Amore Elderly Care Limited

Dalton Court 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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Dalton Court Care Home is a residential care home providing personal and nursing care to up to 60 people. The service provides support to older people and people living with dementia and physical disability. At the time of our inspection there were 41 people living at the service.

The home accommodates people across two separate floors, each of which has separate adapted facilities. One of the floors specialises in providing care to people living with dementia.

People's experience of using this service and what we found
People were at risk of harm as recommendations relating to the health and safety of the service had not always been acted on or addressed responsively. The provider gave assurances action had been taken following our inspection.

People were supported by sufficient numbers of staff, who were knowledgeable about risks to them. Relatives were confident that their family members were safe living at the service. One relative said, "I know that [person] is safe and being looked after." Staff knew how to identify and escalate any concerns about people's safety. Visiting arrangements were in place to ensuring family and friends were able to visit their loved ones, whilst being mindful of infection transmission risks.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The registered manager and provider's quality assurance systems had not been effective in identifying the health and safety issues we found. An action plan was in place to support improvements at the service and enhance people's quality of care. Relatives and staff felt engaged in the running of the service. People received person-centred care from staff who were focused on promoting their quality of life.

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

Rating at last inspection
The last rating for this service was good (published 21 February 2020).

Why we inspected
This focused inspection was prompted by a review of the information we held about this service. This report only covers our findings in relation to the key questions Safe and Well-led.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the

overall rating. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Dalton Court Care Home on our website at www.cqc.org.uk.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment at this inspection. Please see the action we have told the provider to take at the end of this report.

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Dalton Court 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 (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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Dalton Court Care Home is a 'care home' with nursing care. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the CQC to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
This inspection was carried out by conducting a site visit and speaking to relatives and staff remotely. We spoke with two people that used the service and three relatives about their experience of the care provided. We spoke with and emailed 14 members of staff including the regional directors, registered manager, deputy manager, nurses, care workers, agency staff, housekeeper and a maintenance worker.

We reviewed a range of records. This included six people's care plans in part and multiple medication records. We reviewed three staff recruitment records. A range of records relating to the management of the service, including staff training records, quality assurance checks, health and safety records and a sample of the provider's policies and procedures were also reviewed. We observed people's mealtime experiences and staff handover meetings.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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

- People were at increased risk of harm as the provider had not acted on health and safety recommendations.
- The provider had not taken appropriate steps to minimise the risk of people being exposed to legionella bacteria. Legionella bacteria can grow in water systems such as taps and showers and can cause severe illness, particularly in people who may be vulnerable. For example, the provider had not acted on all expert recommendations made in a legionella risk assessment carried out in March 2020 within the specified timescales.
- It was not clear what actions the provider had taken in response to a fire risk assessment from June 2021 or that expert recommendations had been acted on in a timely manner.

Whilst we found no evidence people had been harmed, the failure to take adequate steps to ensure risks to people's health and safety were mitigated and the premises were safe was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following our inspection the provider gave us assurances all actions from the fire risk assessment had been addressed and many of the water risk assessment recommendations. Plans were put in place for addressing the remaining outstanding issues.
- People were supported to make choices to give them control and support their independence, including where this may put them at risk. For example, one person was at high risk of falls and enjoyed walking throughout the home. Measures were in place to support this and mitigate the person's risk of falls.
- Risks to people linked to their health and care needs were clearly identified and records in place to support the management of these. One agency worker said, "We know who needs support and how to support them with moving and handling."
- Staff were knowledgeable about people's dietary requirements. This information was not always recorded consistently. We fed this back to the registered and deputy managers, who immediately addressed this.
- The provider had systems in place to monitor risks to people across the service, including people who were at risk of developing pressure sores and weight loss.

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 MCA 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 found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Systems and processes to safeguard people from the risk of abuse
● The provider had effective safeguarding systems in place. Staff understood how to escalate any concerns and make sure people were protected from abuse.
● Managers worked closely with the local authority safeguarding team to investigate and address any safeguarding issues.
● People told us they felt safe and at ease with the staff supporting them. One person said, "The staff are alright here, I feel safe."

Staffing and recruitment
● There were enough staff to meet people's care needs. One relative told us, "You can always find staff if you need them."
● Staff were knowledgeable about people's care and support needs and how best to meet these. One relative said, "[Person] has strong views and they've got it down to a tee."
● The registered manager closely monitored people's dependency levels and considered any new admissions to ensure the home was appropriately staffed.
● Recruitment checks were completed to ensure suitable staff were employed.
● Staff received an induction to provide them with knowledge about the service and the provider's processes.
● Systems were in place and followed to support the safe use of agency staff.

Using medicines safely
● Medicines were ordered, stored and given to people as prescribed.
● Nursing staff had not received up to date medicines refresher training. The provider had plans in place to address this.
● The provider had robust medicines management policies and procedures, which were understood by staff.
● Protocols were in place for 'as and when required' medicines to guide staff in when people may need these medicines and support their safe use.
● The MCA process was followed for people assessed as needing their medicines to be given to them covertly.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or

managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● Visiting arrangements to the home were in-line with current guidance.
● Relatives told us there was a system in place for booking visits and they were able to visit their family members when they chose. One relative said, "I have to phone and make an appointment, it's never been a problem being able to visit."

Learning lessons when things go wrong
● Records of accidents and incidents showed what had happened, how staff had responded and actions taken to try to prevent a similar incident happening again.
● The registered manager had a system in place to analyse any accidents and incidents to identify and patterns or trends.

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Governance systems did not always support improvement.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider's systems had not always identified issues we found on inspection, including with the fire and water risk assessments.
- The registered manager had not always maintained effective oversight of the premises.
- Effective systems were in place to ensure information about people's care needs was shared within the staff team and any issues acted on.
- The provider and registered manager had an action plan in place to support improvements at the service. This was being worked through and was leading to positive changes.
- The registered manager promoted a culture of continuous improvement and was looking at ways to develop the service and standards of care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People received kind, respectful and attentive care from staff.
- The registered manager promoted a person-centred culture. One care worker said, "It's all about the people with the registered manager, the people need to come first." A nurse also told us, "The registered manager and provider want it to be place like home, staff treat people like family."
- Staff were committed to achieving good outcomes for people. One staff member said, "The best thing about working at the home is keeping people happy and safe and giving them the best care that is possible, if I've done that then I can leave my shift with a smile."

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

- The registered manager understood the importance of being open and honest with people if things went wrong.
- The provider was transparent in reporting any issues or concerns. Notifications were sent to us about events providers are legally required to inform CQC of.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- People, relatives and staff were informed about the development of the service.

● Relatives were well informed of any changes in their family member's needs and any changes planned for the service. One relative said, "The communication is staggering, you can ring up and speak to someone anytime. If they're not available, they'll ring back."
● Staff felt listened to by managers and able to suggest any ideas. One staff member told us, "I feel I am always listened to by the management. The management encourage the ideas I give or give a suggestion on changing."
● The service had good links with community health and social care services. Staff made referrals to other professionals for specialist advice when required, including nurses specialising in tissue care.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to do all that was reasonably practicable to mitigate risks to service user's health and safety and ensure the premises were safe for use. 12(2)(a)(b)(d)