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 effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 18 and 21 July 2017. The visit to the service on 18 July 2017 was unannounced. We told the provider that we would return to the service on the 21 July 2017.

We last inspected the service on 20 June 2016 when the service was found to be in breach of three regulations. Requirement notices were issued. This was because people's medicines were not being managed safely and procedures for obtaining consent to care and treatment did not always follow current legislation and guidance. Also, people who used this service did not have care or treatment that had been personalised specifically for them and important information was missing from the care plans of some people.

The registered provider gave us an action plan setting out how what they were going to do to improve and the timescales to carry out the improvements. During this inspection we reviewed the action taken by the provider to meet the requirement notices. We saw that some improvements had been made. Some breaches in the regulations identified in June 2016 had been addressed but some still remained.

We found that there was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A requirement notice had been issued at the last inspection on 20 June 2016. This was because some people who used this service still did not have care or treatment plans that had been personalised specifically for them. We found this was still the case for some people, including personalised advanced care planning for end of life care and to manage medication changes. This placed people at risk of receiving care or treatment that did not meeting their individual needs or expectations.

We found that improvements had been made to the management of medicines but this was not consistent across both Daffodil and Orchard units. Orchard unit demonstrated some good practice whereas Daffodil unit lacked effective oversight to sustain good practice. Similarly audit systems had been improved and were in place for medication and care plan reviews however Daffodil unit did not apply them with the clarity and effectiveness of other parts of the service.

During the first day of the inspection on 18 July 2017 we asked for further information and assurances from the registered manager of the safe handling of medicines on Daffodil unit. This was to mitigate the risks associated with the medicines management that we had found on that day. This information was provided

and on the second day of our inspection 21 July 2017 we saw that appropriate action had been taken to mitigate the immediate risks to people in respect of medicines management and greater oversight in place. However improvement was required to continue and embed this.

We found a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider had not ensured that the systems in place were effective to make sure the nutritional and hydration needs of people were accurately recorded and monitored. A requirement notice was issued.

We found that the registered provider had met Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. This was because the service had improved procedures for obtaining consent to care and treatment and the practices were in line with current legislation and guidance.

We have made the following recommendations following the inspection 18 and 21 July 2017:

We have made a recommendation that the service seek advice and guidance from a reputable source on support and training for nursing staff on the use of audits and monitoring of practices to help ensure a consistent level of medicines monitoring within the home.

We have made a recommendation in relation to the development of head injury protocols within the home.

We have made a recommendation in relation to continuously reviewing staffing levels in line with changes in dependency.

We have made a recommendation regarding the recruitment procedures in use in regard obtaining references from previous employers.

We have made a recommendation that the service finds out more about training for staff, based on current best practice, in relation to the needs and management of people at the end of their life.

We have made a recommendation at the last inspection that advice and guidance be sought about the management of complaints in the service. We found that formal complaints were now being managed but that verbal complaints still needed greater attention and a prompt response.

You can see what action we told the provider to take at the back of the full version of the report.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Dalton Court is a purpose built nursing home for up to 60 older people and for people living with complex nursing care needs. It is divided into two units. Daffodil unit for people who are living with dementia on the top floor and the Orchard unit on the ground floor for people with mobility and health issues. All bedrooms have en suite toilet and shower facilities. There are accessible gardens for people to use. A mini bus is available for trips out and for attending appointments. At the time of the inspection there were 58 people living in the home.

The service had a registered manager in post and they had been in post since September 2016. 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.

All of the staff we spoke with during our inspection told us of improvements to the staff morale in the home since the new registered manager had started. We were told by a visitor that since the new manager had been appointed "Things have improved".

We observed staff supporting people who used this service in some of the communal areas and with meals and activities. People were treated with respect by staff who spoke with them in a friendly and supportive way. We saw that staff promoted people's privacy and dignity. Staff knocked on doors and announced themselves before walking into people's private bedrooms and kept all doors closed during personal care. People who used the service told us that staff were "kind" and "nice".

We noted that staffing levels could fluctuate and that were not always in line with the levels indicated by the dependency tool being used. Recruitment was underway to increase the permanent staff establishment to a level where staffing was consistent and continuously reviewed against identified levels of dependency.

We observed the service of the lunchtime meal and looked at a sample of the records relating to the support people received with eating and drinking. Staff helped people with their meals but the nutritional and hydration needs of people were not always accurately recorded and monitored.

