Four Seasons Homes No.4 Limited

Dove Court Care Home

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

This inspection took place on 13 July 2017 and was unannounced. This inspection was a focussed responsive inspection that was completed in response to concerns raised by local commissioners and an anonymous whistle-blower in relation to the safety of people living at Dove Court.

We inspected Dove Court on 14, 15 and 21 June 2017 and rated the service as inadequate. We took urgent enforcement action to place restrictive conditions upon the registration of the location to prevent any new admissions into the home.

Following our inspection in June 2017 local commissioners had been working closely with the home to support improvement however, they had raised concerns that the care people received whilst living at Dove Court continued to place people at risk of harm. We also received an anonymous concern from a whistle-blower that raised further concerns about the care that people received. In response to this information we carried out a focussed inspection to assess how the provider and senior management team at Dove Court were working to improve the care and support that people received and how they were ensuring that people's safety, health and well-being was maintained.

Dove Court Care Home is registered to provide residential and nursing care for up to 58 people, including people living with dementia. At the time of this inspection there were 55 people living in the home.

There was not a registered manager in post at the time of our inspection. 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 provider had not worked successfully to ensure that improvements had been made within the home since our last inspection so that people consistently received their care and support safely. We found continuing concerns from our previous inspection that highlighted that the action taken by the provider in response to our inspection in June 2017 had not been sufficient.

The provider had dedicated additional resources to the home in the form of 'Resident Experience Managers' to oversee people's care and to support improvement, however, their roles were not clearly defined and the availability of permanent staffing impacted the improvement that they were able to make.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service well-led?

Inspected but not rated

The service was not well-led.

The roles of the acting management team had not been clearly defined. The result of this was that the shortfalls that we identified during our previous inspection had not been resolved sufficiently or consistently.

The staff providing people's care did not always have the skills, knowledge or experience that they required to do this competently.

The provider had not implemented effective systems to monitor people's nutrition.

Dove Court Care Home

Detailed findings

Background to this inspection

We carried out this responsive focussed 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.

This inspection was prompted because of concerns that had been raised about the care people received whilst living at Dove Court since our last inspection in June 2017.

This inspection took place on 13 July 2017 and was unannounced. The inspection was carried out by four Inspectors.

Before our inspection, we reviewed information we held about the provider including, including information that they had submitted to show the action that they had taken to ensure people's safety since our last inspection in June 2017 where we rated the location as inadequate. We also liaised with health and social care commissioners who place and monitor the care of people using the service.

During the inspection we spoke with seven people who used the service and one person's relative. We also spoke with 11 members of staff including the acting manager, regional manager and four resident experience managers who were supporting the management of the home. We reviewed the care records of 13 people who used the service. We did this to ensure that care was being delivered safely.

Inspected but not rated

Is the service well-led?

Our findings

Since our inspection in June 2017 the provider had implemented a new management structure within the home. This consisted of an Acting Manager who was supported by a number of Resident Experience Managers and a Regional Manager.

Although a member of the management team was present in the home each day their roles were not clearly defined and this had resulted in improvements failing to be made quickly enough or monitored consistently. People continued to be placed at risk of harm because the systems in place to monitor their food and fluid intake had not been established or understood by the staff providing people's care. The provider told us that they had recently introduced a new system to record people's fluid and nutritional intake however; this system was not understood or followed by the care staff providing people's care. Although the provider was aware of the people who were at high risk of malnutrition or not drinking enough the staff providing people's care did not know this information and therefore we could not be confident that people received the care that they needed to maintain adequate fluid intake and nutrition. The provider acknowledged these concerns and told us that they would take immediate action to ensure that staff providing people's care monitored people's nutritional intake closely for people who had been assessed as at risk in this area and that this monitoring would be overseen by a competent clinician.

During in our last inspection we had identified that staff were placing two incontinence pads on people who were doubly incontinent placing them at risk of developing pressure sores. The management team had told us that this practice had now stopped and that people had been assessed by a health care professional and had the correct incontinence pads prescribed for them. However, care staff told us that people still did not have the correct sized incontinence pads and as a result of this they were still "double padding" three people. We bought this to the attention of the Regional Manager who told us that they would take immediate action to ensure that this practice stopped. They had not been aware of this practice continuing at the time of this inspection.

The service was reliant upon agency staff to provide people's care and support. Although the provider was actively trying to recruit care and nursing staff there were still 360 vacant nursing hours and 300 vacant care hours that were being covered by agency staff. The use of agency staff was impacting upon people's experience of living in the home and affecting the improvements that the provider was able to implement.

Although the provider was attempting to book the same agency staff this strategy had not been effective and staff did not always know people well. People continued to receive inconsistent care and support. The staff working within the home did not always have the skills and competency needed to support people. We found examples where Registered Mental Health Nurses were working on the nursing unit, however, they did not have the skills that they required to provide people with dressings to pressure areas and wounds. This placed people at risk of harm. We bought this to the attention of the provider who told us that they would ensure that a Registered General Nurse who was competent to provide people's care would be available at all times to oversee people's clinical care needs.

Following our feedback from this inspection the provider took immediate action to review the management oversight, leadership and governance at Dove Court. The provider clearly defined the respective roles of each of the acting management team so that people's care could be monitored closely and staff held accountable for any shortfalls that were identified. The provider also made contact with us to inform us that due to the difficulties that they were encountering in recruiting a stable, competent permanent staff team they intended to close the home. The provider told us that they would work closely with local commissioners, people and their families to support people to transition to an alternative service that was able to meet their care and support needs safely. As a result of the providers actions we did not take any further enforcement action.