Genesis Residential Homes Ltd

Dothan House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 22 and 23 February 2018. The inspection was unannounced on 22 February and announced on 23 February. At the last inspection on 15 August 2016, the service met all the requirements we looked at. However at this inspection we found multiple breaches of regulations and inadequate systems in place to ensure risks were managed safely.

Dothan House is a 'care home' that accommodates up to 19 people some of whom may be living with dementia. On the day of our visit there were 17 people using the service. 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.

On the day of our inspection there was no registered manager. This was a breach of the registration conditions. 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.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
If not enough improvement is made within this timeframe so that there is still 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 this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to 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 so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The service was unsafe. Risks to people and their environment were not always mitigated. Substances

hazardous to health were not always stored securely to protect people from harm. We found two radiators without covers or risk assessments in place to mitigate the risk of burns. The premises were not always clean or well-maintained posing a health and trip hazard for people.

Fire equipment was not always easily accessible and personal emergency evacuation plans located by the fire exits were not up to date posing a risk in the event of a fire.

Medicines were not managed safely. Procedures to administer covert medicines, homely remedies and as required medicines were not always followed.

People and staff told us the interim manager was approachable and listened. However we found inadequate governance systems in place. These did not ensure that staff training was up to date and people's records were not accurate. Policies although signed as reviewed annually, were not up to date or reviewed regularly. The current systems had failed to ensure we were sent all notifications as required by law.

There were ineffective training systems in place. This left staff without up to date training in essential areas such as moving and handling, dementia awareness and behaviours that challenge the service.

Staff had limited understanding of the Mental Capacity Act 2005 (MCA) and how they applied it in practice. This was evidenced by incomplete or out of date capacity assessments and best interest decisions for decisions such as covert medicines authorisation.

Although the premises had murals to stimulate people living with dementia, staff were unaware of how these could be used to engage with people.

People were supported to eat a balanced diet by staff that understood their needs.

People told us they were able to raise any issues. However, we found shortfalls within the current complaints system. The complaints log did not always contain the details of the full investigation, any outcomes or learning from complaints raised. We made a recommendation to ensure the policy is followed and all complaints are dealt with transparently.

People had access to some information. However we made a recommendation about following the accessible information best practice guidelines.

Care plans were not always reviewed to reflect people's current preferences and support needs. However, they reflected end of life preferences where people and their relatives had outlined their preferences. We made a recommendation for further support for staff in relation to end of life care delivery.

People told us staff were polite and kind. However, we saw instances where peoples dignity was not preserved these included deferring to attend to continence needs and requests for a cup of tea.

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

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 unsafe. We found unsafe practices relating to risk assessments and management of risks to people using the service.

The premises were not always clean or well maintained.

Staff had completed some safeguarding training online but were not always able to explain the steps they would take to recognise and report abuse.

Recruitment practices did not ensure that only staff with the necessary skills were employed.

Staffing rotas showed there was at least one experienced staff member on duty on every shift to ensure people's needs were met.

Is the service effective?

Requires Improvement

The service was not effective. Staff were not supported to ensure they received adequate training to enable them to support people safely.

Staff had limited understanding of the Mental capacity Act 2005 (MCA) and how they applied it in practice.

People were supported to eat a balanced diet that met their individual need although the actual dining experience could be improved.

Is the service caring?

Requires Improvement

The services was not always caring. People were not always treated with dignity and respect. We found their right to confidentiality was not always respected.

People and their relatives told us they were cared for by staff who were caring.

We found although people had access to information, improvements were required to ensure people had information

in a format they could understand.

Is the service responsive?

Requires Improvement

The service was not always responsive. The current complaints system was not always followed to evidence that all complaints were acknowledged, investigated and resolved.

Care plans were pictorial. However they were not always updated to reflect people's current support needs.

People and their relatives thought the care delivered met their preferences.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager in place. The interim manager did not have the necessary qualifications or experience to manage the service safely.

We found systemic failings in the oversight and the monitoring of the service. This resulted in inadequate measures in place that did not ensure, training, records, policies, health and safety checks were robust enough to ensure quality of care delivered was monitored and improved.

Dothan 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

The inspection was prompted in part by safeguarding investigation completed by the local authority following a whistle-blowing alleging neglect and poor staffing issues. The service was currently working through recommendations made by the local authority.

This inspection was unannounced on 22 February 2018 and announced on 23 February 2018. It was completed by an inspection manager, an 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.