We found that staff training and development had improved and that staff felt they were receiving training and support to carry out their roles and responsibilities. There remained some gaps in staff skills and knowledge but the manager was monitoring training and looking for opportunities to access additional training for staff to extend their skills and knowledge.

The service followed the Mental Capacity Act 2005 Code of practice and Deprivation of Liberty Safeguards. This helped to protect the rights of people who were not able to make important decisions themselves. People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible.

We saw that there were systems in place to assess the quality of the services in the home. There was a programme in use to monitor or 'audit' the service provision, to try to identify areas of weakness and then address them. However, this was not being applied effectively across all areas of the service and there remained some inconsistencies in care plan reviewing to make sure all information was always up to date. During the inspection the registered manager increased auditing systems by doing a full check of medication systems. This additional monitoring needed to continue to sustain any improvements.

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.

We found that whilst people on Orchard unit received their medicines safely
people living on Daffodil unit were not always fully protected against the risks associated with the use and management of medicines.

Nursing and care staff levels fluctuated and were not always in line with the levels indicated by the dependency tool being used.

The service had not always followed its own procedures on obtaining references from employers.

Some accidents and injuries that had occurred in the home had not been notified to CQC as required by regulation.

Is the service effective?

Requires Improvement

The service was not always safe.

We found that whilst people on Orchard unit received their medicines safely
people living on Daffodil unit were not always fully protected against the risks associated with the use and management of medicines.

Nursing and care staff levels fluctuated and were not always in line with the levels indicated by the dependency tool being used.

The service had not always followed its own procedures on obtaining references from employers.

Some accidents and injuries that had occurred in the home had not been notified to CQC as required by regulation.

Is the service caring?

Good

The service was caring.

The privacy and dignity of people who lived in the home were being promoted.

The environment was welcoming and was being developed to support the independence of the people who were living with dementia.

Staff we spoke with understood the importance of good end of life care. However, the registered provider had not made sure end of life care was included in the core staff training.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some people who used this service did not have care or treatment that had been reviewed and personalised specifically for them. We found some gaps in person centred care planning

There was a system for logging formal comments made about the service and the care received. Comments or informal complaints were not being given the same level of importance.

People who used this service were supported to take part in activities within the home, maintain family relationships and those in the local community.

Is the service well-led?

Requires Improvement

he service was not always well led.

We observed positive morale throughout the staff team. When we
discussed people's needs the registered manager showed good knowledge about the people in their care.

Improvements were evident in areas of the service but there were still some areas where the registered provider was not meeting the regulations.

Quality assurance audits were in place and being done but had not always highlight shortfalls found at this inspection.

Some accidents and injuries that had occurred in the home had not been notified to CQC as required by regulation.

Dalton Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 took place over two days 18 July and 21 July 2017. The first day was unannounced and we told the registered manager we would return for the second. The inspection was carried out by two adult social care inspectors, a pharmacist inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the course of our inspection we spoke with 20 people who lived in the home we spoke with 13 relatives/visitors, three registered nurses, five care staff, a member of the home's nursing 'bank' staff, two administrative staff, and four ancillary staff that included domestic, laundry, maintenance and activities staff. We spoke with the registered manager, the operations manager and the managing director of the organisation. We looked at the care plans for the people living in the home and we looked at nine of people's care and management plans in greater detail.

We observed the care and support staff provided to people in the communal areas of the home and at meal times. We spoke with people in communal areas and in private in their bedrooms. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not easily talk with us because they were living with dementia. It is a useful tool to help us assess the quality of interactions between people who use a service and the staff who support them.

We reviewed recruitment files belonging to staff members who had been recruited since the last inspection. We also viewed other documentation that was relevant to the management of the service including quality assurance and monitoring systems and training records. We looked at records that related to how the home

was being managed.

We looked at records, medicines and care plans relating to the use of medicines in detail for seven people living on the two units. We observed medicines being handled and discussed medicines handling with the staff involved.

Before the inspection we reviewed the information we held about the service. We looked at any information from other agencies including the local authority and contact from people using the service, professionals involved in their care and/or family or carers. We looked at the information we held about statutory notifications sent to us about incidents and accidents affecting the service and people living there. A statutory notification is information about important events that the provider is required to send to us by law. We looked at the information we held on safeguarding referrals and applications the manager had made under deprivation of liberty safeguards.

