St Michael's Care Homes Limited

Dorley House Residential Care Home

Inspection report

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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?	Requires Improvement

Summary of findings

Overall summary

Dorley House provides care and accommodation for up to 33 older people with care needs associated with older age including dementia. There were 16 people living at the service on the day of our inspection. Dorley House is an adapted building in a residential area of Eastbourne with a passenger lift and access to outside areas.

People's experience of using this service and what we found
We have made recommendations about the management of safeguarding processes, dementia support, Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS).

We found concerns relating to documentation. There was an over reliance on verbal information being shared between staff. Staff were aware of peoples care needs, however, people's daily records were not consistently recorded to include all relevant information about people's care.

At the time of the inspection there was no registered manager in position. There had been four managers appointed by the provider since the last inspection. The newly appointed manager had worked at the service for approximately one month and had commenced the process to register with The Care Quality Commission (CQC).

People felt safe living at Dorley House, telling us it was a nice place to live. Staff told us the repeated changes in management had made things difficult, but they found the new manager supportive and were keen to make improvements moving forward.

Care planning and documentation relating to people's care, support needs and associated risks needed to be improved to ensure people received the appropriate care to meet their needs. Care documentation was difficult to follow and did not demonstrate actions taken in the result of assessments being completed. Nutritional needs were not clearly documented. Specific health care needs did not have appropriate guidance in place for staff to ensure that care was provided safely and consistently.

Improvements were needed to ensure that the environment and the care provided to people met the needs of people with dementia and/or cognitive impairment.

Staff had an understanding around safeguarding people against abuse however, not all incidents had been reported to the local authority or CQC as required.

Care documentation was task orientated and did not demonstrate how decisions had been made in a person's best interest or who was legally entitled to make decisions on a person's behalf. Improvements were needed to ensure the service worked within the principles of the Mental Capacity Act.

Records were not person centred and did not demonstrate measures in place to prevent social isolation.

Activities needed to be improved to ensure that people had stimulating dementia appropriate activities and sensory stimulation, particularly for people who spent long periods alone in their room.

A schedule for audits was in place, and a variety of checks and audits had been completed by designated persons in September and October 2019. However, when an action was identified no information was recorded to demonstrate whether the issue had been rectified or changes implemented.

Staff knew people and responded promptly when support was needed. Staff spoke to people with kindness. Medicine processes were safe. Peoples nutritional needs were met, and the service worked well with other health care providers and professionals.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Requires Improvement (published 12/03/2018)

Why we inspected
This was a planned inspection based on the previous rating. The inspection was prompted in part due to concerns about the home employing a number of different managers since the last inspection.

Enforcement
We have identified a breach of regulation. This is in relation to Regulation 17 (Good Governance).

You can see what action we have asked the provider to take at the end of this full report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of governance. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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	**Requires Improvement**
Is the service effective? The service was not always effective	**Requires Improvement**
Is the service caring? The service was not always caring	**Requires Improvement**
Is the service responsive? The service was not always responsive	**Requires Improvement**
Is the service well-led? The service was not always well led	**Requires Improvement**

Dorley House Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of two inspectors.

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

The service did not have a manager registered with the Care Quality Commission. A new manager had been appointed and had started employment in the service in November 2019. They told us they had begun the registration process with CQC. A registered manager, along with the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was an unannounced comprehensive inspection. The inspection was carried out on 19 December 2019.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service

and made the judgements in this report. We reviewed information from other agencies and statutory notifications sent to us by the home about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law.

During the inspection-
We spoke with six people who used the service and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with one relative about their experience of the care provided. We were not always able to communicate with people, so we spent time observing the interactions between people and staff, in public areas of the home, in order to help us understand people's experiences. We spoke with six members of staff including the manager, senior care staff, care staff, the cook and maintenance staff. We reviewed a range of records. This included three people's care records in full and a further two to look at specific areas related to their health and care needs and other care related documentation. We also looked at medication records including medicine administration records (MAR). Staff files in relation to recruitment, and staff supervision. A variety of records relating to the management of the service, including audits, policies and procedures were reviewed.