Prior to the inspection we reviewed the previous report, the service's website and gathered information from the local authority and commissioners. We used information the provider sent us in the 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.

During the inspection we used the Short Observational Framework for Inspection (SOFI) for a group of four people over a 45 minute period. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with nine people and four relatives. We reviewed five care records, eight medicine administration record sheets, and ten staff files. We looked at maintenance records and health and safety checks,

We spoke with four care staff, the cook, the interim manager and the provider. We also spoke with a social care professional, and two health care professionals.

Inadequate

Is the service safe?

Our findings

We found the service was failing to provide care in a safe way. Risk assessments were not reviewed and updated in a timely manner. One person's risk assessment for delusions had been written on 15 February 2014 and had not been reviewed since September 2015. It still stated that the person had been known to pull their catheter. However, this person no longer had a catheter as confirmed by the interim manager and staff we spoke with. Another person's risk assessment said they were still walking whereas they were now being cared for in bed. Their risk assessment for restriction of movement was dated 29 March 2015 with no review. Both risk assessments were no longer relevant as the person was now receiving care in bed and had started deteriorating in December 2017. Another person was now being hoisted despite their risk assessment still stating they could transfer. Staff told us they were now being hoisted. This showed the service failed to ensure that the risk assessment process was reviewed in a timely manner in order to accurately reflect risks to people and how to mitigate them to ensure people were cared for safely.

Throughout the inspection we observed failures to ensure substances hazardous to health were kept secure in a locked cupboard to reduce the risk of harm to people using the service. Laundry detergents were left unattended and in view within the open laundry room. We also found cleaning solution left unattended in a bathroom. When this was highlighted to the interim manager they did not remove it or lock it away. They did not acknowledge the risk and stated staff needed to use it on a regular basis. This left people using the service at risk of being exposed to substances that could harm them if ingested. This was also a risk for people living with dementia who preferred to walk around the service.

We also observed hazards posed by two radiators. One was portable and hot to touch and was placed in the conservatory. Another was a wall mounted radiator that did not have a cover. Both put people at risk of burns. There were no risk assessments in place to explain the steps taken to protect people from the risk of potential burns.

On 23 February we observed staff using an underarm technique to transfer a person from a chair to their wheelchair. This technique is unsafe and increased the risk of the person sustaining a serious injury, such as a dislocation or fracture. We spoke with the interim manager about this. They told us they would talk to the staff. In addition, the training matrix showed and the interim manager confirmed that moving and handling training was out of date and was currently only theory without a practical session. This meant that staff were not always assessed or observed to ensure they were able to use moving and handling equipment safely. This meant people using the service may be at risk of injury caused by inappropriate moving and handling techniques.

Safety checks to ensure that the premises were safe were not always completed. A gas safety check on 6 October 2017 showed that a gas pipe through wall was not sleeved and an earth bond was incorrectly positioned.
There was no plan in place to ensure this was actioned. Similarly, one toilet on the ground floor had exposed water pipes and was located near an uncovered radiator which got hot. These pipes and the radiator increased the risk of people sustaining injuries such as burns or scalds. This had not been identified by the

checks which were carried out and therefore corrective action to ensure the premises were safe had not been taken.

Health and safety checks were not always completed correctly to ensure fire safety equipment was accessible and emergency lighting was working. The provider failed to ensure that fire doors in the service had intumescent strips in accordance to fire regulation requirements for fire doors. Lack of intumescent strips meant that fire doors may not prevent the spread of fire or smoke. This meant people were at greater risk of harm in the event of a fire.

The service did not appropriately manage the risk to people in the event of a fire. We found a fire extinguisher in a wall mounted box did not have the attached key. This meant staff would not have immediate access to this extinguisher in the event of a fire, thus putting people at risk. External fire doors could only be opened by staff as they had bolts to prevent service users from opening them and leaving the service. On both days we noted that the laundry room fire door was propped open, posing a risk in the event of a fire as it would not automatically close to protect people. The above showed that fire safety procedures were not robust and placed people at risk in the event of a fire at the service.

Current health and safety checks had failed to identify and mitigate risks in relation to emergencies. One emergency light in the downstairs hallway had a red indicator light and one on the staircase had no indicator lights. All others in the service had a green light. This showed the emergency lights were not all in working order. These anomalies had not been identified by the service and could put service users at risk of emergency lighting not working as required when needed, leaving people at risk or trips and falls due to poor lighting.