Requires Improvement

Our findings

People we spoke with who lived at Dalton Court told us about living there. People who were able to tell us how they felt said that they felt safe living there. One person told us, "I feel much happier here than where I was living before". Another commented, "I am happy here I am well cared for, my family come and visit whenever they can". We were told by one person, "I am happy here, the staff do what they can, but are always so busy".

Relatives we spoke with also said they felt their relatives were safe and that they would inform staff and the registered manager if they were worried about safety or anything else. There were differing opinions expressed to us about staffing. One visiting relative said "[Relative] been here several years, this place used to be faultless, now they are always understaffed and the staff turnover is horrendous". Another relative told us, "The carers here are some of the best they've had in the last five years; it's a hard job they are going all the time 8am-8pm".

A staff member we asked about the staff levels told us, "We don't get the time to support how we would like to, the staff turnover doesn't help that either". From our observations, staff were kept busy due to the high needs of several of the people who lived there but they were cheerful, pleasant and worked together well. A staff member told us "Things are getting better since [registered manager] came and we help each other out when we can. Visitors are helpful also as they can feed people when appropriate. We definitely need more staff, as sometimes we have to stay longer".

At the last inspection in June 2016 we had found that medicines were not managed safely and people were placed at risk of receiving their medicines not as prescribed. At this inspection there had been significant improvements but we also saw there was inconsistency in the level of improvement between the two units. Whilst medication management on Orchard unit, where people had physical nursing needs, had been improved, was being well managed and the improvements maintained, Daffodil unit, where people were living with dementia, still needed to be consistent in its medication administration and management. Because records had not been as well monitored on Daffodil unit considerable time had to be spent tracking down records to show what had happened to some medicines. Well maintained and consistent record keeping and monitoring would have avoided that.

We looked at people's medication administration records (MARs) and examined seven of the 60 records for people who lived in the home in detail and across the two units. We looked at the records of two people that received their medicine 'covertly,' disguised in food or drink. Assessments had been done to ensure

medicines were given in the person's best interest and information regarding covert administration had been included in the MAR record. On Daffodil unit, one person had specific needs that staff were familiar with and clearly understood how to give their medicines, however the information was not documented and unfamiliar staff may not know what to do.

Controlled drugs were stored in suitable controlled drugs cupboards and access to them was restricted. We found one discrepancy on Daffodil unit where one item had been destroyed and not removed from the register. We informed the unit manager who investigated the issue and corrected the record during the inspection. We saw evidence of regular balance checks of controlled drugs being done on both units, however the recording issue had not been discovered.

We saw improvements to the 'when required' documentation for the residents on Orchard unit. The records were personalised and instructions were clear. However, on Daffodil we found some people without this information in their record. We also found people that were offered medicine 'when required' even though it had been prescribed as a regular medicine and incorrect coding had been used on the MAR chart. The manager arranged for a GP to review these people and their prescriptions to be altered accordingly.

We examined the records of a person who was prescribed an essential medicine that had a varying dosage. The medicine record was not completed accurately and a concern was raised with the manager that they may have been given too much. The registered manager took action and gave us assurance that the problem was a recording issue and the medicine had been given properly. We found a medicine had been signed as given for two days in the previous week but the medicine was still in the trolley. The manager investigated and staff said they had signed the chart before realising the person was asleep. This meant that we could not be sure if any medicines had been given as recorded.

Medicines were stored securely in locked cupboards and temperature sensitive medicine was stored in a locked fridge. There was evidence of daily monitoring which complied with guidance and all medicines were kept safely. We watched some people being given their lunchtime medicines. Staff gave medicines in a kind and patient way and signed the records after the person had taken their medicine. We observed a medicine being prepared and given to a person that had medicine disguised in food. This was done properly and sensitively.

Orchard unit had clear personalised documentation for each person requiring their medicine to be given via their percutaneous endoscopic gastrostomy (PEG) tube. There was also clear information in the MAR records for a people requiring insulin for diabetes.

Medicines audits or checks were being carried out on a monthly basis by the unit managers. We saw that issues had been identified but actions had not always been monitored to correct the problems found. These audits had not identified all the concerns we had seen on Daffodil unit during this inspection. The registered manager produced an action plan and took action on this during the period of this inspection. This was to help prevent a repetition of the concerns we had found and to mitigate any risks associated with them. Stock balance sheets were created, when required protocols were produced, people had medicine reviews and staff were given supervision to use the correct MAR coding.