After the inspection –
We looked at staff training records, staff rotas, supervision records and the service improvement plan provided by the manager. We spoke with the provider who sent us auditing schedules and audits completed in 2019. We sought feedback from the local authority contracts and monitoring team.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse

- Health and safety had not been consistently maintained. Although people had risk assessments in place for identified needs, these did not provide all relevant and up to date information. For example, nutritional risk assessments for one person provided conflicting information to their care plan. Information about peoples identified risk was not easy to locate and had not been consistently reviewed or updated in a timely manner when changes had occurred. This needed to be improved.
- People had Personal Emergency Evacuation Procedures (PEEPS) in place, however these did not provide information regarding everyone's mobility needs. Two recently admitted people were not included in the PEEPS displayed around the home. A number of people required hoisting or the assistance of two care staff to enable them to leave their room safely in an emergency. Two were on the first floor of the building and both were in bed or their room at all times. People had dementia and would need support to ensure they vacated the building safely. Fire evacuation plans did not demonstrate how this would be managed safely in the event of an emergency evacuation being required, particularly at night. The manager informed us a new fire risk assessment was scheduled to take place in January and most staff had attended recent fire training. Emergency evacuation procedures are an area that needed to be improved to ensure peoples safety.
- Checks and servicing were completed, including, electrical, gas and water safety checks. These were completed to identify any risks associated with the safety of the environment and equipment.
- Systems and processes had not been maintained to ensure that people were protected from the risk of abuse. Although the service had its own safeguarding policy this did not include recent additions and changes to safeguarding procedures. Staff did not have access to the East Sussex Safeguarding Adults Policy and Procedures and were unclear of the local authority safeguarding reporting criteria. This was an area that needed to be improved.
- Staff were able to tell us how they would safeguard people if they had any concerns. Telling us, "If I saw something I would report it to the senior or the manager." However, we found recent incidents, which, although referred to other health professionals, had not been referred to the local authority by senior staff.

We recommend the provider seek appropriate guidance and support to ensure that safeguarding processes and criteria are followed at all times.

- People told us they felt safe living at the home and felt looked after. One said, "They look after us well, staff are very kind."

Learning lessons when things go wrong

●Accidents and incidents were recorded by the person who witnessed them. Although some follow up checks took place such as 24h hour observations if a person had a fall, it was not always clear how these were reviewed to identify learning and prevent accident and incidents reoccurring going forward. Actions had not been reviewed, so it was unclear what changes to care had been implemented or whether there was any learning taken forward or follow up fed back to the staff.
●Referrals were made to other agencies for example people's GPs or emergency services.

Preventing and controlling infection
●There were designated housekeeping staff. Cleanliness of the home was maintained in people's rooms and newly renovated areas of the home. However, some areas of the home needed attention to ensure they were clean, for example, communal bathrooms and people's ensuite facilities.
●Measures were in place to prevent and control the risk of infection. Staff had access to protective personal equipment, such as gloves and aprons if needed and there were handwashing facilities throughout the home. One member of care staff was the infection control champion. They told us, "I have attended additional training with the local authority. We still need to improve our infection control practices, but we are 80% there. I check the cleaners work by using a checklist and I offer supervision to the cleaners. I am in the process of developing an audit."
●The home had received an Environmental Health Office (EHO) food hygiene rating of 5.

Staffing and recruitment
●Recruitment and selection procedures were in place for new staff. Required safety checks including references and Disclosure and Barring Service (criminal record) checks took place before a person could start work at the service.
●Staff told us they felt there were enough staff to support people during the day as the home was not full. We saw people were responded to in a timely manner and staff were available to assist them when needed.

Using medicines safely
●Staff followed policies and procedures to support the safe storage, administration and disposal of medicines. There was guidance for administering 'when required' PRN medications to ensure people received these medicines in accordance with GP instructions.
●Staff received training, medicines competency checks had taken place to ensure staff practice remained safe.
●We observed a member of staff administering medication safely. People told us, "They help me with my medicines, so I don't have to worry."

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement . At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

At the last inspection we found the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent, in relation to MCA and the use of surveillance cameras. At this inspection, surveillance cameras were no longer in use, however we found new concerns in relation to MCA and DoLS and assessing people's needs and choices.

Ensuring consent to care and treatment in line with law and guidance
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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

- A number of people living at Dorley House had DoLs authorisations in place. DoLs information was recorded in a folder kept in the managers office. Staff were able to tell us who they thought had a DoLS but were unclear regarding any specific conditions.
- Staff had a basic understanding of MCA and DoLS. This needed to be improved to ensure people were not being unduly restricted. Best interest decisions had not been recorded in all care plans. Care plans included that decisions had been made in a person's best interest, but no details were included for specific decisions to identify who had been involved in the decision. Staff were not aware who had a Lasting Power of Attorney, or who was legally entitled to make a decision on a person's behalf.