Medicines were not managed and administered safely. We found significant shortfalls in the way in which covert medicines (medicines given concealed in food without the person's knowledge), homely remedies and as required medicines (PRN) were managed. Covert medicine authorisation did not list all the medicine or describe how to administer it to ensure it did not lose its potency. This left people at risk of receiving medicine as prescribed. PRN protocols were not always up to date. This meant that the rationale or the need for the specific as required medicine was not always reviewed to show why and when the person required the medicine. This left people at risk of receiving medicines inappropriately. Homely remedy authorisations were not signed by the GP and did not specify which homely remedies each individual was able to receive but rather listed generic remedies. This showed shortfalls in the current process to review and ensure as required and homely remedy medicines were managed safely. This meant that people were at risk of not receiving their medicine as prescribed thereby negatively impacting their health.

We also found expired eye drops for one person on the medicine trolley. Another person did not receive their medicine as prescribed. Instructions clearly stated 'Do not chew or crush, take 30-60 minutes before food.' However, when asked staff told us they gave this with food at breakfast time and we witnessed this on 22 February 2018. This was likely to reduce the effectiveness of the medicine. This meant the current medicine administration process did not always ensure staff read and understood the implications of medicines being administered as prescribed. This meant that people did not always receive their medicines as prescribed potentially causing the medicines not to work effectively.

Medicine administration records (MAR) were completed inconsistently with variable codes used that differed from the explanations on the MAR sheets for four people. When asked, staff told us they were still using codes from the old MARs. This meant staff were not reading the MARs and using the correct codes when people refused their medicines or were away. This showed staff were not given enough support to enable them to manage medicines safely leaving people at risk of not receiving their medicines as prescribed.

People thought there was enough staff to support them. One person said, "There is usually someone around." However although rotas showed sufficient staff, they were not always deployed effectively in order to keep people safe. The interim manager was frequently counted as part of the staffing numbers. This meant they did not always have enough time to do their management checks properly or in a timely manner. We saw at one point people were left in the main lounge and in the conservatory without staff engagement especially in the morning when people were being assisted. We noted another incident were staff had left people unattended in the lounge resulting in one person touching another person's feet. We had to intervene by calling the staff to come and assist the person. One staff told us "We are two but should be four." When asked if there was any agency they said" Agency was rarely used." We did note that by 11 am there were four staff on duty on the first day of inspection and an agency staff came to cover the afternoon shift. We spoke to the interim manager about this and they confirmed that they had been lots of recruitment. The above showed that staff were not always deployed efficiently to ensure that there was always someone overseeing the safety of people in communal areas where most people were based during the day. This left people at potential risk of harm.

Staff had limited understanding of safeguarding processes in place despite having had some training recently. They demonstrated knowledge gaps relating to their understanding of how to recognise and report abuse. A staff member told us, "If abuse happened the manager would deal with it. It doesn't happen here so I am not sure what else would be done." This meant that staff had not received all the training and support in understanding safeguarding processes, which exposed service users to the risk of harm. We looked at recent safeguarding incidents and found that not all safeguarding was reported to all the relevant authorities. We saw two safeguarding incidents that had been reported to the local authority but not to the Care Quality Commission.

The above findings were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Premises were not always clean or well maintained. We observed that the carpet in the main lounge had visible stains in several places and was well worn. The skirting boards towards the door leading to the toilet adjacent to the lounge were chipped and there was peeling wall paper. The toilet next to the lounge had visibly dirty flooring that was also lifting at the edges potentially causing a trip hazard. One of the upstairs bathrooms also had visibly dirty flooring with some stains that appeared to be coming from a toilet leak. We noticed when coming down the stairs that chandeliers were dusty with visible cobwebs. We asked to see the cleaning schedules and found they were not comprehensive. We spoke with the interim manager about this and were told the carpets were going to be replaced. However, we have not been sent any confirmation of when the flooring will be replaced. This meant that the current cleaning and maintenance systems in place were not robust to ensure people were cared for in a clean environment. People using the service were at risk or exposure to dust and potentially harmful bacteria.