We looked at accident records held in the home and found that accidents and incidents and injuries that affected people living in the home were being recorded and monitored internally. They were recorded on incident forms and stated what staff had done, such as give first aid, manage head injuries, contact the ambulance service, out of hour's doctors and/or transfer people to hospital for x-rays and assessment. We noted that the service did not have formal protocol for the management of head injuries so staff had not

direct guidance to follow. However, the records of incidents kept internally indicated that staff had managed the accidents and incidents and obtained assistance when needed.

We looked at the staffing rotas for the previous four weeks and spoke to people living at the home and staff about the staffing levels. We saw that staff levels had fluctuated on day duty and were not always in line with the levels indicated by the dependency tool being used. For example, on Daffodil unit, where people were living with dementia, the last dependency tool assessment indicated that there should be 1.5 nursing staff on duty on a day shift and five to six care staff, which included the hostesses who helped people with meals and drinks. The actual care staffing over the previous week had been six care staff on duty for three days, then five for three days and then four staff for one day. On that one day the carer levels were down 11 hours on what was indicated. The staffing tool showed the nursing staff levels for the week on that unit had not been 1.5 but one registered nurse on day duty. This made the nursing staff levels for the week 3.5 days down. Levels of staff had altered although there had not been any changes in dependency noted to indicate reductions were warranted.

The staffing levels using the dependency /staffing tool looked to be more aspirational than always actual. When examined during the inspection the information about one person's level of dependency was not correct and reflected in the dependency assessment. We spoke with the registered manager about the management and monitoring of staff levels and they acknowledged the service needed to improve the consistency of its staffing provision. We noted that the registered manager had been trying to cover all shifts to an adequate level and worked night shifts themselves to provide cover and try to maintain safe staffing levels at night. A member of night staff had left at short notice and this had put added pressure on the staffing establishment.

There were sufficient staff available to meet people's personal care needs but this was not always in a person centred way as staff were constantly busy attending to people's needs. This made the approach in the home more task orientated to get work done rather than person centred and focused around the individual. In order to try to maintain staffing levels the registered manager had also obtained help from staff from other homes owned by the registered provider. They also had some experienced bank nurses and used one agency nurse regularly to promote continuity. A relative also told us, "When they're short on nurses here two can get sent down from the home in Scotland, I believe".

The registered manager was able to confirm that the rotas were covered in line with the levels of dependency in the home by the second day of the inspection. Recruitment was also underway and the manager confirmed they had just recruited some additional permanent and bank nursing staff. This should allow them to be able to provide the level of nursing cover indicated by their dependency assessments on Daffodil unit where people were living with dementia. There were also plans to implement a late evening shift to support the night staff during the busy evening period when people might be wanting to go to bed.

We looked at the recruitment files of staff who had been employed at Dalton Court since our last inspection. The registered provider had started to use a software system overseen centrally to manage recruitment. The records available to us made it difficult to be sure, on site, that all the necessary checks had been carried out. However, the registered manager and administration staff did their utmost to get information to support that checks had been properly carried out. This issue was being escalated through the organisation so this could be addressed. We noted that a reference had been provided in line with the organisations own procedures and a reference had been accepted from a colleague rather than the last employer. We recommend that the service reviews the use of its own policies and procedures in regard to obtaining references from previous employers.

Requires Improvement

Our findings

We received some positive comments about the staff skills in the home. We were told by a relative, "Two senior carers are spot on". A person who lived there said, "The two night nurses work hard, staff are getting better trained now". Another relative told us, "The nurses and carers are excellent, generally, but some of the young ones don't seem to know much".

We spoke with people who lived at Dalton Court and their relatives about the food on offer and we joined people on Daffodil unit for their lunch time meal. We also observed the lunch time on Orchard unit. We found a range of views being expressed about food. A relative spoke with us about the food on offer to people and said, "I have complained, the food can be disgusting. I have taken and provided photos of meals showing soggy black chips, raw doughnuts taken straight from the freezer, Cornish Pasties from the freezer, cooked but still bits frozen inside and still served up". The relative was concerned about the risk of food poisoning, as they had found some food was not properly defrosted and cooked. The relative showed us the photographs they had taken and had shown to the registered manager. We were unable to identify what some of the meals were from the photographs.

We were told by relatives, "Christmas dinner, the plates and the turkey were cold, and no plate warmer here" and "I contacted Amore HQ to be told there is no catering manager. Another visitor said "Sometimes the food is like slops on a plate, this home used to be a home from home and has gone down".

