Sivanta Care Limited

Dovercourt House Residential Care Home

Inspection report

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12 December 2018
13 December 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Dovercourt House Residential Care Home provides personal care for up to 27 older people, including people living with dementia. At the time of the inspection 22 people lived in the service.

What life is like for people using this service:

- Risks associated with people's environment, health and wellbeing were not always being identified and acted on.
- People did not live in an environment that was well maintained. We have recommended that the environment is made more dementia friendly.
- There was not always enough staff on duty to monitor people's needs and provide personalised care.
- People and their relatives were not always involved in making decisions about their care.
- Care records did not always provide enough information to support personalised, safe care and show what people had consented to.
- People were not sufficiently supported to take part in activities or pursue interests, to enhance their wellbeing.
- People said staff were friendly, that they could enjoy exchanging banter and having a laugh. Their visitors felt welcome.
- Staff supported people in a compassionate, dignified and engaging way which provided positive experiences for people.
- The service was not well led and systems were not in place to ensure that people received care that met their needs.

Rating at last inspection: Requires Improvement (Report published 23 November 2017)

Why we inspected: This was a planned inspection based on the rating at the last inspection.

Enforcement: Please see the 'action we have told the provider to take' section towards the end of the report.

Follow up: We will meet with the provider to discuss how they will make changes to ensure they improve their rating to at least good. We will continue to monitor all intelligence received about the service to ensure the next planned inspection is scheduled accordingly.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our Safe findings below.

Requires Improvement

Is the service effective?

The service was not always effective.

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our findings below

Inadequate

Dovercourt House Residential Care Home

Detailed findings

Background to this inspection

The 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 checked 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.

Inspection team: This inspection was carried out by two inspectors.

Service and service type: Dovercourt House Residential Care Home provides accommodation and personal care for up to 27 older people, including people living with dementia.

The service had a manager that was registered with the Care Quality Commission (CQC). This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager had not been working in the service since 5 December 2018, and had applied with the CQC to cancel their registration.

Notice of inspection
The inspection was carried over two days: 12 December 2019 which was unannounced, and the 13 December 2019 which was announced.

What we did:
Before the inspection we reviewed information that we had received about the service since the last inspection in August 2017. This included information we have received from people who had contacted us direct and the service's provider information return (PIR) which they are required to provide us annually. The PIR gave us information about what the service does well and improvements that are planned. We also contacted the local authority for their views about the service. After the inspection we received feedback

from two health care professionals and spoke with the local fire safety officer.

During the inspection we spoke with four people using the service, four of their relatives and a health care professional. We also spoke with the provider's representative, who is a director of the company (who we refer to as provider in this report), two acting care managers, and seven staff including senior care assistants, care assistants, domestic, maintenance and kitchen staff.

We spent time observing how staff interacted with people and monitored their welfare. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the understand the experience of people who could not fully express their views to us. We looked at five people's care records, medicine records, risk assessments, audits and quality assurance reports, menus, fire safety, staff recruitment and training records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm.

Some aspects of the service were not always safe and there were limited assurance about safety. There was an increased risk that people could be harmed.

At our comprehensive inspection of August 2017, we rated this key question, 'requires improvement.' We found improvements were needed in risk management, medicines, and staffing levels. At this inspection we found this key question continues to require improvement.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Lessons were not learned which impacted on the service continually improving. Where reports from external regulators and professionals identified potential risks, systems were not in place to ensure action was taken.
- Management and staff did not always demonstrate an understanding of how to keep people safe. One person told us, "I'm really worried," as staff had not ensured their call bell was in reach before they left, and they wanted assistance. A relative told us that they didn't feel the service was safe as staff did not always identify when a person's condition changed.
- Risks associated with people's individual needs, and their environment were not always identified, reviewed and recorded, to guide staff in providing safe care.
- Risks associated with legionella had not been identified. Although legionella was not present, a risk assessment had not been carried out by a competent person to identify any potential risks of the bacteria growing. The provider contacted CQC after the inspection to evidence this had now been arranged.
- Staff were not following safe guidance in handling and storage of fluids as cleaning fluids were being decanted into unlabelled / or inappropriately labelled bottles.
- There was a system to record incidents and falls however there was no learning from these incidents. One person sustained minor injuries following a fall. Their risk assessment hadn't been reviewed to prevent further falls.

The failure to ensure risks relating to the safety and welfare of people using the service are assessed and managed was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- One relative said they had, "No worries," that the person would soon tell them if there were any problems with their medication.
- The provider had a policy in place for the safe handling of medication however this was not always followed. Not all records had been completed correctly and as required medication was not always administered as prescribed.

