Care South

Dorset House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This focussed inspection took place on 15 October 2018 and was unannounced. Following a comprehensive inspection in March and April 2018 we rated the service as good overall, with no breaches of legal requirements. This shorter inspection was carried out due to concerns that were raised with us.

Dorset House is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Dorset House accommodates up to 52 older people in one building. There are two floors, which are connected by a passenger lift. Nursing care is not provided. When we inspected there were 42 people there, many of whom were living with dementia.

There was a registered manager, which is a requirement of the service's registration. 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 registered manager had recently been providing management support to another care home operated by the registered provider as well as Dorset House. The deputy manager had stepped up to manage the home in the registered manager's absence and confirmed that the registered provider had also provided additional management support.

We received allegations regarding poor staffing levels which were impacting on the provision of care, and about poor management of the service. We also had concerns about the management of some specific types of medicines following an incident in the home. We reviewed this information and carried out an inspection focussing on the questions, is the service safe? and is the service well led?

People were protected from potential abuse and avoidable harm by staff who were knowledgeable about recognising and reporting different signs of abuse. There were sufficient numbers of appropriately qualified staff available on each shift to ensure people were cared and supported safely. Medicines were not always stored appropriately and managed effectively. People were not always protected from the risks of infection. There was a system in place to review and learn from incidents when things went wrong.

There was an open, honest, friendly culture and people told us they had confidence in the management team and the staff. People and their relatives were consulted and involved in their care and support. There was a programme of quality checks and audits to ensure the quality of the service was maintained. These had not always been effective in identifying concerns and the registered provider took immediate steps to remedy this.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were concerns about some aspects of the management and administration of medicines.

Systems to prevent and control the spread of infection were not always followed appropriately.

Staff were safely recruited and there were enough staff to make sure that people received the care and support they needed.

Is the service well-led?

Requires Improvement

The service was not always well led.

Issues highlighted at this inspection had not been identified through governance procedures at the service.

Dorset 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 took place on 15 October 2018 and was unannounced. The inspection was carried out by an adult social care inspector and a pharmacy inspector.

The inspection was prompted in part by notification of an incident following which a person using the service died. This inspection examined those risks as well as issues that had been raised with us regarding staffing levels and the management of the service.

We did not have access to information from an up to date Provider Information Return (PIR), because the inspection was carried out in response to concerns. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We were able to gather the information we required during our site visit.

We reviewed all the other information we held about the service, including previous inspection reports and any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law. We also contacted the local authority commissioners and safeguarding teams to establish their views of the service.

We met and spoke with six of the people living in the home and two visitors. We also spoke with the registered manager and six members of staff.

We observed how people were supported and looked at three people's care and support records and documents about how the service was managed. This included staff records, audits, meeting minutes, maintenance records and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

We carried out an unannounced comprehensive inspection of this service on 19 March and 10 April 2018 at which the service was rated Good overall. After that inspection we received concerns in relation to staffing levels and the impact this may be having on people's care needs, and the management of the service. We also looked at the management of medicines following an incident in the home. As a result, we undertook a focused inspection to investigate these concerns. No risks or concerns were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity, so we did not inspect them. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Dorset House on our website at www.cqc.org.uk.

People were supported by staff who understood the risks they faced and were motivated to support them to live full lives. People told us they thought the staff were "very kind", and that they felt safe. One person told us: "I feel really well looked after, my family can come and see me whenever I want, there is lots to do and the food is really good." We saw that people were relaxed in the company of staff throughout our visit.

During our inspection we reviewed how medicines were managed. We observed the morning medicines round and saw that medicines were being administered in a caring way. However, we did see one medicine which had been left unattended on top of the medicines trolley in a communal area. This meant there was a risk that someone would consume a medicine that was not prescribed for them.

Trained senior carers administered medicines and recorded this electronically. After reviewing administration records for 11 people we saw medicines were being given as prescribed. When issues had arisen with the electronic system, appropriate contingency plans were in place to ensure medicines administration was recorded.