Another relative told us, "Sometimes there is a good meal, but they don't season food, I make up fluids in [relative's] room myself". A relative said "Everything else here is good, it's just the food that is awful". The expert by experience took lunch with people who lived on Daffodil unit and sampled a chicken meal and found the food to be warm but "very bland" in flavour. Relatives showed us a fruit crumble dessert, served that day, and the fruit was not cooked through and was still hard. We did observe home baked cakes and biscuits being taken out to people during the day and these were well received.

During our lunch time on Daffodil unit we observed staff coming and going taking out meals and three staff assisting people eat and enjoy their meal at the tables. Care assistants sat at the tables with people and there was some good and positive interactions between staff and people living there. Some people struggled to eat their lunch independently. We observed that people did not have adapted cutlery offered or plate guards to assist them to eat their meals more independently. Staff members we asked said they "assist" those with "needs" first.

People were offered a choice of meal, however, this was done verbally. There were no pictorial menus available for people to see the food being offered. Using pictures of the food offered would help people living with dementia to make more independent choices.

We looked at the ways in which people were supported with their eating and drinking to have sufficient fluids. We looked at how fluids were recorded and monitored for people who needed this. The fluid intake records were not always completed by staff or dated so we could not be sure how much fluid people were taking in a 24 hour period. According to the amounts recorded on one chart the person had only received 540 millilitres of fluid over five days. We also noted for one person receiving thickened fluids there was no assessment on this and the consistency needed.

We looked at how people's weight was being monitored and managed. People were assessed on an individual basis and nutrition care planning showed people's needs and preferences in most cases. We looked at the care records for one person on Daffodil unit who had lost three kilograms in weight in a seven week period. The nutritional care plan had been reviewed but this weight loss had not been identified and action taken promptly. We also noted that some scores for nutritional risk were not being done accurately so giving an incorrect indication of the actual risk. We were also told by a person who lived there and their visitor that weight gain was causing them mobility problems but they had not had support from a dietician to help them.

We noted differences between the two units in the management of weight loss. One person on Orchard unit had lost seven kilograms over a six month period and had been referred to the dietician and had a risk assessment for weight loss put in place and was taking a fortified diet.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (meeting nutritional and hydration needs). The registered provider had not made sure that appetising food was available and that food and fluid intake was accurately monitored and had not always taken appropriate action if people's weight fluctuated and always obtain specialist nutritional advice.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At the last inspection in June 2016 we had found that mental capacity assessments had not always been completed in line with the company policy and there was confusion around mental capacity assessments and best interest decisions. This had been a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations because people were placed at risk of receiving care or treatment that they had not agreed or consented to.

At this inspection 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 were being met. We saw in care records that people who had capacity to make decisions about their care and treatment had been supported to do so. Some people were not able to make some important decisions about their care or lives

due to living with dementia. We looked at care plans to see how decisions had been made around their treatment choices and 'do not attempt cardio pulmonary resuscitation' (DNACPR). The records in place showed that the principles of the Mental Capacity Act 2005 Code of Practice were being used when assessing a person's ability to make a particular decision. Staff had received training on the MCA and those we spoke with understood the basic principles of the act. We did note however that one person's DoLs application to the supervisory authority had not mentioned the sensor mat that was in use. We raised this with the registered manager to address.

We noted that the information around who held Power of Attorney for a person was being recorded so staff knew who had this in place. Powers of Attorney show who has legal authority to make decisions on a person's behalf when they cannot do so themselves and may be for financial and/or care and welfare needs. However it was not always made clear if the PoA was for finances or health and welfare or both. The registered manager told us a matrix was being developed to capture all relevant information on this.

We looked at staff training records and the training programmes in place for staff. There was an on going programme of staff training in place and staff were being given the opportunity for supervision. There was a mixture of face to face and also e- learning for a number of the training topics. We spoke with a new member of care staff who told us, "I like it here, I think things are in place around my training and I am looking forward to that". They confirmed that had received an induction and had worked alongside experienced staff when they first started to work at the home.

We looked at the formal training provided for nursing staff on the use of equipment at the end of life. The registered manager told us that she made sure that the registered nurses practiced setting up and priming syringe drivers so they were familiar with its use. [A syringe driver is a pump that delivers a measured dose of a medication] for the provision of effective symptom control in palliative care]. We recommend that the service find out more about formal accredited training for nursing staff on the use of syringe drivers and the supporting documentation and protocols.