● Medication audits carried out by the management team had not identified the concerns that we found. This included one person's medication record providing conflicting information on whether they had a drug allergy
● Guidance for staff on the use of 'as and when required' medication was not always in place.
● Where people's medicines were delivered through adhesive (transdermal) patches, guidance on the rotation of one person's patch, did not meet current best practice in reducing the potential risk of skin irritation.

The failure to protect people from the risks associated with the unsafe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

Staffing and recruitment

● During the inspection, calls bells were being answered promptly. However, staffing levels did not provide enough time for staff to spend with people and be visible. We saw that a relative was trying to support a person who was unsteady on their feet. This went unnoticed by the staff team.
● People and their relatives told us at times when staff were busy, it impacted on how quickly they responded. One relative commented, "Not enough staff on the ground," and that their relative had told them they would ring the call bell to alert staff when they heard people asking for the toilet.
● One visiting professional told us, "Not always enough staff on, in the morning there is, but in the afternoon, there isn't, I can sometimes be looking for someone."
● Following our August 2017 inspection, the provider had increased the staffing levels. Visiting consultant's reports showed that this had a positive impact on people's wellbeing; but these levels had not been maintained.
● The provider used a dependency tool to support them in setting staffing levels, but was not always considering, other factors that could impact on staffing levels. This included the layout of the service and the impact it has on staff monitoring people in their bedrooms. In the absence of an activities organiser, staff trying to provide social interaction.
● There had been a high turnover of staff and as staff left, new staff were not always recruited. Agency staff were not used to cover absences and there was a reliance on staff to cover.
● The provider took action following our feedback to allocate one of the acting care managers to work with, and oversea the deployment of staff; to assist them in identifying any staffing shortfalls. Also they would start using agency staff to cover shifts.

The above concerns showed a continued breach of regulation 18 of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Staff had received training in safeguarding and knew how to report any concerns. One staff member told us they had found the safeguarding training to be, "Good."
● Systems were in place to record any damage to a person's skin, so any concerns on how it had happened could be investigated. However, one person had bruising on their hands. Staff did not know how the bruising had occurred and an investigation had not taken place.
● Appropriate recruitment checks were carried out to ensure staff were suitable to work with vulnerable adults. However, one staff member had started work before a check had been received confirming that they were suitable to work with vulnerable people. The provider confirmed this would not happen again.

Preventing and controlling infection

● People and their relatives told us their bedrooms were kept clean and tidy. We found that this was the case.
● The use of disposable gloves and aprons, and staff following good hand hygiene prevented and controlled the risk of infections.
● Wet mops were not being air dried making it a potential source of breeding bacteria. The, provider said they would address this.

Requires Improvement

Is the service effective?

Our findings

Effective – this means that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

At our comprehensive inspection of August 2017, we rated this key question, 'requires improvement.' We found improvements were needed in training, consent and monitoring nutrition. At this inspection we found this key question continued to require improvement.

Assessing people's needs and choices, delivering care in line with standards, guidance and the law; Staff skills, knowledge and experience

- People were not consistently having their needs assessed, and their care and support planned and delivered in line with best practice. This included best practice in supporting people with their hydration needs, medicines, risk management, and social inclusion.
- Feedback from health professionals, described staff as trying their best, but needing further training to build up their confidence and knowledge.
- Staff said most of training was delivered through E-learning and that they had to complete this in their personal time. One staff member said, "We get told that we have to do them in our own time, we don't get paid, I just want a break as we don't get enough time to do it. It's about 15 hours of your own time…. got told by the owner last Friday that we had to do it all by the Sunday."
- There was no effective system in place to check the training provided staff with the information they required to carry out their roles effectively. One staff member said, "We have done E-learning on tissue viability and diabetes, it was no more than common sense and didn't help me support people."
- Where 'face to face' training had been organised, poor communication and organisation of the staffing roster, had resulted in staff non-attendance.
- Systems were in place to ensure staff received regular supervision and yearly appraisal, but the support was not consistent. One staff member told us, "We were having it every three months, but this stopped a few months ago."

The above concerns showed a continued breach of regulation 18 of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough with choice in a balance diet.