People who were prescribed high risk medicines had information in their care plans on how they should be managed. The service had been proactive in response to a recent incident regarding the provision of care for people who were prescribed blood thinning medicines. Systems had been put into place to ensure that staff understood the significance that blood thinners could have in the event of an injury to the person and there were clear instructions for staff to follow. The registered provider had also ensured that this learning was shared with all of the services that it managed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Some people were receiving covert medicines (medicines given without their knowledge). This was because they were refusing to take their medicines but did not have the mental capacity to understand the implications of making such a decision. We checked the care plans and records for one person who was receiving their medicines covertly. Records showed that their mental capacity had been assessed, but there was no record of the best interests decision and how this was made.

Some medicines were prescribed to be taken 'when required'. Most of these medicines were for pain and symptom relief. Staff did not always have additional guidance to explain why and when these medicines could be given and the maximum amount that could be administered within a 24 hour period. This was especially important for people who were not able to request medicines for themselves. This meant that there was a risk that people would not receive their medicines when they needed them.

Medicines were stored in a locked room which was only accessible to staff who were trained to administer medicines. There were suitable arrangements for storing and recording medicines that required extra security.

Room and fridge temperatures were recorded daily to ensure medicines were stored at appropriate temperatures. Medicines can become ineffective when stored incorrectly and this put people at risk of not receiving effective prescribed medicines. The service had a specific fridge for the storage of medicines which needed to be kept at a low temperature. The fridge had broken and an alternative fridge was used while a new one was ordered and delivered. The temperatures of the alternative fridge had not been monitored throughout the whole of July 2018 and for part of August 2018. Temperature records for the new fridge showed the maximum temperature had been outside the recommended range and there was no evidence that this had been identified by staff or that any action had been taken. This had not been identified in the monthly audit for August 2018 and September 2018.

On the day on the inspection we also found the minimum temperature was outside the required range. The registered provider took immediate action when we highlighted this. Following the inspection, the registered provider also completed an investigation and confirmed that there had been an issue with the type of thermometer that was used. They stated that the fridge was very new and believed that it was highly unlikely that medicines had been stored incorrectly. They also confirmed that they had taken professional advice about the safety of the medicines concerned and had put procedures in place to ensure staff understood the thermometer and the importance of the information they recorded.

When liquid or topical medicines were opened the dates were recorded to ensure they were discarded within the required time range. We checked a random sample of medicines and found that one medicine should have been discarded after 28 days but was still being administered during the inspection which was seven days past the expiry date. We also found three medicines stored in the treatment room which had expired. Following the inspection, the registered provider completed a full stock take and confirmed that all out of date medicines had been removed. They also confirmed that additional processes had been put in place to ensure expiry dates were properly checked.

We saw, and staff confirmed, that a high number of people living in the home required the use of a wheelchair to transfer them from their bedrooms to the lounges and dining room. Most wheelchairs were for general use and not for specific people. We noted that the handles and arm rests for a number of wheelchairs were stained or worn. Staff confirmed that wheelchairs were not cleaned between different people using them. Because wheelchairs could be used by a number of different people over the course of a day, this meant that there was a high risk that any infections could spread. Extractor fans in the laundry, some bathrooms or toilets and a lounge were dusty which also caused a fire hazard was well as being unclean. Sinks in two kitchen/diner areas were stained. Issues with the reliability of laundry equipment and the poor condition of walls and floors in the laundry were also noted. Infection control and housekeeping audits had not previously identified any of these issues. The registered manager took immediate action during the inspection to ensure full cleaning took place and the registered provider later confirmed that audit and checking processes had been amended to prevent this recurring.

The premises and equipment were generally well maintained and there had been some redecoration since the last inspection. There were regular checks on maintenance, health and safety and fire alarms and equipment. Staff told us that they experienced difficulty using some wheelchairs and were concerned for both themselves and the people using them. The registered manager was not aware of their concerns. The registered provider took immediate action to assess all wheelchairs and arrange necessary repairs. They later confirmed that systems to ensure regular safety checks were completed in future had been implemented.