We saw that people could move around the home as they wanted and there was signage in place to support people living with dementia. This provided visual information to help people to know where facilities like toilets were. Records indicated that staff had received 'dementia awareness' training to help them to understand the condition and how they could support people living with it.

Good

Our findings

We asked people who lived at Dalton Court and their relatives about the care and support being provided. One person who lived there said, "It's good here" and another said, "I think I am being well cared for". We saw staff talking to people in a polite and friendly manner. They called people by their preferred names as stated in their care plans.

One relative told us "My [relative] has been here for a year now and I am a different person as was not coping very well at home. I find the staff, loving, caring and we have a good relationship. I go away from here with a smile on my face and happy because [relative] is being well looked after". Another commented, "All the carers do seem to be genuinely caring".

We used the Short Observational Framework for inspection, (SOFI) to observe how people in the home were being supported and were spending their time. We sat with people living with dementia in a communal lounge. We saw that people who could not easily tell us their views appeared relaxed and were at ease with the staff that were supporting them. We saw staff distracting people and offering reassurance when people became upset.

The nursing and care staff we spoke with understood the importance of providing good care at the end of a person's life. Training records indicated that care staff had not received formal training on supporting people at the end of life. Training records did not evidence that permanent nursing staff had received this training or held post registration nursing qualifications or training in palliative care. However, some nurses had done training in this aspect of care in previous jobs. The service's website states palliative and end of life care is a specialism available within the service. As nursing and care staff were supporting people at the end of life they required recognised levels of training to help make sure they could provide care that reflected best practice. We recommend that the service finds out more about training for staff, based on current best practice, in relation to the needs and management of people at the end of their life.

The service encouraged families to be with their relatives when their conditions deteriorated. There were two family rooms where people could stay and be close to family at the end of life. We looked at cards and letters of thanks sent by the families of people the home had cared for. There were also some positive comments about the activities provided such as a Valentine's Day celebration that families had been able to enjoy with their relatives in the home.

We did see that staff protected people's privacy by knocking on doors to private rooms before entering and

making sure doors were closed when care was being given. All the bedrooms in the home had en suite toilet and shower facilities so people could have privacy for their personal care needs. From observations it was clear the staff were pleasant and caring and trying to do their best but we observed that sometimes residents had to wait for help to go to toilet.

Bedrooms we saw had been personalised with people's own belongings, such as photographs and ornaments to help people to feel at home. Throughout the time we spent in the home we saw that people had free access to their own rooms at any time and some people chose to remain in their own rooms for a lot of the day. This allowed people were able to spend their time in private if they wished to. Relatives of people who lived at the home told us they could visit anytime of the day or week, there were no restrictions and they felt welcomed. This meant that people were able to continue maintaining important relationships in their lives.

We found that a range of information and leaflets were available for people in the home and their relatives to help inform their choices. This included information about the services offered, about support agencies such as Age Concern and financial help. The registered manager told us about the advocacy services that people could use. An advocate is a person who is independent of the home and who can come into the home to support a person to share their views and wishes if they want or need this. We spoke with an advocate who was visiting a person during the inspection.

Requires Improvement

Our findings

During our observations in the lounges and dining rooms we spoke with people who lived in the home about how they spent their time. One person told us, "We sometimes go out and I thoroughly enjoyed going to see the film The Lady in the Van". We were also told, "I like it here, my visitors are always welcome".

A relative commented, "I come in every day… we have reviews every six months…the unit manager actively encourages our input". Another said, "I come every day and stay a while. I help with feeding and sometimes tidy up the room and do some personal care, just as I would at home, it works very well for us". Some relatives told us that if they had any worries about their relative they would either call staff them on the phone or have a chat with them when they came in.

At the last inspection in June 2016 we had found that important information and guidance for staff was missing from the care plans of some people. At this inspection we found that whilst some care plans had been updated appropriately as people's condition, wishes or needs altered, some had not.

The reviews of care in the home were not consistently identifying when changes had occurred. The reviews were not making clear what the new management plans for a person were or that some people's needs required new or more detailed assessments. For example, individual management strategies to support people during changes in condition, mobility, in medication and when end of life care was being considered. For one person we found that there was no information in their pain and behaviour management plans on the use of covert medication that was being given for pain and agitation. We found that care was not always person centred to enable staff to support people safely and with dignity during periods of changes in treatment or when agitated or distressed. [Person centred care is care or treatment that is personalised specifically around the individual and their needs and is based on up to date assessments of their needs and preferences].