- A meal service provided precooked hot meals and accommodated people's cultural and medical needs. Staff reheated the meals, which for safety, had to be eaten within a set timescale.
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● Views on the meals provided were mixed. One person told us they had just eaten, "A lovely lamb casserole," A relative asked, "What's happened to home cooked food?" Where their relative told them they had been, "Looking forward to a nice bit of chicken with crispy skin." They had been disappointed with the bland looking meal, "Half of which they didn't recognise."
● Staff raised concerns that the meal service, did not provide flexibility for people to eat when they wanted and that the high calorie content of the meals, although supportive of people of low weight, for others had resulted in gaining weight.
● The provider told us they were in the process of employing a cook and returning to home cooked meals to improve choice and flexibility.
● One person said they were offered plenty of fluids, "Drinks, drinks and more drinks, cups of tea and coffee, whatever you want…in-between meals you get jugs of water."
● There was no system in place to monitor people who remained in bed were being given enough to eat and drink. Although staff said that they had been assisting people with fluid and offering snacks in-between meals, we did not observe this. The management acted straight away to keep a record of people's diet/fluid intake.
● Systems were in place to monitor people's weight. Where people were identified as being under weight, referrals were being made to dieticians. To support people of low weight, staff lacked awareness of using fortified snacks.

We recommend that the provider use a reputable source to support them in the use of fortified snacks.

Healthcare support

● Systems were in place to ensure people received the support from health professionals when needed.
● A health professional said staff would contact them if there had concerns about a persons' welfare. "If I need them to do anything, they will follow instructions."

Ensuring consent to care and treatment in line with law and guidance

● We checked whether the service was working within the principles of the Mental Capacity Act (MCA), whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
● The provider was unable to confirm what applications had been made, and if they had been processed. That they would look into the situation and ensure any required paperwork had been processed.
● Staff gained people's consent, before providing assistance.
● Not all staff had received training in MCA, which was being addressed.
● The service was also being supported by external consultants and commissioners of the service, to improve their understanding of the MCA
● The provider did not demonstrate their understanding of the MCA. People's photographs were being used on the service's social media page. The provider said they had gained the consent from people's relatives, however, it was not evidenced in people's care records.

Adapting service, design, decoration to meet people's needs

● Since our inspection of August 2017, a new call bell system had been installed which could be used with sensor mats.
● Areas of the service had been redecorated and flooring replaced.
● One person invited us to see their brightly painted, personalised bedroom, which had a view of the sea, "I

love my room, I love it altogether, every bit of its mine, it's home…look at the view."
● One relative felt a, "Walk in shower" would be beneficial to people, as an alternative to using a bath chair.
● The service supports people living with dementia. Although some signage was in use, the steep stairs, use of colour, and layout of the service was not supportive of current best practice in promoting a dementia friendly environment.

We recommend the service uses a dementia environmental tool, to support them in this area.

Requires Improvement

Is the service caring?

Our findings

Caring – this means that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Respecting and promoting people's privacy, dignity and independence

- Staff were respectful of people's personal space. One person told us, "No one can walk in without a knock – they (staff) knock on here (pointing to the door) if you answer, they come in."
- The environment did not always ensure people's dignity and privacy. The bathroom door had a hole where the lock was, and the door did not close. A relative confirmed it had been like that for a while. Once alerted, the provider took action to address the issue.
- Where a person living with dementia had great attachment to their doll. Staff demonstrated a good understanding of how important it was to the person, and all interactions were dealt with in a dignified manner, which enhanced the person's wellbeing.
- People were supported to maintain and develop relationships with those close to them.

Ensuring people are well treated and supported

- One person told us, "I am happy here, they [staff] know me. They are excellent."
- One relative described the staff, as, "Lovely…they know your name and [person] can have a laugh and a joke with them, that what [the person] likes." Another relative told us, "Staff are lovely here, have a lot to do."
- Where a person living with dementia became anxious as their visitor was leaving, staff dealt with the situation in a sensitive and supportive manner, which enhanced the person's wellbeing.
- The staffing levels impacted on the time staff could engage with people, which led to a 'task' led approach; especially for people who remained in their bedroom.

Supporting people to express their views and be involved in making decisions about their care.

- People were supported in making decisions about their day. One said they liked to eat lunch in their room, then they would "Go downstairs," to the lounge. Another person was heard discussing with staff when they had decided to have a bath.
- People care records did not always demonstrate how they were being supported to express their views and be involved in decision making.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means that services met people's needs

People's needs were not always met. Regulations may or may not have been met.

How people's needs are met

At our comprehensive inspection of August 2017, we rated this key question, 'requires improvement.' We found improvements were needed in care planning, and people having access to social activities. At this inspection we found this key question continued to require improvement.

Personalised care

- Since our last inspection, care plans had become more person-centred. However, some areas of the care plans required further development to ensure people consistently received personalised care that responded to their needs.
- People, and where applicable their relatives were not always involved in the development and review of their care plan to ensure it was accurate and reflected their wishes. One relative said although the registered manager confirmed they would be involved, they still, "Hadn't seen the care plan."
- Care plans did not always provide accurate information and conflicting information was not being picked up. This included one person being referred to by the wrong name in one area.
- Oral mouth assessment templates were in place, but had not been completed.
- The manager told us they were in the process of reviewing all the care plans, and took note of our comments to ensure they were actioned.
- There was a lack of stimulation and activity for people. A relative said, " It's a shame the activities co-ordinator is gone as they got people doing things." They said they had, "Noticed a difference," as their relative was no longer received the same encouragement but that staff tried their best but were too busy.
- Most of the social interaction for people was from their visitors, each other, or watching TV. When staff had time to sit and chat with people it enhanced their wellbeing. We heard joking and laughter, as people were being engaged in meaningful conversation. However, these opportunities were limited.

