobilise. There was no one available and it was five minutes before anyone came to help them. Following this incident the nurse in charge ensured this person was given more oversight and was supported on a one to one basis by a new member of staff.

People who were being looked after in bed or in their own rooms had their buzzers to hand so they could call staff when they wanted them. We observed staff keeping an eye on people who stayed in their own rooms. Staff went in to chat, offer help and offer food and drinks. Personal care needs were managed behind closed doors and people needing help were asked and supported with their needs discreetly and with dignity.

The staff that we spoke to knew the people they supported very well. They demonstrated concern for people's wellbeing and understood the need to spend meaningful time with the people who used this service. We did not receive any adverse comments about the staff who worked at Dalton Court everyone was very complimentary about the care and support they received.

On the day of our inspection visit there was no one at the home receiving end of life care. We spoke to staff about how people were supported at the end of their life and we looked at a sample of care records that included care plans specifically documenting people's preferences when they came to the end of the life. We saw that one person had decided that they did not wish to be resuscitated in the event of a cardiac arrest. Their records clearly documented that they had been involved in the decision making process, together with their GP and a close relative. Their preferences had been clearly recorded.

One of the qualified nurses that we spoke to told us about the processes involved with regards to obtaining and using special medicines to help ensure people were made comfortable at the end of their life. The nurse spoke about these matters sensitively and had regard for people's preferences and choices.

Requires Improvement

Is the service responsive?

Our findings

People who used this service told us that there were plenty of social and leisure activities available if they wished to join in or attend them.

One person said; "We have things to do, I like scrabble, we play that often." Another person told us; "I can't do so much now. I have things to do if I want, I am quite content here." One person we spoke to spent most of their time in their own room. They said; "I don't want to do much now, I like it in here (own room). I have my own TV, books and daily newspaper."

Staff told us and we saw that the personal care planning system had changed and new methods of recording and reviewing people's care needs were being introduced by the new manager. Staff understood that care plans had to reflect people's individual needs, preferences and centred on them as individuals.

When we visited the home in May 2016, the new system was just starting. The manager told us that this would be completed by the end of May 2016, but at the time of our inspection in June 2016, it had not.

We found, in the sample of care plans we looked at, that people's choices and preferences had started to be discussed and recorded. A really useful addition to the care plans were "pen pictures" on the front of each person's care plan. This recorded at a glance the things that were important to them, their likes, dislikes and preferences. Visitors to the home and people who lived at the home, confirmed that they had been involved in the development of these "pen pictures".

Important information was missing from the care plans of some people. For example; clear, individual management strategies to enable staff to support people safely and with dignity during periods of agitation or distress. Some people were prescribed medicines such as painkillers, laxatives and creams that were to be used only 'when required', but there was not enough personalised information available to enable staff to support people to take these medicines correctly and consistently.

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

There were two activity co coordinators on duty at the time of our inspection. One of them told us; "There are two of us in every day. We try and plan things to include everyone." We observed this member of staff working with three less mobile people. She told us; "I'm just trying to engage the ladies with some things." The activity co coordinator had craft papers and the group were making paper lanterns.

The activity co coordinators told us that a musical group were booked to come into the home that afternoon. They told us that anyone who wanted to attend would be brought up to the lounge. They told us that the group were "Very good and the residents enjoy it." We observed that a large group of musicians

arrived later and a large proportion of the people who lived at Dalton Court and their visitors attended and seemed to enjoy a 'join in' programme of entertainment. Staff were present too and helped less able people to participate.

Throughout the day, we observed people in the main lounges looking out of the windows, actively listening to the radio and singing.

We observed on the dementia unit that there were hats and bags around for people to use or carry about. Small 'tool 'boxes with tape measures and paint brushes were also accessible and 'fiddle' blankets and sleeves had been knitted for use at the home. These items helped to provide stimulation and meaningful activities for people who used this service.

The corridors on both floors of the home had interesting local pictures and the corridors had been named after local roads.

Downstairs there was a piano, bookcases with up to date paperback books and TV's in some lounges but these were only on if people were present in the room and wanted them on.

We noticed that everyone had voting cards for the referendum. The deputy manager told us; "We have a minibus, so we can take anyone who wants to vote to the polling station. A lot of families like to take their relatives themselves, but everyone has had a polling card, it's so important."

The local church have recently recommenced attending the home and we observed staff arranging to meet with the group for the first time in quite a while.

We noted that the registered provider had a complaints process in place. This was available throughout the home on the notice boards. People we spoke to during our inspection all told us that they knew who the manager was and that they would raise any concerns they had with her. Everyone knew the manager by her first name and all were confident that their concerns would be listened to and acted upon appropriately. No one we spoke to during our inspection of this service raised any concerns or complaints with us directly.

We looked at the way in which the service managed and monitored complaints. One complaint had been raised since April 2016 but there was no evidence that the investigation had been completed and the complainant had received information regarding the outcome. The policy and procedure gave clear timescales for this but these had not been achieved. We spoke to the manager about this during our inspection as this needed to be completed quickly and the complainant updated with the outcome of the investigations.

