Care Quality Commission

Priory Elderly Care Limited

Dalton Court Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

We visited the home on 14 May, 15 and 19 June 2015. We also met with the provider on 25 June 2015. The inspection was unannounced and in response to concerns and information received by the Care Quality Commission (CQC).

Dalton Court Care Home is registered to provide accommodation for people who require personal and/or nursing care. The home can accommodate up to 60 older people and people with complex healthcare needs. Dalton Court Care Home is operated by Amore Elderly Care Limited, a unit of the Priory Group.

Accommodation is provided in single, en-suite rooms, over two floors, with the upper floor accessible via stairs or passenger lift. There is a separate unit at the home that provides accommodation for people living with dementia.

There is a registered manager in post at the home. 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.

During our inspection of this service we found:

Summary of findings

Information recorded in care records contained gaps. For example, pre-admission assessments had not been fully completed or left blank, particularly in the areas relating to people's mental health, well-being and personality profile.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were placed at risk of receiving care and support that was not personal or centred around their individual needs and wishes. You can see what action we told the provider to take at the back of the full version of the report.

We found that the provider did not meet the requirements of the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS). Appropriate assessments of people's capacity to make decisions had not been carried out. People who used this service had their liberty restricted because they were not freely able to leave the home if they wished. Where people lack the ability to make decisions about their lifestyle, the MCA and DoLS require providers to submit applications to a 'supervisory body' for authority to restrict people's liberty.

We also found examples of incidents that had not been reported to social workers and CQC. These were potential allegations of abuse and should be referred under the Local Authorities Safeguarding procedures and a notification submitted to CQC.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people who used this service were deprived of their liberty and were not protected from abuse or improper treatment. You can see what action we told the provider to take at the back of the full version of the report.

We looked at the way in which people's medicines were handled and managed at the home. We found that medicines were not managed safely and care plans relating to the management of medical conditions were poor. The records and care plans with regards to the administration of topical medicines such as creams and ointments were poor. The management of "when required" medicines such as pain relief and sedatives was not robust. This meant that staff did not have clear guidance to help make sure people received the correct treatment, as their doctor had prescribed and at the time they needed it.

Everyone who used this service had a plan of their care and support needs. Not everyone was aware that they had a plan and whilst some staff saw care plans as a valuable source of information, others relied on their own knowledge to support people with their care needs. Care plans and records had not been maintained to provide an accurate and up to date account of people's care and support needs. There was confusing and contradictory information recorded about people's care needs. Staff had told us that communication was poor and this meant that they may not always be up to date with changes in people's care needs.

These are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not receive their medicines in a safe way or as prescribed. People were placed at risk of receiving inappropriate care, particularly when their needs changed. You can see what action we told the provider to take at the back of the full version of the report.

The service did have a complaints procedure in place, the details of which had been made available to people using the service and their relatives. However, we found that the process had not been operated effectively and some of the people we spoke to during our visit felt that they had not been listened to or that their concerns had been addressed.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because although people were able to raise concerns, they were not confident that they would be taken seriously or that action would be taken to resolve them. You can see what action we told the provider to take at the back of the full version of the report.

Monitoring audits regarding the safety and quality of the service had been undertaken. The samples we were shown during our visit to the home were of variable quality and content. The staff we spoke to at the home told us about concerns regarding staff morale, poor management of work rotas and a "bullying" style of management. Staff also told us that communication was poor and that the "management was unapproachable."

Summary of findings

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The audits were not robust and failed to identify important breaches in compliance with the regulations. Incidents were not routinely reviewed to help mitigate any risks and ensure people who used this service were safe. You can see what action we told the provider to take at the back of the full version of the report.

Some of the care plans we looked at contained DNACPR (do not attempt cardiopulmonary resuscitation) forms. We found little evidence to confirm that these decisions had been lawfully made in the best interests, or with the consent of, or proper consultation with the people they related to.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People had not been properly consulted about their wishes with regard to their end of life care and support. You can see what action we told the provider to take at the back of the full version of the report.

We observed the service of two mealtimes at the home and looked at samples of people's nutritional assessments and records. We found that people either were not supported appropriately with eating and drinking or that staff had failed to complete their nutritional records accurately.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were placed at risk of malnutrition and dehydration. You can see what action we told the provider to take at the back of the full version of the report.