We recommend the provider seeks appropriate guidance to ensure that principles of MCA and DoLS are being met.

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

●Although people had their needs assessed before moving to the home. Information in care plans did not reflect people's current needs and choices. Care plan updates did not identify who had been involved in providing information and had not been further developed as staff got to know people. Care documentation included conflicting information and little guidance for staff regarding people's choices and preferences. Information regarding people's dementia was limited, for example, there was a lack of understanding around behaviours for people with dementia. Information recorded informed staff to use distraction if people wandered or became anxious. There was minimal information explaining people's individual triggers, or what type of distraction to use. This is an area that needed to be improved.
●Staff had an understanding of equality and diversity, however the provider needed to ensure this was embedded into practice. For example, two people were in a shared bedroom. Staff were not able to tell us why these two people shared a room. Staff told us both of these people lacked capacity to be involved in decisions. No rationale had been recorded in their care plans to explain the decision, or who had been involved. This is an area that needed to be improved.
●Religion and disability were considered as part of the assessment process, if people wished to discuss these, however this information was not revisited and updated to ensure information for staff was relevant and up to date.

Staff support: induction, training, skills and experience
●The manager had identified that training needed to be reviewed to ensure all staff had completed required training. Training provided was mostly completed by staff online via e-learning. The manager was in the process of reviewing staff training needs and following up on any outstanding training. Improved systems were needed to check staff understanding and competency in key areas such as supporting people with dementia. For example, we observed one person who appeared anxious and confused. When this person stood up from their chair and wanted to walk around the home, staff did not appear to know how to support the person effectively, and their response was to ask them to sit back down. This approach did not support the person or alleviate their anxiety. This is an area that needed to be improved.
●New staff were supported to understand their role through a period of induction. The manager told us staff new to care would complete the Care Certificate training and competency checks. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care. It sets out learning outcomes, competencies and standards of care that care workers are nationally expected to be achieved.
●Supervisions had taken place. The newly appointed manager had commenced a review and a new schedule implemented to ensure all staff continued to receive regular supervision.

Supporting people to eat and drink enough to maintain a balanced diet
●We noted some issues with the recording of people's nutritional needs within their care documentation. Risk assessments did not always correspond with the care plan, for example, one persons Malnutrition Screening Tool said, 'continue with fortified food', however, this was not on their care plan. Their food and drink preference form stated food to be 'fortified and cut in small pieces'. This meant that information for staff was contradictory. This needed to be improved.
●For people whose food and fluid intake was being recorded daily, there was no evidence that the daily total intake was being reviewed. For example, one person had daily charts in their room folder for the previous two weeks. There was no documentation to show whether this had been reviewed or if any actions had been identified and taken.
●We saw people being asked in the morning for their choice of lunch and supper. By supper time many had forgotten what they had ordered. The cook told us that they had pictorial menus to aid people's choices. However, when care staff were asking people for their daily choice during the inspection, these were not used. Issues identified in relation to nutrition needed to be improved. The risk to people was minimised as

the cook and care staff knew people well and was able to tell us about people's likes, dislikes and dietary needs. Meals looked appetising and choice was offered when people declined to eat their meal. People told us they enjoyed the meals provided. One said, "Food is hot and looks tasty."

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

●A period of refurbishment had been commenced since the previous inspection and was still ongoing. This had provided a new lounge and seating areas on the ground floor and new bedrooms on the second floor. The bedrooms were not yet in use.

●The building was adapted, and we saw that the second floor had a narrow corridor which led to one person's room. A steep slope on both the first and second floor, would not be easy for people to use independently if they had any mobility issues. The manager told us this is considered when people were located rooms.

●We noted that bedroom doors did not always display any recognisable labelling. This could be confusing to some people. There was minimal dementia friendly signage to orientate people around the home to encourage them to remain independent. Communal bathrooms, toilets and peoples ensuite facilities had not been decorated or designed to support independence and dignity for people with dementia. Bedrooms were sparsely decorated, and many did not include personal items or photographs to make the room look and feel homely and personalised. We found clocks in people's rooms which did not show the correct time.

We recommend the registered provider reviews best practice guidance and introduces further development to the environment to meet the needs of people living with dementia and cognitive impairments.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

●Staff knew people well enough to know when something was wrong with them. Staff had handovers at the end of each shift to pass on information about people's health.

