

St. Dominics Residential Home Limited

St Dominics Residential Home

Inspection report

London Road
Kelvedon
Colchester
Essex
CO5 9AP

Date of inspection visit:
24 November 2016

Date of publication:
06 January 2017

Tel: 01376570359

Website: www.stdominicsrh.co.uk

Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Summary of findings

Overall summary

Say when the inspection took place and whether the inspection was announced or unannounced. Where relevant, describe any breaches of legal requirements at your last inspection, and if so whether improvements have been made to meet the relevant requirement(s).

Provide a brief overview of the service (e.g. Type of care provided, size, facilities, number of people using it, whether there is or should be a registered manager etc).

N.B. If there is or should be a registered manager include this statement to describe what a registered manager is:

'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.'

Give a summary of your findings for the service, highlighting what the service does well and drawing attention to areas where improvements could be made. Where a breach of regulation has been identified, summarise, in plain English, how the provider was not meeting the requirements of the law and state 'You can see what action we told the provider to take at the back of the full version of the report.' Please note that the summary section will be used to populate the CQC website. Providers will be asked to share this section with the people who use their service and the staff that work at there.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

The service had systems in place to reduce the risk to people in the event of a fire.

Good ●

St Dominics Residential Home

Detailed findings

Background to this inspection

St Dominics Residential Home provides personal care for up to 39 older people, some living with dementia. There were 37 people living at the service on the day of our inspection.

During our last inspection on 28 September 2015 we found the use of door stops to wedge people's bedroom doors open, contravened fire safety guidance and good practice. The provider wrote to us and told what action they would be taking to address this.

We carried out this unannounced focused inspection on the 24 November 2016 to check that action had been taken by the provider. We found that improvements had been made. The door wedges had been replaced with automatic door closures. The use of these self-closing devices reduced the potential risk to people, as it allows for safe evacuation, by safeguarding the means of escape.

Since our last inspection the registered manager had left and a new manager had been appointed, who was in the process of submitting their application to be registered with the Commission. 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.

We received positive feedback from staff about the new manager who they described as approachable and committed to driving continuous improvement within the service.

This report only covers our findings in relation to the area of safety that we focused on during our inspection of 24 November 2016. You can read the report from our comprehensive inspection of 28 September 2015, by selecting the 'all reports' link for 'St Dominics Residential Home' on our website at www.cqc.org.uk

Is the service safe?

Our findings

Our last inspection of 28 September 2015 we found that improvements were needed to ensure the service followed safe fire practices. The provider wrote to us to tell us how they had addressed this. During this inspection we found that improvements had been made.

A walk around the premises showed where people had requested to keep their bedroom doors open, automatic closures had been fitted, which were activated when the fire alarm sounded. The provider said they were not planning to fit all of the bedroom doors with the device, as they left it up to the person to decide if they wanted one fitted. One person told us that staff had been responsive in fitting an automatic closure to their bedroom door after they had requested it to be left open, "I know they have their fire regulations." They said that being able to safely leave their bedroom door opened had been, "Much better," and less claustrophobic. The use of these self-closing devices reduced the potential risk to people, as it allowed for safe evacuation, by safeguarding the means of escape in the event of a fire. The manager confirmed that they had spares which enabled them to be flexible to people's requests.

Records showed that each person had a personal emergency evacuation plan, which provided staff, and if required emergency services, information on the level of support a person would need to evacuate safely. Using the 'traffic light' system, people's bedroom doors also had a discreet marker to let staff know how much assistance a person would need. Green requiring no assistance with their mobility, where red would require the assistance of two staff. Staff were aware of what the codes meant and all had received fire safety training to ensure the safety of those who lived, worked and visited the service.

Prior to our inspection the service had notified us action taken following a medicines error. Discussion with the person concerned, staff and records viewed, showed that staff had taken appropriate action to ensure the person's safety and well-being. The management had learnt from the experience and taken action by organising further training and instigating their disciplinary procedures, to reduce the risk of it happening again.