We found that the home was not always adequately staffed, particularly during the night shift. People who used the service and staff working at the home told us about the low staffing levels experienced at times.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not ensured sufficient numbers of staff had been deployed in the home in order to effectively meet the needs of people who used this service. You can see what action we told the provider to take at the back of the full version of the report.

We checked the information we held about this service and compared this with the accident and incident records kept at the home. We found that the provider and registered manager had failed to notify CQC of serious events and allegations that had occurred or been made at the home.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. It is a requirement of the Care Quality Commission (Registration) Regulations 2009, that the provider must notify the Commission without delay of allegations of abuse, accidents or incidents that had involved people who used this service. This is so that we can monitor services effectively and carry out our regulatory responsibilities.

The staff we spoke to during our visit to the home told us that they did not have the skills and knowledge to safely support people who may display distressed or aggressive behaviours. We have made a recommendation that the service finds out more about training for staff, based on current best practice, in relation to the specialist needs of people living with dementia.

The people we spoke to during our visit to the home all told us that they felt safe living at Dalton Court. They told us that the staff looked after them well. However, people also said that they had noticed the nursing and care staff at the home were much busier and had less time to chat now. A relative described the staff as "fantastic" but was concerned about the numbers of staff leaving.

We noted at mealtimes that there were plenty of food options for people to choose from. We saw that the food was presented attractively and that there was fresh fruit and home bakes available for snacks.

The home was generally clean, tidy and fresh smelling. We spoke to the housekeeper during our visit to the home and were provided with information about the cleaning schedules and infection control protocols in place. These were well managed and when necessary, appropriate specialist advice had been sought.

CQC met with the provider as part of this inspection of the service. The provider had taken our concerns seriously and started to take immediate action to address the issues identified at the inspection. Additional support has

Summary of findings

been provided at the home in the form of a peripatetic manager to help and support the registered manager carry out her role and bring about the required improvements to make the service safe.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate 

The service was not safe.

People who used this service were not protected against the risks associated with the use and management of medicines. Medicines, including topical creams, were not administered and recorded correctly.

The safeguarding systems and processes in place at the home were not effective. People were not protected from the risks of harm or abuse.

There were times when there were insufficient numbers of staff on duty to effectively deliver safe and appropriate care. There were no contingency plans in place to ensure the home was always adequately staffed.

Is the service effective?

Inadequate 

The service was not effective.

Staff told us that they had not had any specialist training regarding appropriate and safe intervention and de-escalation techniques to help them support people who may display distressed or aggressive behaviours.

There was limited understanding and application of the Deprivation of Liberty Safeguards or the key requirements of the Mental Capacity Act 2005. This meant that people's human and legal rights were not respected.

People's nutritional needs were not consistently or accurately monitored and placed them at risk of poor nutrition and dehydration. Staff were not always able to support people adequately with eating and drinking at mealtimes due to staff shortages. However, we saw that people who needed help received this with care and dignity.

Care plans for the management of medicines and creams were inadequate. This meant that staff did not always have clear guidance available to them to make sure that people who used this service received appropriate care.

Is the service caring?

Requires Improvement 

The service was caring but there were inconsistencies in the caring approach.

People who used this service told us that they were happy with the care and support they received.

People looked well dressed and well cared for but staff told us that care provision was "rushed".

We found gaps in care plans where important information had been omitted, for example care plans did not detail how people wished to be cared for at the end of their life and did not include life histories.

Summary of findings

Is the service responsive?

Requires Improvement

The service is not responsive.

We were told by relatives that complaints were not listened to or taken seriously.

Staff were concerned that when poor practice had been identified, it had not been dealt with properly and that they received no feedback from management when matters of concern had been reported.

Important information about life histories, interests and activities had been missed out, including those for people living on the dementia unit.

Is the service well-led?

Requires Improvement

The service was not well-led.

We found that the quality monitoring audits carried out were not robust and that they had failed to identify the shortfalls found during our inspection of the service.

The staff we spoke to identified issues with the management and leadership styles at the home. This had led to poor staff morale.