Improving care quality in response to complaints or concerns

- People and their relatives knew who to complain to.
- The service had a complaints policy in place which was displayed in the service.
- Complaints were not always effectively managed. Where a relative had raised concerns, they said the action taken by management to address it, had not been sustained. This resulted in complaining about the same issues again.

End of life care and support

● People's care plans did not always show they had been consulted over their end of life care.
● One visiting professional told us, "End of life care has been very good, they [staff] do everything to support the person, repositioning and they [the person] always look very comfortable. Another said in one case, staff needed to be more responsive in monitoring pain relieving equipment, and alerting health professionals if there were any problems.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong:

- People were not consistently receiving safe, person centred care. One relative felt the service was, "Good 75% of the time, just needs tinkering with, not sure if there is enough money going in…just doesn't seem a continuity of standards." A staff member told us, "I wouldn't put my loved one in here because they don't get the proper care they need. We are always rushing."
- The provider had failed to learn from our August 2017 inspection. They continued not to have sufficient oversight of the service to drive and maintain continuous improvement. This included monitoring the management of the service and providing structured support to the registered manager.
- There was no effective system in place to ensure appropriate action had been taken following concerns from external agencies, and specialists.
- Where staff were covering high number of extra hours, there were no risk assessments in place to ensure they were sufficiently rested and fit to provide safe care. A staff member referred to seeing staff getting, "Grumpy" at work because they were tired.
- The provider was not using quality assurance visit reports from their own consultants as a tool to support them in improving the quality of the service people received. Significant shortfalls and repeated recommendations identified in the 2018 reports, reflected our findings and had not been acted on.
- There was no effective plan in place to ensure resources were allocated in a timely manner to repair or replace equipment. The dish washer had been broken for some time and a care worker was washing up which impacted on staff availability to provide support.
- A relative voiced their concerns over the high turnover of staff, which impacted on the consistency of care, "A lot of things happening…staff leaving, has anyone asked staff why?" One person had picked up it was because, "Staff were not getting paid."
- Staff said they were getting paid, but they could not rely on the date they would get paid, or the amount. They said that the inconsistent approach caused them problems in meeting their financial commitments. One staff member said their pay day was, "Usually due on the 28th of the month, but more like the 29th or 30th.
- Staff did not always feel supported by the provider and management. One staff member commented, "If we say things, they say we will sort it out later and they never sort it out. If I could fix one thing it would be management… the provider can come in more than he does, we just get messages." Another felt the provider was unapproachable, "Gives the impression you are annoying him and in his way."
- Staff demonstrated commitment to people living in the service and told us they just wanted to provide good quality care, and be supported to do so.

● The provider told us they were determined to make improvements, would be visiting more often, and would be increasing consultancy input to assist them.

The above, demonstrated an ongoing breach of regulation 17 of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014.

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements

● The registered manager who had been in post since February 2018 had left on the 4 December 2018 and had submitted their application to the CQC to cancel their registration.
● The provider told us they were activity looking to recruit an experienced new manager. Two 'acting care managers' were sharing the management post between them, however they were not fully clear about their specific role. Clarification was provided by the provider following our inspection to ensure more effective management.
● Management were not always communicating effectively with staff. Staff were not aware there was a 'petty cash' account. This had impacted on staff not taking immediate action to purchase items locally, where shortages impacted on them doing their work.

Continuous learning and improving care; Working in partnership with others

● Throughout, and following the inspection, the provider spoke about their commitment to act on our findings, and those of visiting professionals.
● The Clinical Commissioning Group pharmacist team, visited the service on 18 December 2018, to support improvements in their management of medicines, and found staff, "Were very engaged and keen to learn."

Engaging and involving people using the service, the public and staff

● The service had a social network page which kept people updated on what was happening in the service.
● The provider had written to relatives to inform them of the current changes in management.
● Surveys had been sent out to relatives and staff in April 2018. The feedback had not been given to people on the outcome, and action taken from the results. The PIR stated the feedback had been positive about the care being provided. Where relatives had raised issues over the state of decoration, this was being addressed through the provider's refurbishment plan.
● There was no system in place to gather feedback from visiting professionals, but the management were looking to do this in the future.