Care South

# Dorset House

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| Is the service safe? | Good |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Good |

# Summary of findings

## Overall summary

This comprehensive inspection took place on 19 March and 10 April 2018 and was unannounced. Following a comprehensive inspection in August 2015 we rated the service as good overall, with no breaches of legal requirements. We subsequently inspected the service in June 2016, in response to information of concern about someone falling on the stairs. The June 2016 inspection considered only the key question of Safe, and identified breaches of legal requirements in relation to safe care and treatment. We rated Safe as requires improvement, although the overall rating was unchanged. The breaches concerned shortcomings in risk assessment and management and the administration of medicines. Improvements have since been made to meet the relevant requirements.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question Safe to at least good. They told us they would meet the relevant requirements by 5 July 2016. At this inspection we found the improvements had been sustained. The evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. The service met all relevant fundamental standards. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

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

Dorset House accommodates up to 52 older people in one building. There are two floors, which are connected by a passenger lift. Nursing care is not provided. When we inspected there were 38 people there, many of whom were living with dementia.

There was a registered manager, which is a requirement of the service's registration. 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.

At the last inspection in June 2016, we found shortcomings in relation to risk assessment and management, with particular reference to the stairs, and the administration of medicines. Some people had not received pain relief when they might have needed this. One person had missed a number of doses of some of their medicines, yet their GP had not been consulted about this. These constituted breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider took immediate steps to address the shortcomings and returned an action plan, stating they would meet the legal requirements by 5 July 2016. At the current inspection we found the relevant legal requirements had been met.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. The provider had updated their risk assessments and put measures in place to manage the risks stairs presented to people. There was no longer open access to stairways and people were supported to use the lift instead.

People's medicines were managed and administered safely. Staff who administered medicines were trained and competent to do so.

People were treated with kindness and compassion. Their privacy, dignity and independence was respected and promoted. The care staff and managers knew and respected the people they were caring for.

People were protected against abuse and neglect. Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe.

Staffing levels were sufficient for people to receive care they needed. The registered manager acknowledged that call bell responses had at times been slow and was already acting to improve these.

Safety was promoted in the staff recruitment process, with pre-employment checks to help ensure staff were of good character and suitable to work in a care setting.

The premises and equipment were well maintained. The building was visibly clean and smelt fresh. Staff had training in infection prevention and control, including hand hygiene. They used protective equipment, such as disposable gloves and confirmed this was readily available.

Staff followed clear reporting procedures for accidents and incidents. There was robust oversight by the registered manager and by the provider's senior management team.

People's physical, mental health and social needs were assessed holistically, and care was planned and delivered accordingly. Assessments and care plans were reviewed regularly with the involvement of people and their relatives. People received individualised care that was responsive to their needs.

Technology and equipment was used to enhance the delivery of care and support

Care was delivered by staff with the skills and knowledge to provide effective support.

People told us the food was very good, always served hot and with ample portions. Where people required assistance from staff, this was provided sensitively, at the person's pace.

People's weights were monitored and appropriate action taken if people were identified as being at risk of malnutrition, such as pursuing referral to a dietitian. Similarly, if people were observed to have difficulty swallowing, a swallowing assessment was sought with a speech and language therapist.

People had access to healthcare services, such as doctors and district nurses, and were supported to manage their health.

Staff worked in line with the requirements of the Mental Capacity Act 2005, including the deprivation of liberty safeguards. People were supported to express their views and to be involved in decisions about their care.

The service was actively involved in building community connections. Many people using the service and its

staff were drawn from the local community.

A team of activity coordinators facilitated a programme of individual and group activities based on people's interests, needs and secret ambitions.

People's concerns and complaints were taken seriously and used to improve the service.

People were supported, at the end of their lives, to have a comfortable and dignified death.

The service had an open, friendly, informal culture. The registered manager and deputy were accessible to people, relatives and staff. Staff morale had improved since the last inspection and there was a sense of more going on at Dorset House. This included the development of links with local community organisations, which had benefited both residents and staff. Staff were supported through observed practice and supervision.