Accidents, incidents and safeguarding matters were not routinely recorded and reviewed to help mitigate risks and improve the quality and safety of the service.

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 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 inspection took place over several days; 14 May, 15 and 19 June 2015 and was unannounced.

The inspection was carried out by two adult social care inspectors and a pharmacist inspector from CQC. The inspection team also included 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.

Before the inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider. A notification is information about important events which the service is required to send us by law. We planned the inspection using this information. We also asked the provider to submit pre-inspection information (PIR) about the service.

During the inspection we spoke to people using the service, their relatives and friends. We interviewed staff, looked at a sample of care records (pathway tracking) belonging to people who used this service and we observed staff supporting people in communal areas.

Inadequate

Is the service safe?

Our findings

All of the people we spoke to told us that they felt safe in Dalton Court. We were told by people who use the service that whenever they had used the call system, it had been quickly responded to by the staff on duty.

People said; "They (the staff) make sure you cannot hurt yourselves."

"The girls look after you well." And one person told us, "I didn't feel safe at home and that's why I came here. I'm not worried anymore."

Two people, who had lived at Dalton Court for a number of years, told us that both the nursing and care staff were much busier and hence had less time for a chat than they had previously.

One of the relatives that we spoke to during our visits thought that "The carers are fantastic and try their best, but there aren't enough of them. Staff are leaving and the new girls (staff) are very nice but they don't know my relative and don't have time to speak to them."

We checked the information we held about Dalton Court including information relating to the safeguarding of vulnerable adults. We found that the manager at the home did not always follow the correct safeguarding protocols. This meant that people who used this service were sometimes placed at risk of harm and abuse. For example we had been told of a serious allegation when a person who used this service experienced abusive treatment by two members of staff. When these allegations were investigated by social workers, it was found that the incidents had occurred and that the manager had carried out an internal investigation without informing anyone.

In another case, allegations regarding a care assistant's attitude and behaviour towards a person who used this service were not taken seriously by the management at Dalton Court and this resulted in more vulnerable people being placed at risk of abusive practices.

During the inspection we found examples of incidents that should have been reported, but were not, to social workers and CQC as potential allegations of abuse between people who used the service. We found that the home had an out of date copy of the local safeguarding procedures and, although the manager had promised to provide staff with safeguarding training, this had been delayed due to staff shortages.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were not protected from abuse or improper treatment.

The provider is required to supply CQC with information about the service prior to our inspections, including information about staff. We found that the home had experienced a high number of staff leaving the service in the last 12 months. Relatives and people who used the service told us about the low staffing levels they had experienced at times.

We looked at the staffing rotas for the home. We noted that the rotas showed frequent staff shortages, particularly at night. For example one nurse would be on duty for the whole of the home (59 service users) together with four care staff.

Most of the people that used this service had complex nursing needs and/or had a diagnosis of dementia. We found that some nights an additional nurse was on duty for two hours to help with the medicine round.

During our visit to the home we observed a member of staff sent home mid-morning to come back on duty for the night shift and we found that there were occasions when staff had insufficient amounts of rest time between shifts.

All of the staff we spoke to during our visit to the home told us about their concerns regarding the number of staff leaving the service and staff shortages on shift. We were told by staff that the staffing problem had been made worse due to the provider withdrawing enhanced payments for working nights, weekends and bank holidays. Staff told us that people "just go off sick".

We spoke to the regional operations manager about staffing levels. They told us that the home did not have any contingency plans with regard to staffing levels at the home.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

People who used the service did not always have their care and support needs met because the provider had not ensured sufficient numbers of staff had been deployed in the home.

As part of this inspection we looked at records, medicines and care plans relating to the use of medicines in detail for eight of the people that used this service. We observed medicines being handled and talked to staff and residents.

Medicines were not safely administered. We found that care plans relating to the management of medicines and medical conditions were poor and this could result in residents receiving incorrect or inappropriate treatment.

We observed the administration of oral medicines by nurses and this was done correctly. However, we found that creams were not administered correctly and we found that two medicines were out-of-stock. One was a medicine for the management of diabetes. The service user had missed fifteen doses because it was not available. This placed their health and wellbeing at risk due to not receiving their medicines that control diabetes.