On the first day of the inspection we had identified two care plans, from the nine we looked at in detail, that did not give accurate and up to date information on a person's care management and support needs. We asked the registered manager to make sure these plans were reviewed and updated before the second day of the inspection to make sure the information was an accurate reflection of need and the care management these people required.

On the second day of our inspection, 21 July 2017 we found that both care plans had been reviewed. One contained more current information to reflect the person's needs and risks. The second one still lacked

important information, such as current skin care needs and had some contradictory information, including on mobility should an emergency evacuation be needed. The assessments were still not up to date pictures of the individual's needs.

For this person we found that assessments were not being reviewed and updated. The personal evacuation plan (PEEP) had not been reviewed since 5 May 2017. In the time since then their mobility level had altered so that two carers rather than one was required for the person to make transfers safely. The person's care plan stated that they would like staff to make sure their sensor mat was positioned beside the bed at night but the person did not get out of bed at night so this was not current. The dependency level for this person was not accurate as they were no longer low risk but this had not been made clear in the person's care plan nor included in the staffing dependency tool assessment.

Some people were prescribed medicines to be used to prevent pain and other unpleasant symptoms should they be needed at the end of life care. Limited information was recorded in people's care plans to guide nurses as to when these drugs should be commenced in order to relieve unpleasant symptoms. One person had been prescribed such medication following a visit from the doctor and had all other medicines discontinued. This included medication for mental health issues. There had not been any review carried out or person centred care management plan put in place for the person who was apparently at the end of life and in need of holistic care. When we inspected we found them to be highly agitated and distressed and no medical support had been requested to assess the person's condition or how this was to be managed. We requested a medical assessment and this was obtained. We also noted that the person's falls risk assessment had not been reviewed after the medication changes.

This is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service did not have care or treatment that had been reviewed and personalised specifically for them.

At our last inspection we had made a recommendation that the service seek advice and guidance about managing complaints. We found that the service had a complaints procedure that was on display in the home for people living there and their visitors to refer to and use. There was a clear system in place for logging any formal/written complaints received and this recorded any correspondence and what had been done in response.

We spoke with three different relatives who told us they had raised verbal complaints about the food in the home but their concerns had not been responded to and there had not been any action they were aware of. We spoke with the registered manager about this. We recommend that the service seek guidance on the management of verbal complaints and keeping people informed of the progress of a verbal complaint.

People's care records showed that their personal and health care needs were being assessed prior to admission to the home. The information gathered had been used to develop care plans. We found evidence that people were being referred to their own GP's as well as other health professionals and services for treatment and assessments. Where possible people were being supported to make their own daily choices and take part in activities outside the home as well as within.

We found that people were able to follow their own beliefs and faiths and see their own priests and clergy as well as take part in religious services. We spoke with a local clergyman who had been in the home to give monthly holy communion to those who wanted this. They told us that part of their role was pastoral and to listen to people and let them speak about what they felt or thought. They told us that they had never found anything "untoward" and that staff had, in their experience, "Always been polite and patient even with

people who can be quite difficult".

The home had a programme of organised activities and dedicated activities staff to support this. We saw on the home's notice boards many pictures of social events, trips out and celebrations that people living there had taken part in. We saw that the hairdresser came to visit twice a week to provide this service.

Information on people's preferred social, recreational and religious preferences were recorded in their individual care plans. One person went out to a church group once a week supported by care staff. This allowed them to maintain their social links outside the home. They told us that this was important for them.

We observed that there were attractive gardens with patio areas and garden furniture leading off the ground floor Orchard unit. There were raised vegetable beds at the back of the home and some people liked to spend time gardening. The home had its own gardener and they supported people to do gardening tasks such as planting and potting. The weather on the day of our visit was very warm and people who used this service were able to access the gardens and join in activities outside in the fresh air.

We saw that staff had taken on a project to develop a sensory room in the home for the people who lived there. We saw this room in use and observed it was a relaxing and calming place with subdued lighting and soft music. It provided people with a calm and supportive environment if they were distressed or upset. Staff had raised the idea of its use and value to people and had taken the idea forward to develop a useful facility for the people who lived there.