The service operated openly and transparently. Whenever there was an accident or incident involving a person who used the service, the management team exercised their duty of candour, ensuring that the person, and where appropriate their next of kin, was kept informed. Staff understood and had confidence in the provider's whistleblowing procedures.

The registered manager and provider maintained oversight of the service, to manage risks, maintain and improve the quality of the service and meet legal requirements.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service has improved to Good.

Risks to people were assessed and managed safely, in the least restrictive way possible. The premises were kept clean and were regularly maintained.

Medicines were stored securely and people received them as prescribed.

There were enough safely recruited staff on duty to meet people's support needs, although on occasions people had to wait for care at busy periods.

### Is the service effective?

Good

The service remains Good.

### Is the service caring?

Good

The service remains Good.

### Is the service responsive?

Good

The service remains Good.

### Is the service well-led?

Good

The service remains Good.

# Dorset House

**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 was planned to check 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 was a routine comprehensive inspection, which had not been prompted by information of concern.

The inspection took place on 19 March and 10 April 2018, and was unannounced.

The inspection team comprised an adult social care 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, in this case care services for older people.

Before the inspection we reviewed information we held about the service. This included notifications the service had sent us and information from other parties. The provider had submitted a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We also obtained feedback from two health care professionals and commissioners of services.

During the inspection, we met people who used the service and spoke with five of them, and with three visitors. We also spoke with three staff, the deputy manager, the registered manager and the nominated individual. We 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 made general observations around the service and reviewed records. These included five people's care plans and records including their medicines records, four staff files, quality monitoring audits and accident and incident records.

Good

# Is the service safe?

## Our findings

At the last inspection in June 2016, we found shortcomings in relation to risk assessment and management, with particular reference to the stairs, and the administration of medicines. Some people had not received pain relief when they might have needed this. One person had missed a number of doses of some of their medicines, yet their GP had not been consulted about this. These constituted breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider took immediate steps to address the shortcomings and returned an action plan, stating they would meet the legal requirements by 5 July 2016. At the current inspection we found the relevant legal requirements had been met.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. Risk assessments covered areas such as moving and handling, risk of falls, use of bed rails, vulnerability to pressure sores, malnutrition and choking. These were reviewed at regular intervals or when people's needs changed, and were updated as necessary. As at previous inspections, people mobilised around the building and were encouraged to do so. The provider had updated their risk assessments and put measures in place to manage the risks stairs presented to people. There was no longer open access to stairways and people were supported to use the lift instead.

People's medicines were managed and administered safely. Medicines were stored securely. Where people had medicines prescribed 'as necessary', staff had clear instructions as to when and how often these could be used. Staff also had clear instructions for administering prescribed skin creams. There were procedures for ensuring sufficient quantities of people's medicines were stocked, so people could receive these as prescribed. The computerised medicines recording system identified when medicines had not been recorded and these were followed up. Staff knew people well and recognised indications that they were in pain. However, a recognised pain assessment tool was available for staff to use in event of any doubt. Medicines were audited each week to ensure amounts in stock were all accounted for and to check for errors in recording. Staff who administered medicines were trained to do so, and they were observed at least annually to ensure they were competent in handling medicines.

People were protected against abuse and neglect. People and visitors told us they felt they or their loved ones were safe living or staying at Dorset House. For example, a person commented, "I feel safe and comfortable living here." Information about reporting concerns about abuse and neglect was displayed in public areas. Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. They had safeguarding training each year, and the registered manager had attended training about managers' responsibilities in relation to safeguarding. Where staff had identified safeguarding concerns during the year, the management team had referred these to the local authority safeguarding team. The service had worked in cooperation with the local authority safeguarding team to investigate concerns.

Staffing levels were sufficient for people to receive care they needed. People said there were generally enough staff on duty such that they did not have to wait a long time for care. Comments included: "At all

times there were always enough staff on duty at times to help us." One person told us they sometimes had to wait for a long time for their call bell to be answered, particularly when they wanted to get up in the morning. The registered manager confirmed that call bell responses had at times been slow. They had taken action to reduce delays and continued to monitor this. Staff confirmed there were enough of them on duty to be able to provide the support people needed in an unhurried way, although this was challenging on days when sickness could not be covered. The service did endeavour to cover staff absences through staff working overtime or through the use of agency staff.