Appropriate arrangements were not in place in relation to the recording of the administration of medicines. We saw that records for 'when required' pain killers did not always record the time of administration. This meant that staff could not be sure that it was safe to administer further doses by ensuring the correct time interval. Additionally, a care plan for a service user who was not able to communicate effectively failed to describe the assessment of pain for the appropriate administration of painkillers.

There was poor management of "when required" medicines. Care plans were not in place. One of the records we looked at showed that a sedating medicine had been used regularly without justification for use. We found discrepancies in care plans where dosages of medicines or consistency of thickened fluids were not correctly recorded.

The administration of skin softening and barrier (skin protecting) creams was delegated to care workers. Records for the administration of these creams were poor. There was no guidance for use and some records were missing altogether. Body maps had not been completed so there was no indication of where to apply the creams. Some creams were not labelled so there were no prescribed directions for staff to follow. This was a particular concern where people had been identified as high risk of breakdown of skin. Care plans for the use of creams were either absent or poor and did not identify the creams to use or instructions for use. This meant that care workers did not have clear guidance to follow to ensure people who used this service received correct treatment to protect their skin.

We found that medicines were not kept safely. We found a cupboard in a public area where creams were stored that was not locked. One person we spoke to had an insecure medicine in their room. There was no risk assessment in place to ensure that this was safe and the person told us that nurses gave this to them at bedtime. There were no records for this and no evidence that it had been prescribed or was appropriate to give.

We counted a sample of medicines liable to misuse, called Controlled Drugs. These samples were correct and storage was safe.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because medicines were not managed properly or safely.

Prior to our inspection of this service, we had been told of an infectious outbreak that had occurred at the home affecting many staff and many of the people that used the service. We spoke to the housekeeper during our visit to the home about her role and duties. We found that the home was clean and fresh on the days of our visits.

The manager at the service told us that infection control and prevention training had been arranged for staff and that the Health Protection Specialist for Cumbria had visited the home to provide helpful advice following the outbreak.

The housekeeper we spoke with told us about the training they had received to help ensure they carried out their role effectively and safely. She was able to tell us about the cleaning schedules that were in place and about the processes that had been followed with regards to the deep cleaning regimes during and after the infectious outbreak.

We saw from the recent staff meeting minutes that there had been discussions about infection control and prevention. Staff had been provided with instruction and guidance with regards to their roles and responsibilities in relation to infection control and prevention.

We observed that two members of staff wore varnished, false nails. One member of staff told us that they had never

Inadequate

Is the service safe?

been spoken to about their nails. We spoke to the manager about this matter because it posed a risk to infection prevention and placed people who used this service at risk of skin damage. This needed to be addressed quickly.

Inadequate

Is the service effective?

Our findings

The people we spoke to who used this service told us that they were happy with the support they received from care staff. Everyone spoken to said that the staff had a very positive attitude towards them and responded quickly to any requests. We were told;

"They (the staff) keep an eye on you to make sure you are not badly."

"The girls (the staff) are always asking you how you are."

One person told us that they had to have their food puréed. The person told us that they did "not like this at all but I am happy that this is being monitored by both the home and the dietician so I can get back onto normal food as quickly as possible."

We spoke to most of the staff that were on duty during our visits to Dalton Court, including the home manager, the operations manager and a compliance manager from within the Priory Group company. We discussed their training, support and supervision and spoke about the effectiveness of the communication methods within the home.

Staff told us that they had mandatory safety training during their induction period which was regularly refreshed by in-house trainers. We were also told that more senior care staff were encouraged to go on 'train the trainers' courses so they could set up a cascade refresher training system in the home. From the training records provided, we noted that much of the staff training had been provided by e-learning.

The manager told us that infection control training was planned and that this would be provided by the Health Protection Specialist for Cumbria. We asked about the provision of safeguarding vulnerable adults from abuse training as this should have taken place in March 2015. The manager confirmed that it had not yet taken place and provided us with dates by which this would be completed. The manager also told us of specialist training that was also planned, for example end of life care from the MacMillan nurses and refresher training for the qualified nurses with regards to the use of syringe drivers. The effective use of this type of equipment helps to ensure people coming to the end of their lives receive the medicines they need when they need them. One of the nurses we spoke to confirmed that they were encouraged to develop their careers by taking specialist courses such as tissue viability, palliative and end of life care.