Records for the tests and checks of the fire prevention system highlighted that there had been faults detected with four fire doors over a number of months. The registered manager told us that contractors had been contacted but the issue had not been resolved. Following the inspection, the registered provider confirmed that contractors had been able to resolve the issue.

These shortfalls were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not always protected against the risks associated with the unsafe management and use of medicines and because systems and procedures to keep the home clean and prevent and control the spread of infection were not always robust.

Staff understood their role and responsibilities to protect people from abuse. Staff and the senior management team advocated for people to promote their safety and human rights.

People had help from, safely recruited and appropriately trained, staff. People and relatives commented that staff were available when needed. All staff that we spoke with confirmed there were generally enough staff on duty to meet people's needs but acknowledged that some shifts could be more stretched if people were unwell or there were last minute staff absences. The registered manager confirmed that this was an infrequent occurrence and, when this happened, steps were taken to bring additional staff into the home.

There was an open approach to learning when things went wrong. There were clear reporting procedures for accidents and incidents. Staff were encouraged to report incidents even if there was no apparent injury so any emerging risks to people could be identified, such as if a person was falling frequently. Information was shared appropriately with other professionals, people and relatives and advice was sought and shared amongst the staff team. The registered provider had taken proactive steps across all of the registered services following an incident that had occurred at Dorset House.

Requires Improvement

Is the service well-led?

Our findings

We carried out an unannounced comprehensive inspection of this service on 19 March and 10 April 2018 at which the service was rated Good overall. After that inspection we received concerns in relation to staffing levels and the impact this may be having on people's care needs, and the management of the service. We also looked at the management of medicines following an incident in the home. As a result, we undertook a focused inspection to investigate these concerns. No risks or concerns were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity, so we did not inspect them. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Dorset House on our website at www.cqc.org.uk.

The registered manager had recently been providing management support to another care home operated by the registered provider as well as Dorset House. They confirmed that they were still spending time at Dorset House but could not be there full time with the responsibility of managing another service. The deputy manager had stepped up to manage the home in the registered manager's absence and confirmed that the registered provider had also provided additional management support. A temporary manager had also started work in the home on the day of the inspection because the registered provider had already identified that this was necessary. The management team were responsive throughout the inspection and took immediate steps to rectify the issues that we highlighted and ensure that procedures were introduced to prevent any recurrence.

A range of audits to assess the quality of the service were regularly carried out. These audits included medication, infection control, care plans and health and safety checks. However, none of the issues identified in the safe section of this report had identified through these processes.

The registered provider was highly responsive during the inspection and took immediate action to identify why this had happened and ensure learning from this was implemented. We have not been able to check whether their actions have been effective or sustained.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All of the people and visitors we spoke with were positive about the registered manager and the way the home was managed. People and relatives told us that there were always staff available to them if they had queries or concerns and that they knew the registered manager and deputy manager were available for them if required. They added that they knew that they would be listened to and that action would be taken if they raised concerns.

Staff were all clear about their roles and responsibilities and understood who they could seek guidance from. They knew how to raise concerns about poor practice and suspected wrongdoing under the provider's whistleblowing procedures.

The service operated openly and transparently, working cooperatively with other organisations to ensure people were safe and received the care and support they needed. There was open communication with people who used the service, their relatives and staff. As well as the manager's informal conversations with people, there were resident's and relative's meetings. Minutes of recent meetings showed that topics that were discussed included activities and events, menus and a discussion about satisfaction surveys and quality assurance. Staff received updates about the service at staff meetings, at which they were encouraged to contribute their points of view.

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 People were not always protected against the risks associated with the unsafe management and use of medicines and because systems and procedures to keep the home clean and prevent and control the spread of infection were not always robust.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not always been effective in monitoring the quality and safety of services provided.