We recommend that the service seek advice and guidance from a reputable source, about the management of and learning from complaints.

Requires Improvement

Is the service well-led?

Our findings

People who used this service told us they were very happy with the service and support they received at Dalton Court.

We received many positive comments from relatives, staff and visitors. Everyone we spoke to during our inspection of Dalton Court were very satisfied with the current situation at the home.

One relative told us; "It's improved so much since the new manager came, she has the door open and you can ask her about anything. It's so much better, more staff and so much better organised, it's like a different place."

Two other relatives commented on the new manager. One said; "The new manger introduced herself and said if there was anything wrong I was to come and see her but I've never had to." The other told us; "The manager is very approachable, she talks to you and checks everything is alright."

We were also told by a visitor to the home; "This place has improved no end. You didn't realise what was wrong here until it got better."

A member of staff said; "It's improved really, staff are really happy and it makes a difference, it really does, I think some of the negative staff have gone now and that has helped."

Another member of staff told us; "It (the service) needed to change and it has really improved. The manager is so much better. When someone comes on the floor in flat shoes and a tabard to help, you know they are for real. The manager really does support us."

We found that the registered provider had taken the situation of Dalton Court being in special measures very seriously. A new manager had been appointed although at the time of our inspection the manager had not gone through the CQC registration process. When we checked the information we held about the service we found that an application to register had been made by the new manager.

The registered provider had been very supportive of the new manager to help her settle into her role and understand the expectations and responsibilities. We found evidence to confirm that frequent visits to Dalton Court had been, and continued to be, made by the operations manager, senior managers and the internal compliance manager. We found that monthly audits had taken place to help measure improvements and the successful implementation of the recovery action plan. Where continuing shortfalls had been identified, actions had been put in place to address them.

The registered provider had been transparent and honest to people who used this service and their relatives. We found that frequent meetings had taken place to explain the situation at the home and to explain how the registered provider was going to put things right and improve the service.

We observed that a copy of the last CQC inspection report was available to people using and working at Dalton Court. The registered provider had clearly displayed their CQC rating of "inadequate" and they had also provided people with a copy of the recovery action plan for the service, should they wish to look at this.

The health and social care commissioners had previously suspended the home from taking new admissions. Following continuous quality monitoring by CQC and health and social care agencies, improvements had been noted and the suspension had been lifted at the time of our inspection.

The home manager told us about the plans in place for accepting new admissions into the home. There was a clear plan in place to help ensure admissions were done safely and service user numbers did not increase too quickly.

In addition to holding meetings with people who used this service and their relatives, a satisfaction survey had also been carried out with 16 people responding. The satisfaction survey reflected some of our inspection findings. For example, people felt safe at the service, were pleased with the standard of their rooms and the cleanliness of the home. The lowest score (78.6%) was in relation to the standard and presentation of the food. People had made comments to us about this during our inspection, although we did find that the standard had improved since our last visit to the home.

The home manager showed us some of the work and checks she was currently undertaking. The home's fire risk assessment had been reviewed and updated. The general fire safety records were in the process of being reviewed to check that they were accurately completed and up to date. Staff fire drills had been carried out at various times of the day and night, including early morning (5am). Fire evacuation protocols have been discussed with staff at meetings and supervisions to help ensure everyone knew what to do in the event of a fire.

We saw evidence to confirm that staff were supervised in their work and that their practices had been monitored and questioned where standards had fallen short. Staff told us that they felt well supported now and were able to use their own clinical skills and judgements in line with their role at the home. They said that they felt "trusted" and "valued."

Every member of staff we spoke to told us that Dalton Court was a "nice place to work now" and that they all felt part of a "team."

Everyone knew who the manager was and referred to her by her first name. Staff, relatives and people who used this service all confirmed that the manager spends time working alongside staff and goes round to meet relatives and people who use the service. We were told about the improvements to the service by everyone we spoke to about Dalton Court, including external, professional agencies.

We found evidence to confirm that the standard and quality of the service had, and continued to improve. However, during this inspection we also identified some areas where the registered provider was not meeting the requirements of the regulations. These breaches in the regulations had an impact on the well-being and continued safety of people who used this service. We have identified the breaches in the relevant sections of this report.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People who used this service did not have care or treatment that had been personalised specifically for them. This placed people at risk of receiving care or treatment that did not meeting their individual needs or expectations. Regulation 9(1)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Procedures for obtaining consent to care and treatment did not always follow current legislation and guidance. This meant that people who used this service were placed at risk of receiving care or treatment that they had not agreed or consented to. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from the risks of receiving unsafe care, treatment and avoidable harm. Additionally, medicines were not managed safely and people were placed at risk of receiving their medicines not as their doctor

intended.

Regulation 12 (1)(2)(a)(b)(g)