Care staff we spoke to also confirmed that some training was available to them. Some people had undertaken national vocational qualifications in addition to the training provided at Dalton Court. However, staff also told us that they could not always attend training sessions because they were planned for when they were "on shift" or that they were "taken off shift to attend and this results in staff shortages on the floor." Staff told us that disciplinary action was possible if they did not attend training. They told us that they saw this as a "threat for not attending".

Some of the staff that we spoke with worked on the dementia care unit. They told us that they had not had any specialist training regarding appropriate and safe intervention and de-escalation techniques to help them manage people who may display distressed or aggressive behaviours. One member of staff described a recent traumatic event that involved people who lived in the dementia unit. The member of staff was upset about the incident and told us that they did not have the skills to handle the situation well. They added that they had not been debriefed or supported following the incident.

We observed the morning shift "flash meeting". This meeting was used to pass information between the senior staff on the floor, the chef, the housekeeper and the home manager. The information communicated at this meeting including issues with staffing levels, details of the menu and snacks planned for the day, leisure and social activities planned and any concerns regarding the welfare of people who used the service. Although this method of communication worked well for the staff involved, care staff working the floor told us that; "Communication is poor, we don't get a handover anymore" and "senior carers get a handover but we care staff don't get told much."

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). The Mental Capacity Act (MCA) and DoLS provide legal safeguards for people who may be unable to make decisions about their care. The records and care plans in place showed that the principles of the Mental Capacity Act 2005 Code of Practice had not always been followed appropriately when assessing an individual's ability to make a particular decision.

Inadequate

Is the service effective?

The manager confirmed that there were policies and procedures in place at the home with regards to DoLS and the Mental Capacity Act 2005. Staff training records showed that the majority of staff had received some training to help them understand the principles of the Mental Capacity Act 2005. We could see that the home had made two applications to deprive people of their liberty, the outcomes of which were still to be decided. The manager had systems in place to help monitor and track the progress of any applications made.

However, we found that there were 26 people living with dementia who lived in the dementia unit of the home. These people were unable to leave that unit if they wished as the door was secured with a numerical key pad. People living in this part of the home were under constant supervision by staff. The movements of some people were monitored by the use of assistive technology (sensor mats) and other people had bed rails in place when they were in bed. In the sample of records we looked at we could not find any evidence to support that best interest meetings or mental capacity assessments had been undertaken to demonstrate how these decisions had been made and if these were the least restrictive methods of keeping people safe. We spoke to the manager and the provider about our concerns regarding the people at the home who, potentially had their rights, liberties and choices restricted.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people living at the home potentially had their rights, liberties and choices restricted.

Five of the care plans we looked at contained DNACPR (do not attempt cardiopulmonary resuscitation) forms. We found little evidence to confirm that these decisions had been lawfully consented to, or made in the best interests, with proper consultation with the people they related to.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People had not been properly consulted about their wishes with regard to their end of life care and support.

The chef showed us their copies of the diet sheets of people who use this service. The chef told us that this information was initially obtained at the time of the service user's admission to the home. The diet sheets were then developed over time with inputs from the person, their family as well health professionals. This helped to ensure that nutritional needs were met and that staff at the home were aware of people's likes and dislikes as well as incorporating any medical dietary guidance.

We observed lunch and breakfast and we noted that people had plenty of options for the meals they took. At both breakfast and lunch time we noted that the care staff were under some pressure due to staff shortages. We also observed a food thickener being used for service users at breakfast time. One tin was in use for everyone rather than each individual having their own (this supplement is usually prescribed for individuals). We spoke to the care worker about this who explained that this was because the home "had run out" and was waiting for the new stock to come in. Additionally, the lid had been left off the tin and the tin left out unattended. This meant that people could easily access this thickener themselves and this potentially placed them at risk of choking.