Safety was promoted in the staff recruitment process, with pre-employment checks to help ensure staff were of good character and suitable to work in a care setting. The service obtained a full employment history from candidates, with a written explanation of any gaps and reasons for leaving employment in care. Criminal records and barring checks were made with the Disclosure and Barring Service, and references taken up, prior to staff starting work.

The premises and equipment were well maintained and there had been some redecoration since the last inspection. There were regular checks on maintenance, health and safety and fire alarms and equipment. Timed practice fire evacuations took place every few months. Hoists and lifting bath seats had been checked six monthly. These checks had just fallen due and due to an administrative error the contractor for the lifting equipment had not contacted the service. The registered manager arranged for this to be done; it was completed a few days later.

The building was visibly clean and smelt fresh. An ozone cleaning machine had been acquired in recent months with a view to reducing odours and the use of cleaning chemicals. Staff had training in infection prevention and control, including hand hygiene. They used protective equipment, such as disposable gloves and confirmed this was readily available. Staff wore disposable aprons when assisting people at mealtimes.

Lessons were learned and improvements made when things went wrong. There were clear reporting procedures for accidents and incidents. Staff were encouraged to report incidents even if there was no apparent injury so any emerging risks to people could be identified, such as if a person was falling frequently. Incidents were now logged on the provider's electronic recording system as they arose, whereas previously the service had made monthly statistical returns. The Dorset House registered manager or deputy checked each report to ensure all necessary action had been taken to ensure people's safety and wellbeing. Incident reports were also monitored and analysed by the provider's head office teams for any developing trends. Accidents and incidents were reviewed at the provider's board meetings every six weeks or so. The board received reports on any situations where there had been multiple incidents, including actions taken or in progress. Emails from the provider's clinical lead and minutes of staff meetings demonstrated that learning from wider incidents and 'near misses' within the company were shared to improve safety of all who used its services.

Good

# Is the service effective?

## Our findings

People's physical, mental health and social needs were assessed holistically, and care was planned and delivered accordingly. Assessments were undertaken before people came to stay at Dorset House, so the service could be sure it was able to provide the care people needed. Protected characteristics under the Equality Act, such as religion and sexual orientation were considered as part of this process, if people wished to discuss these. Assessments and care plans were reviewed regularly with the involvement of people and their relatives.

Technology and equipment was used to enhance the delivery of care and support. Shortly after the last inspection, the service had changed its standard mattresses for an improved model, with a view to reducing pressure sores. These were specialist mattresses for preventing and treating up to grade two pressure sores. The registered manager confirmed the incidence of pressure sores had indeed reduced. No-one at the service during the inspection had a pressure sore that had started while they were at Dorset House. The registered manager and nominated individual advised us there had been a zero incidence of home-acquired pressure ulceration since the mattresses had been introduced. Another example of the use of technology was a robotic dog, research having indicated that robotic pets can benefit people who live with dementia. The service had recently started using this to provide mental stimulation, and at times when some people became agitated. The registered manager said it had been a great hit with residents and showed us a video clip of people having fun interacting with it. The service also used therapeutic lifelike baby dolls. The registered manager said these were proving very successful with men and women, who remembered their children as babies and valued the sense of purpose and responsibility looking after the dolls.

Care was delivered by staff with the skills and knowledge to provide effective support. Comments from people and relatives included: "The staff seem to know what they are doing so I think they well trained." Staff confirmed they were able to access the training they needed. Staff new to care were expected to complete the Care Certificate, which represents a nationally recognised set of standards that workers in health and social care are expected to adhere to. Key training, such as moving and handling, safeguarding and fire safety, was refreshed annually. Other training of interest and relevance to staff was also available. Training and development needs were considered during regular supervision from more senior staff and annual appraisals.