● Staff referred people to other health care professionals, such as district nurses, GP, and dieticians. One health professional told us the provider engaged with them openly, however they were aware that there had been repeated changes of manager at the home over the last year which was a concern.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

- Many people living at Dorley House had a dementia diagnosis. Information on how to support and encourage their independence had not been explored or recorded.
- Staff told us one person spent most of their time in the communal lounge. We saw that this person was asleep in a recliner chair on our arrival dressed in nightwear. Although they were assisted to the toilet and taken to a communal bathroom for personal care, they spent all their time in the chair and appeared to be asleep. Staff told us the person preferred to be in the lounge rather than their bedroom. It was not documented in their care plan what measures had been considered to ensure this person's dignity and privacy was maintained. Or whether any other options had been considered other than this person remaining in the communal lounge at all times.
- People who shared a bedroom had no divider or curtain between the beds to ensure their privacy and dignity could be maintained, for example if personal care was required. Staff told us one person had behaviours that challenge, and staff were recording this on a daily chart. We found a chart on a cupboard in the communal dining area which was dated three days prior to the inspection. This form was accessible and could be picked up and read by anyone in the room. This did not ensure the persons privacy and dignity were maintained.
- Information in people's care plans was limited regarding how to support and encourage their independence. One person asked repeatedly what the weather was like and walked to the door. Staff did not ask the person if they wanted to go outside or provide any means for people to explore outside.
- We saw staff respond to people when they needed assistance and spoke to them with kindness and respect. People told us staff were 'Nice and kind' and "Staff help me when I need it I am lucky to be here."

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

- Information regarding how people had been involved in decisions about their care was difficult to find in care documentation. Information regarding Lasting Powers of Attorney (LPOA) and best interest was not recorded clearly in care plans to identify who had been involved in specific decisions for those with a dementia and who lacked capacity. For example, care plans stated decisions 'made in a person's best interest', however no further information was recorded.
- Monthly care reviews when completed, did not include whether conversations had taken place with people or their Next of Kin (NoK).

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Staff were unable to tell us anything about people's lives before they moved to Dorley House. They did not know about people's previous employment or what their hobbies or preferences where. For people with dementia or memory loss, being able to talk about the past can aid reminiscence and support active communication.
- There were no designated activity staff at Dorley House, activities provided were not always accessible to everyone. On the day of the inspection we saw a member of care staff instigate a game of catch in the lounge, however, they were called away on several occasions. The game only involved the more active people in the lounge, whilst others were only able to watch. People who sat in chairs were not given any items to look at to stimulate or occupy them. No sensory items, books or pictures were given to people to aid reminiscence or to provide meaningful occupation. Music was playing in the background which people seemed to enjoy.
- There was minimal evidence in people's rooms of the things they liked. People who remained in bed only had the television or music to occupy them throughout the day. People spent long periods on their own without anything meaningful to occupy their time and were at risk of social isolation. For example, one person who remained in bed due to their poor health and dementia had no sensory items in their room to stimulate or occupy them. The manager assured us staff spent time with the person, however, care records only included tasks completed by staff and did not demonstrate any social interaction. Staff had not received any training on dementia appropriate activities to provide for people.
- The cook who had worked at the home for many years, was seen to engage people in conversation about dancing and there had been a Christmas party at the home the week before the inspection, and people had recently been supported to participate in baking a cake. The newly appointed manager told us that they were aware that improvements to activities were needed.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs had been assessed on admission, however, it was unclear what measures were in place to support people's communication needs. For example, no guidance was provided for people with limited verbal communication to inform staff of how to communicate effectively. Pictorial meal choices were available, but we did not see these being used when people were asked for their meal choices for that

day.
●The provider needed to ensure that information was provided in ways that met people's needs so that people had access to information about the service and the care they received in an appropriate format. This is an area that needed to be improved.

Improving care quality in response to complaints or concerns
●The provider had no ongoing complaints. The newly appointed manager told us they had an open-door policy and was keen to talk to people and relatives about the care provided.
●The service had a clear complaints policy with information available within the home.