We looked at a sample of people's nutritional assessments and care plans. We found that people identified at risk of poor nutrition were not effectively supported with eating and drinking. For example, where care plans and risk assessments had identified that staff needed to keep a record of people's food and fluid intake, we found that these had been poorly and inaccurately maintained. It was impossible to tell from the information recorded exactly what, when and how much someone had eaten, or whether they had been offered alternatives at a different time. Fluid intake records had not been completed at all or only partially completed and the total amounts were not accurately calculated. This meant that people either were not supported appropriately with eating and drinking or that staff had failed to complete their nutritional records accurately. This placed people at risk of malnutrition and dehydration.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because appropriate strategies were not in place to ensure people who used this service received adequate nutrition and were supported effectively with eating and drinking.

However, the meals were served nicely and people who needed help received this with both care and dignity. Drinks and snacks were served between the main meals

Inadequate

Is the service effective?

and people told us that there were always drinks available if they wanted one. We noted that the quality of the food appeared to be very good and people enjoyed what was provided.

Requires Improvement

Is the service caring?

Our findings

The people we spoke to when we visited Dalton Court were very complimentary about the care and support they received.

People described the staff as "very nice and very helpful." One person said; "The manager looks after everyone, she really cares about you."

Others told us; "They (the staff) ask me how I am every day."

"There is always someone there if you want help."

"It's all kept lovely and clean."

One relative we spoke to commented that; "The care staff are fantastic, they always try their best but there aren't enough of them."

Another person described how they were able to participate in the care and support of their relative when they had first moved to Dalton Court, partly because there were no male staff to carry out personal care tasks. They added that they did not mind helping with their care as their relative "was so happy in a home where everyone was kind to them."

A relative we spoke to in the dementia unit at the home, told us that they felt completely involved in their relative's care and were not only included in the formal review of their care plan but could ask for changes to be made at any time.

We observed that all of the people that lived at Dalton Court appeared well dressed and cared for with positive interaction from the staff about how nice they looked.

However, one member of staff told us that people who used the service did not always get the support they needed, for example bathing and showering. They felt that care was "rushed", especially "downstairs" where more people needed support with moving and handling. They said, "It's horrendous downstairs (the nursing care unit) getting care done."

We looked at a sample of people's care plans and found that there were gaps in the information recorded. The care plan for one person who was not able to communicate effectively failed to describe the assessment of pain for the appropriate administration of painkillers. Another person was prescribed a 'when required' sedating medicine but there was no care plan in place to help staff decide when the use of this medicine was necessary. We found that the medicine had been administered regularly without justification for use.

We looked at the care plans relating to people's end of life care. The plans did not include a comprehensive, holistic assessment or details of how people should be cared for and supported at the end of their life. End of life care was not appropriately planned for. Care plans had only been drawn up in the last days of people's lives despite this stage of peoples' live being identified much earlier. This did not follow the home's protocols or best practice guidance regarding end of life care.

Whilst care plans were available their perceived 'value' to both staff and people using the service was rather mixed. Some staff found them to be an important resource, whilst others knew the people well and relied on this knowledge, although some of the staff we spoke to told us that communication was poor and that they were not always updated with changes in people's care and support needs.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were placed at risk of receiving inappropriate care and support, particularly as their needs changed.

Most of the people who used this service were unaware that they had care plans in place. However, they were confident that the staff knew them and their needs well and wanted to do their best for them. We observed there to be a strong relationship between staff and people using the service throughout the care home.

We asked several people about how the staff treated them when asking them to undergo any intimate care or medical procedures. They all confirmed that permission was asked before anything was done and they felt supported and looked after during the process.

We observed one incident during our visit to the home where a service user was not treated with dignity nor was their privacy respected by the care staff attending them. The service user had been left lying on their bed, uncovered with their bedroom door left open. We also observed incidents of good practice and care too. For example, during the lunchtime meal, two people were

Requires Improvement

Is the service caring?

encouraged to eat their meal by a member of care staff. They demonstrated behaviour that challenged at times but the care worker managed them well and in a very supportive and positive manner.

We spoke to the manager about these two incidents during our inspection of the service.

The home has in the past held formal residents meetings every month to which relatives were also invited. These meetings provided a platform for people to speak about in how the home should run and to discuss people's dislikes and preferences. The meetings had not convened for some time, initially because of the infectious outbreak. The manager told us that these were due to restart again soon.