People told us the food was very good, always served hot and with ample portions. A regular visitor commented, "[Person] looks so well, now he has put on weight. He always looks clean and smart. He says the food is good and there is plenty of it." There was a choice of courses at each meal. The lunch menu was displayed on a blackboard in the dining room. People were asked what they wanted to eat when they were seated at their tables, and some were shown plated meals to help them choose. Menus were varied and enabled people to choose a balanced diet, including fruit and vegetables. One person commented that they would prefer a wider selection of vegetables. People's religious, cultural and health-related dietary needs and preferences were documented in their care records; details were kept in the kitchen also.

People ate where they chose, although most people had their meals in the dining room around tables with

small groups of other residents. Tables were set with suitable cutlery, tumblers and condiments. If people needed special cutlery or crockery to enable them to eat independently, this was provided. Where people required assistance from staff, this was provided sensitively, at the person's pace.

People's weights were monitored and appropriate action taken if people were identified as being at risk of malnutrition, such as pursuing referrals to a dietitian. Similarly, if people were observed to have difficulty swallowing, a swallowing assessment was sought with a speech and language therapist. Where speech and language therapists had devised safe swallow plans, copies were available for kitchen and dining room staff. People at risk of choking or aspiration were provided with thickened fluids and mashed or pureed foods in accordance with their safe swallow plan.

People were encouraged to eat and drink. Hot drinks were served during the morning and afternoon, with biscuits and snacks. Covered jugs of squash were available in communal areas for people to help themselves to. These were too heavy for frail people to lift; we drew this to the registered manager's attention and they organised for lighter, less full jugs that were easier for people to pick up.

People had access to healthcare services and were supported to manage their health. When people appeared unwell or asked to see a doctor, staff organised for the doctor to visit. District nurses regularly visited the service and staff also liaised with them. Each person had a hospital transfer form, which summarised their main care needs, in the event the person needed to go into hospital.

The building was purpose built as a care home, with individual bedrooms of varied sizes on the ground and first floors. People had decorated their rooms with personal pictures and possessions. There were a large lounge and four smaller lounges on the ground floor, and a further lounge upstairs. Bathroom and toilet facilities were mostly shared. There were baths on the ground and first floor adapted for people with mobility difficulties. Bathrooms and toilets were clearly signed with yellow doors, and had strategically placed grab rails for the ease of people with mobility needs. Outside, there were parking areas to the front and side of the building, an orchard to the other side and an enclosed garden at the back. This included paved areas, seating, raised vegetable and flower beds, a lawn and a summer house. People and their relatives had been consulted about planned garden improvements, such as the restoration of the summer house and were encouraged to get involved with gardening if they wished.

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's rights were protected because the staff acted in accordance with the MCA. Where people were able to give consent to aspects of their care, staff sought this before providing assistance. If there were concerns that people would not be able to consent to their care, staff assessed their mental capacity. Where they were found to lack mental capacity, a decision was made and recorded regarding the care to be provided in the person's best interests. People were involved as far as possible in this process and the relevant people, such as close relatives, were consulted. Examples of best interests decisions related to providing care and administering medicines, the use of bed rails to prevent falls from bed and restricting access to the staircase.

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). The management team had identified

where people were being deprived of their liberty and had applied to the relevant supervisory body to authorise this. Where DoLS authorisations had conditions, they ensured these were met. There was a system for tracking the expiry date of DoLS authorisations and ensuring applications for renewed authorisations were made in time.

Good

# Is the service caring?

## Our findings

People were treated with kindness and compassion. People and visitors described the staff as caring. Comments included: "It's not like your own home, but staff are lovely and kind", "[Person] is very happy here and staff are very supportive and caring despite their often challenging behaviour", "Some carers are better than others, but on the whole they are very supportive" and "I can have a shower or bath whenever I like, it is very relaxed here." Care interactions were kind, patient and sensitive to the person's needs and abilities. Staff responded quickly to people's needs. For example, over lunch in the dining room someone was calling out loudly, causing annoyance and discomfort to others. Staff took the person to eat in a quieter setting that they might prefer. The person stopped shouting out and people in the dining room became happier and more relaxed.