Requires Improvement

Our findings

One person who lived in the home told us, "Yes, I do think it's well run, seems all right to me". A relative commented, "The manager is always interested when we speak, but sometimes it takes some time to get things done and she's busy and can forget".

We asked relatives about meetings in the home where they and their relatives could give feedback on service provision. One relative told us these were held approximately three monthly but another relative told us "It's not well attended, seems the old faithful attend this". Another relative commented to us, "The manager didn't come to the last residents meeting anyway".

All of the staff we spoke to during our inspection told us of improvements to staff morale in the home since the new registered manager had started. We were told by a visitor that since the new manager had been appointed "Things have improved somewhat which has helped staff morale. Before [registered manager] came things were dreadful". We noted that the registered manager did make herself available to staff and visitors and spent time on the units. We found the registered manager was familiar with people who lived at the service and their needs. When we discussed people's needs the manager showed good knowledge about the people who lived there.

We observed that a copy of the last CQC inspection report was available to people using and working at Dalton Court. The registered provider had clearly displayed their CQC rating in the foyer to the home.

We found that the registered provider had not ensured that CQC had been notified of the all the accidents and injuries that had occurred in the home as they were required to under the regulations. We looked at records from January 2017 to the date of the inspection and found that there had been a failure to notify CQC about at least 15 injuries people had sustained where they should have been notified. The failure to notify CQC meant we had not been able to check that the registered provider had taken appropriate action at the time of these incidents and accidents so that, if needed, action could be taken to protect the person or their rights. We told the registered manager they needed to report in line with Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

The failure to notify us of injury as outlined in the registration regulations is a breach of the registered provider's condition of registration and this matter will be dealt with outside of the inspection process. We spoke with the registered manager about this failure and the breach of regulation. We informed them that that we would deal with this breach separately.

The service had a registered manager in post, as required by their registration with the CQC, at the time of this inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

There were systems in place to assess the quality of the services provided in the home and records of the checks made. The registered provider had a system of checks or 'audits' in place for the registered manager and unit managers to use to undertake quality monitoring across all the different departments within the home. We could see that some had been done and had highlighted issues in some areas. However, some audits had not been consistently effective in identifying the concerns we had seen during this inspection on Daffodil unit.

This was most evident in the monitoring of medication management and procedures. Medicines audits were being carried out monthly by the unit managers. We saw that there had been times when issues had been identified but no actions or timescales had been set to correct the problems found. It was also evident in the incomplete care plan and risk assessment reviews we saw that had been carried out by nursing staff. We saw that there was a difference in performance between the two floors and the work needed to continue to raise the performance of Daffodil unit.

We discussed with the registered manager and managing director the difference in medicines management and care planning on the two units. They demonstrated a clear recognition that staff needed their skills improved and greater management scrutiny on Daffodil. Both confirmed this would be done swiftly to improve the practices on Daffodil to the level of performance seen on Orchard. We recommend that the service seek advice and guidance from a reputable source on support and training for nursing staff on the use of audits and monitoring of practices to help ensure a consistent level of medicines monitoring within the home.

We saw that the registered manager was trying to obtain people's views and feedback in a variety of ways. There were records of the staff meetings being held in the home. This helped to give staff the opportunity to raise issues and discuss practice, care matters, and promote communication about what was going on. There were heads of department meetings on a daily basis to deal with any pressing matters that needed attention. We saw records of 'residents activity meetings' when general matters were discussed. There were also quarterly 'residents and relatives' meetings. A care home website was also used to gather opinions on the service from reviews. There were two reviews posted by relatives within the last three months and both were positive about the service and rated them highly.

We noted that some improvements had been made in monitoring some aspects of the service. The registered manager had improved the way in which accidents were being recorded for internal monitoring and analysis for patterns and triggers. Training was also monitored and a check kept on where staff were up to with their e-learning. There were also support and monitoring visits from the operations manager and the service was making some progress with improving its quality monitoring.

We spoke with the registered manager of the home, the operations manager and the managing director during the inspection. All were responsive to any issues raised, took action quickly to mitigate risk when raised with them and gave us proposed courses of action to make necessary improvements quickly. The registered manager developed an action plan for inspectors to see what was being done and what was being implemented during the inspection. We could see there was a commitment within the senior management team to make the improvements identified as quickly as they could sustainably do so.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered provider had not made sure that appetising food was available and that food and fluid intake was accurately monitored and had not always taken appropriate action if people's weight fluctuated and always obtain specialist nutritional advice.