In addition to the meetings the home provided a daily newsletter, "The Daily Sparkle". This provided people with reminiscence items, quizzes and letters.

Requires Improvement

Is the service responsive?

Our findings

One relative told us that they had cause to complain to the manager of the home on one occasion. However, they felt that their complaint was not listened to or taken seriously. They told us that the manager did not appear to be "bothered" about their concerns.

Another relative contacted CQC following the inspection and during conversation mentioned that they also had raised a concern with the manager. The manager did not appear concerned and was described as "unapproachable". The relative said that the manager never came round to speak to anyone and that they did not even know the name of the manager.

One of the members of staff we spoke to told us that they felt concerns raised by staff "are not dealt with properly." They described incidents that they had reported or were aware of and stated that they had not been kept informed of whether concerns had been taken seriously and addressed (no feedback from management).

We asked the manager at the home whether there had been any recent complaints made and we were told there had not. We checked the complaints log book and found that there were no records of any recent complaints being raised with the service.

We found that there was a complaints process in place at the home and that this had been made available to people who used the service and their relatives.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the complaints process had not been operated effectively when receiving, handling or responding to complaints.

Although we received these comments, other staff and people who used the service told us that they had no problems raising concerns or complaints either with on duty staff or with the manager herself. We were told that comments were well received and actioned with staff going out of their way to be helpful.

We asked staff what they would do if they had any concerns and they all said that they would take the concern up with their immediate line manager. Asked what they would do if this did not work or they felt their position was exposed they were all aware of whistle blowing procedures and safeguarding practices.

The people who used this service, that we spoke to thought that their care was focused on their individual needs. They told us that the staff regularly asked them what they wanted or how they wanted something doing.

However, the sample of care plans and records we looked at contained gaps in important information about people's care needs. We found that pre-admission assessments had not been fully completed, particularly around people's mental health and wellbeing, personality profile, eating and drinking preferences and needs. Life histories and activities care plans had not been completed, including those for people living on the dementia unit.

National Institute for Clinical Excellence (NICE) guidance for Supporting people with dementia and their carers in health and social care states that; "Care managers and care coordinators should ensure that care plans are based on an assessment of the person with dementia's life history, social and family circumstance, and preferences, as well as their physical and mental health needs and current level of functioning and abilities."

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were placed at risk of receiving care and support that was not personal or centred around their individual needs and wishes.

The care home had a well-advertised program of activities organised by the single activities organiser. As the home has 60 beds the one activities organiser was very busy especially as they were only employed for 33 hours per week and part of that involved them helping with breakfast. On one of the days of our visits, we observed that the activities organiser was providing direct care for the whole of their shift because of staff shortages.

We noted that activities included a variety of table games, visits from singers and yoga teachers. The home also had a minibus that the activities organiser was qualified to drive and this means that service users are offered trips out such as the regular Tuesday 'Singing for the Brain' activity run by the local Alzheimer's society. Shopping trips either as small groups, or on a one to one basis, are also offered; but, we were told, staffing them can be an issue.

Requires Improvement

Is the service well-led?

Our findings

Dalton Court Care Home is part of the larger organisation Amore Elderly Care Limited. The policies, procedures and auditing arrangements in place at Dalton Court are corporately provided by Amore Elderly Care Limited.

The home is regularly visited by the organisation's Regulatory Compliance Co-ordinator and Regional Operations Manager. We found that audits of the service had been carried out by both of these people with reports and action plans drawn up to help identify any gaps in quality and ensure compliance. We were shown examples of the audits that had taken place. However, these were of variable quality and accuracy which meant the manager at the home was provided with inaccurate and inconsistent information about the status of the service. We found that the audits carried out were not robust and they had failed to identify the shortfalls found during our inspection of the service.

We checked some of the records during our visit to the home including care plans and maintenance records. We found gaps in care plans which meant that people who used this service did not always receive appropriate, safe care which was centred around their individual needs and requirements. We found that people were at risk of being deprived of their liberty and human rights because staff at the home had not followed policies and procedures or the requirements of the Mental Capacity Act 2005, which had been put in place to protect people who used this service.