The care staff and managers knew and respected the people they were caring for. This was evident in the way they spoke about people to us and to each other. They discussed people with affection and were able to tell us about people's histories, preferences and interests. They also understood how people preferred to communicate. People readily approached the managers and staff to chat or to make requests. For example, someone came to ask the deputy manager about replacing their broken clock.

People were supported to express their views and to be involved in decisions about their care. They and their relatives had regular meetings with the member of staff who was their key worker, to discuss their care. This included care planning and reviews. Relatives and friends were able to visit whenever it suited them and the person they were visiting.

People's privacy, dignity and independence was respected and promoted. People received discreet assistance with personal care if they needed this. Personal care took place in private, behind closed doors. People were encouraged to do what they could for themselves, such as when washing and getting dressed. They were also encouraged, and got the assistance they needed, to maintain their mobility. We observed people moving slowly and independently, being enabled to do so. Care records were stored securely, out of public view.

Good

# Is the service responsive?

## Our findings

The service was actively involved in building community connections. People were encouraged and supported to maintain relationships with friends and family, and to maintain links locally. There were visitors throughout the inspection. The service had a strong identity as part of the local community, many people and staff having come from it. The registered manager had fostered further links through community groups. College students and the local youth centre came into the home and had involved people in redecoration of the summer house and garden fences, promoting people's involvement and independence. The youth centre had worked with people and staff to organise the summer fete. There was a relationship with a Poole marching band who visited regularly and played concerts. Outings were arranged to follow the same band when they played in the community. Players, including a premiership player, from AFC Bournemouth visited the service regularly; people enjoyed lounge football activities with them. People from Dorset House and the provider's other homes also attended an annual Christmas coffee morning at AFC Bournemouth, with football memorabilia and musical entertainment. Children from a nearby nursery visited fortnightly and people welcomed them, sharing meals together and spending time with them. There were ongoing supervised garden maintenance as part of community service orders, placements for local college students, and other links with local schools. People had been involved in a pen pal scheme, where they exchanged letters with people who lived in another Care South service.

Arrangements for social activities met people's individual needs, enabling them to live as full a life as possible. A team of activity coordinators facilitated a programme of activities based on people's interests and needs. They gathered information from people and their families about their histories, interests and secret ambitions, which provided inspiration for activities. A 'wishing well' provided a way for people to express their wishes in connection with prior and unfulfilled interests.  One person had been a keen ice skater and this activity was supported through risk assessment and involvement to enable them to enjoy their favourite activity again in later life. In another instance a person aged over 100 was supported to attend twice weekly Zumba classes, thereby maintaining extraordinary fitness at an advanced age.

Individual and group activities took place on site and from time to time in the wider community. Forthcoming activities included visits from music groups, nursery children, alpacas and a marching band. There were also regular visits from therapy dogs and their owners. A music festival was being planned for the summer, involving local bands to bring popular music for people's benefit and to further engage the local community. We observed activities staff and students with people in communal areas, chatting and playing games. On the first day of our inspection there had been snow. An activities coordinator brought a tray of snow to people in the lounges and in their rooms, to enable them to experience the texture and coldness of the snow.

People received individualised care that was responsive to their needs. Care plans reflected people's personal histories and preferences. They covered areas such as eating and drinking, moving around, pressure area care, eating and drinking, communication, personal hygiene, continence and care at night. Staff had a good understanding of care plans and followed these.

The service met the Accessible Information Standard. The Accessible Information Standard is a law that aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. People's sensory loss and communication needs were flagged up in assessments, care plans and hospital transfer forms. Staff provided the support people required in these areas. For example, people were supported to wear hearing aids or glasses where they needed these.

People's concerns and complaints were taken seriously and used to improve the service. A person commented that they felt comfortable to raise concerns or complaints; when they had done so, these had been resolved immediately. Information about how to make a complaint was available in communal areas. There had been no complaints recorded in 2018 and only four in 2017, which had been outnumbered by the compliments received. The complaints had been dealt with promptly and transparently, and complainants had recorded their satisfaction with the responses.