End of life care and support
●At the time of the inspection no one was receiving end of life care. We found that minimal information was recorded in people's care plans regarding their end of life wishes. However, they did include that people and their NoK would be consulted at the point that end of life decisions were needed.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At the last inspection we identified that improvements were needed to ensure improvements were embedded in practice to drive continuous improvements.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There were significant shortfalls in the oversight and leadership of the service. For example, people's records were not always completed and updated to ensure staff had the right guidance to support people safely.
- Since the last inspection there had been a number of managers employed who had since left. This meant that changes introduced had either not been completed or fully actioned. For example, a number of recording tools had been completed. However, it was unclear what the results indicated or if any actions or changes to care had been implemented.
- Care records were vast, and information was recorded in a number of different folders. This meant relevant care information was difficult to locate and not easily audited. It was unclear what action was in place to review daily records to ensure people's health was monitored and actions taken if appropriate. Information about specific health needs were incorporated into other care plans, for example, stoma care was recorded within personal care but lacked specific guidance to inform staff how to care for people's specific needs.
- DoLS, MCA and LPoA information was not clear in care files to ensure staff were aware of specifics, including who was legally entitled to make decisions on a person's behalf. Decisions made about people's care included that they were made in the persons 'best interest' however, information did not include who had been involved in decisions or the rationale for decisions. For example, shared rooms. Documentation was not person centred and did not demonstrate how people were involved in their care choices and decisions.
- There was an over reliance on staff sharing information verbally. Staff knew more about people's care needs than was documented in people's care files. For example, staff told us about a person's stoma care and how to support the person, giving us information regarding their skin integrity and how to minimise infections and redness. Care staff told us, "People's care documents could be better."
- Quality assurance systems needed to be improved to ensure the provider and manager had oversight of all care documentation, systems and processes used within the home. A schedule for audits was in place, and a variety of checks and audits had been completed by designated persons in September and October 2019.

However, when an action was identified no information was recorded to demonstrate whether the issue had been rectified or changes implemented. One stated 'to discuss'. Audits did not include checks on documentation, for example individualised care plans and person centred risk assessments. One person had a wound which staff told us had occurred some time previously. Although a wound was mentioned within care documentation, no specific care plan had been written. Records did not include guidance for staff on how to care for the wound or what to do if it deteriorated.
●Fire safety and evacuation plans needed to be reviewed to ensure staff had appropriate guidance and support to safely evacuate people in the event of an emergency.
●We observed that some of the staff's approach was task focused and they did not always have the skills and knowledge to support people with dementia appropriately and sensitively, for example when people were distressed. It was unclear how the provider ensured training was embedded into practice. A more robust system was needed to assess staff competency and to ensure that care was continually meeting required standards.

The provider had not ensured good governance had been maintained to ensure systems were assessed, monitored and used to improve the quality and safety of the services provided. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The provider visited the home regularly and participated in supervision and audits. They told us that the changes in manager had been unfortunate and had meant a lack of stability at the home. However, the newly appointed manager was working closely with the provider to identify and implement improvements.
●The new manager had identified many of the issues we found during the inspection. In particular the need to improve care documentation and dementia care for people. The manager had recently enrolled for dementia champion training and had already started looking into alternative care planning systems.
●Staff told us that repeated changes of management had been difficult. Staff made sure they told each other when changes to people's care had occurred. Staff confirmed that they did not read all the care plans as it would take too long. Staff spoke highly regarding the new manager and felt that they were supported by the provider and manager to make improvements. Staff meetings had taken place with more scheduled to support any improvements and improve communication.
●There was a relaxed atmosphere and staff told us they were happy and enjoyed working at Dorley House. One told us "It's a nice place to work, I enjoy my job."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
●There was a new manager recently appointed at Dorley House who had commenced the process of registering as a manager with CQC.
●The provider understood the requirements of duty of candour that it is their duty to be honest and open about any accident or incident that had caused, or placed, a person at risk of harm.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
●The provider and manager were working with people to continue to improve the services provided. Staff told us, "Staff meetings have not been consistent due to the changes in management. But one is booked on Monday."
●The manager was unable to show us any recent feedback from people and families. However, engagement was an area identified within the service improvement plan moving forward.

Continuous learning and improving care; Working in partnership with others

●The service had previously worked with the falls prevention and the local authority Quality Monitoring (Market support) Team. The new manager told us they were keen to engage with other health and care professionals to ensure ongoing improvements to care provision.

●A Service Improvement Plan had been completed by the provider and manager prior to the inspection. This included a number of the issues found during the inspection. The manager felt confident that given time they could work with the provider and appropriate healthcare professionals to ensure all the issues identified during the inspection could be resolved and improvements made.

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 17 HSCA RA Regulations 2014 Good governance The provider had not ensured good governance had been maintained to ensure systems were assessed monitored and used to improve the quality and safety of the services provided. Regulation 17 (1) (2)(a)(b)(c).