The main issues identified by staff during our conversations with them was regarding poor staff morale, a "bullying" management style, poor management of the work rotas and the withdrawal of enhanced payments for working unsocial hours. Staff reported that there had been issues regarding personal information about themselves and the lack of confidentiality. Staff also told us that communication was poor and that the "management was unapproachable." However, all of them said they would report any concerns they had about the welfare and safety of service users to their direct line manager.

Prior to the inspection, concerns had been raised via the CQC website by a member of the public regarding the care of their relative whilst living at Dalton Court Care Home. The concerns related to poor support with their personal care needs and personal items belonging to their relative "going missing." Although this matter was reported to the local safeguarding team, it was not pursued as allegations of abuse. However, neither did the provider carry out further investigations as per the company's complaints procedure.

We looked at the complaints log during our visit to the home, but there were none recorded even though one person we spoke to during the inspection told us of concerns they had raised. We looked at the incident and accident records at the home and found four examples of incidents that should have been reported to CQC and/or the local social work team but had not. Additionally, these matters had not been identified by the internal auditing systems in place at the home.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Incidents were not routinely reviewed to help mitigate any risks and ensure people who used this service were safe.

We checked the information we held about this service. We found that the provider and registered manager had failed to notify CQC of serious events and allegations that had occurred or been made at the home. We checked the accident and incident file during our visit to the home and found four matters that should have been reported and had not. We checked with the local social work team with regard to incidents that had been reported to them to try to identify gaps in the notification and reporting processes at the home.

We spoke to the organisation's Regulatory Compliance Co-ordinator who was unclear about what needed to be notified and when. We were told that there were no contingency plans at the home to make sure accidents and incidents are reported, appropriately and without delay, when the manager was absent from the home.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 because the provider had failed to notify CQC of incidents occurring at the home as specified in this regulation.

We spoke to the provider about these matters during a meeting with them on 25 June 2015. The provider took our concerns seriously and assured us that these matters would be dealt with quickly. They supplied us with a robust action plan later that same day. The provider has continued to keep CQC appraised of improvements made at the home on a regular basis. In addition to regular

Requires Improvement

Is the service well-led?

updates on progress, the provider has ensured that the registered manager at Dalton Court has been supported by members of the organisation's quality management team and by appointing a peripatetic manager to Dalton Court Care Home.

The principal form of feedback from people who used the service and their relatives was obtained from the resident/relative meetings, but these had been suspended during the infectious outbreak and had not recommenced by the time of our inspection. We did, however, see that people who used this service had been given satisfaction questionnaires to complete. We saw examples of some that had been returned completed and with additional comments made about how the service could improve.

People who used this service also told us that they were satisfied that if they asked any of the care staff about a change the request would filter up to the manager, and be acted upon.

We looked at a selection of the health and safety records maintained at the home. For example, water temperatures and water hygiene checks, inspections and servicing of equipment such as profiling beds and handling equipment and records showing how day to day maintenance of the home was managed. We found that the checks and records had been very well maintained and gave an up to date account of these matters. We also checked that the home's fire risk assessment had been reviewed and that staff had received appropriate fire prevention and evacuation training. These records appeared to be up to date at the time of our visit.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 9 HSCA (RA) Regulations 2014 Person-centred care Care and support assessments did not include all the needs of people using this service, including for example, emotional, social and cultural needs. Regulation 9

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Decisions regarding people's wishes with regard to their end of life care and support had been made without proper consultation and consent. Regulation 11

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People did not receive their medicines in a safe way or as their doctor intended. Regulation 12(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Assessments, planning and delivery of care were not based on risk assessment and people's choices. Regulation 12

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People who used this service were deprived of their liberty and were not protected from abuse or improper treatment. Regulation 13
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 Nutritional and hydration needs of service users were not being met. Regulation 14
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider did not have or operate an effective system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. Regulation 16(1)(2)
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not have a robust system in place to ensure sufficient numbers of staff were available at all times in order to safely meet the needs of the people that used this service. Regulation 18(1)
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider failed to notify CQC of incidents occurring at the home as specified in paragraph 2 of this regulation.

This section is primarily information for the provider

Action we have told the provider to take

Regulation 18(1)(2)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.