People were supported, at the end of their lives, to have a comfortable and dignified death. The service worked with GPs and district nurses to provide the support needed as people were dying. Staff had discussions with people and their families about their preferences regarding end of life care, if they were willing to discuss this. These discussions were recorded in 'What I want for the future' documents. The management team advised us that 90% of people had an advanced care plan written with the involvement of GPs and families, ensuring that end of life wishes were catered for and supporting a comfortable and dignified end of life. As a result people reached the end of their lives comfortably in the home, which was their choice. This was reflected in numerous thank you letters from relatives praising the home for their support and sensitivity. All family members were offered a bed to stay overnight, while their loved one was dying. In one instance, the service responded to a person's rapid deterioration, providing a specialist air mattress the same day and implementing end of life care planning. Ten staff, including night staff, were undertaking accredited training in end of life care.

Good

# Is the service well-led?

## Our findings

The service had an open, friendly, informal culture. The registered manager and deputy were present within the service seven days a week, available to support people who used the service, relatives and staff. They spent time in communal areas and were aware of the how things were at the service. Their offices were situated on a busy corridor near the front door. People, relatives and staff often stopped by to talk with them.

Staff morale had improved since the last inspection and there was a sense of more going on at Dorset House. This included the development of links with local community organisations, which had benefited both residents and staff. A relative told us how they felt their family member had benefited in all aspects of their care since the change in management: "He was back to his old self, smiling and chatting more, which is so good to see." A member of staff commented how there seemed to be more emphasis on activities now.

Staff were supported through observed practice and supervision meetings. The format for these had recently been revised; supervision meetings were now called 'Heart to Hearts'. They focused on the provider's HEART values: honesty, excellence, approach, respect and teamwork. The provider and registered manager advised us that staff at Dorset House had been very positive about this change. Staff also received information and updates about the service at staff meetings, at which they were encouraged to contribute their points of view. The registered manager regularly brought items for learning and development to staff meetings.

The service operated openly and transparently. Whenever there was an accident or incident involving a person who used the service, the management team exercised their duty of candour, ensuring that the person, and where appropriate their next of kin, was kept informed. Guidance about how to raise concerns about poor practice and modern slavery were displayed in the staff room. Staff understood the provider's whistleblowing procedures and some had raised concerns with managers about colleagues' practice. These had been taken seriously, investigated and acted upon, in consultation with the local authority safeguarding adults team.

The registered manager and provider maintained oversight of the service, to manage risks, maintain and improve the quality of the service and meet legal requirements. This had been strengthened through the introduction of new incident reporting system, which meant the provider's board and senior management teams had access to contemporaneous information that could be interrogated and analysed, rather than general monthly summaries. The provider ensured lessons learnt in one service were acted upon across all of its services. For example, following an accidental fatal fall on the stairs, a rolling barrier was installed to prevent a recurrence and similar preventative measures were put in place at the provider's other homes with open stairway access. Innovation and success in the provider's other services was also translated to Dorset House, such as the introduction of a robotic therapy pet that had proved successful in a sister home.

The registered manager was supported by the provider's board and management team. The service's operations manager visited regularly, and during the inspection, the quality manager was present for a

quarterly audit. The registered manager maintained a rolling action plan based on his own audits and those by the quality and operations manager, to drive improvements. Items were rated as red, amber or green and prioritised accordingly, with specific actions to take and deadlines for these. Current items included seeking to improve call bell response times further by implementing further checks, and improving staff awareness of Equalities Act protected characteristics, which were to be discussed in staff meetings.

The provider celebrated achievements by the home and its staff through its annual awards ceremony. Nominations were made by people, relatives and staff. Winners were selected by a panel of judges that included someone who lived in one of the provider's services, alongside the trustees and Chair of Care South. Awards were presented at a gala ceremony held at the conference facilities at AFC Bournemouth, as part of the provider's community partnership with the premiership club. Dorset House was the Home of the Year and the registered manager Home Manager of the Year in the 2017/18 season.

The inspection rating following the last inspection was clearly displayed in the hallway and on the provider's website.