Cleaning checks were in place but not completed since 9 February 2018, as the main domestic was on annual leave. These checks showed that deep cleans, mattress checks and additional cleaning tasks were supposed to be carried out, but records did not support this. For example, the schedule stated that curtains should be cleaned every three months, this was last recorded in August 2017. This showed that the schedules were not always followed resulting in some areas being left visibly dirty posing a health risk to people using the service.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The recruitment system was not robust. There was no system in place to ensure disclosure and barring checks were refreshed periodically although they were in place at time of recruitment. We found three recruitment files for new staff members who were about to start induction in March had essential information missing. All had three application forms which were not completed in full. They lacked information regarding education, training or employment history. There were no interview notes on file for new staff members. Furthermore six staff files had application forms which were not completed in full. There were unexplained employment gaps and no interview records to show how this was explored. This showed that the service was not following the provider's recruitment and selection procedure. This meant that appropriate steps were not always taken to ensure suitable staff were employed leaving people at risk of receiving care staff without the required skills and experience needed to deliver care safely.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives had mixed reviews about safety. One relative felt that they could go away knowing their relative was 'safe' however, another relative thought more could be done to keep people safe and said, "I am glad that the inspection is taking place." They went on to describe an incident where a person went missing. This incident was confirmed in the records we reviewed and steps had been taken to try and prevent this from happening.

Staff were aware of the accident and incident reporting procedure. We found accidents and incidents were recorded and there was evidence of action being taken as a result. For example where falls had been noted staff told us how they tried to monitor and remove trip hazards. Similarly they told us about ensuring the door was shut properly following an incident where a person had walked out as a result of the door not being secured.

Requires Improvement

Is the service effective?

Our findings

People were supported by staff that had not received sufficient training. Training records showed several staff members had not completed training in fire safety, medication training, COSHH (Control of Substances Hazardous to Health), and equality and diversity in the last three years. Training records also showed that moving and handling training was out of date for 13 staff, with a further seven staff having no record of moving and handling training. The interim manager confirmed that the current moving and handling training was theoretical with no system in place to check competency of staff in carrying out moving and handling procedures. This left people at risk of harm because staff had not been given the appropriate training to enable them to move people safely.

One staff member told us training was offered but they had missed some due to annual leave and no alternative dates had been provided. This showed staff were not always supported to have training in order to ensure they delivered safe care based on up to date knowledge. We spoke to the interim manager about this. They told us they were in the process of getting all staff up to date with training. We requested but did not see or receive any documentary evidence to support this. This left people at risk of unsafe care that did not always meet their needs because staff lacked the essential skills and knowledge required.

People were supported by staff who were not always given the opportunity to update their knowledge in order to support people safely. The service provided support to people living with dementia, some of whom may have behaviours that could challenge the service. However, the training records showed some staff members had not received dementia awareness training to enable them to support people effectively. A staff member confirmed when asked that they had not attended specialist training due to being on annual leave. Training records also showed that only four out of the 23 staff had completed a behaviour management course. This showed staff were not always supported to have training in order to ensure they delivered safe care based on up to date knowledge. This left people at risk of unsafe care that did not always meet their needs.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions

on authorisations to deprive a person of their liberty were being met. We found deprivation of liberty authorisations had been sought legally. Staff had limited understanding of capacity although they were aware of consent. One staff when asked about DoLS said, "It's because we lock the door and they can't get out." They could not tell us which people had a DoLS in place or the best interest's assessment process that took place before the decision to deprive people of their liberty was made. However, capacity assessments were not always completed properly or reviewed regularly in four out of the five care records we reviewed. For example one capacity assessment for consent to care and treatment had not been reviewed since 2016 similarly all four covert medicine records we reviewed did not have comprehensive best interest's decisions for that particular decision. This meant that capacity for people to make decisions such as whether to take their medicines were not always assessed in accordance with the MCA. Decisions made in peoples best interests such as administering medicines covertly were not always made following best practice guidance. This showed shortfalls in the understanding of the MCA.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We found that prior to living at Dothan House, comprehensive assessments were completed to establish people's needs. These included people's physical, social, emotional needs and included night time habits, religious preferences and sexuality. Although all these needs were assessed they did not always outline what people wanted to achieve or their hopes and aspirations. One person told us, "I would like to go out more." We asked staff about this and they told us people went out more in the summer but this was usually to the back garden. Another person had blurred vision but did not have any measures in place to enable them to partake in activities they told us they enjoyed such as reading. This meant that although assessments were made there were not always measures in place to ensure effective care delivery and outcomes for people.

People told us they were supported to maintain a balanced diet. One person said, "The food is good." Staff were aware of people's dietary preferences. One staff member told as about the people on special diets due to their medical condition and about people's likes and dislikes. However we noted that the dining experience could be improved. For example we saw a person struggle for some time to eat because their food was not cut up. Staff eventually came to cut up their food 25 minutes after it had been served. Food diaries were maintained and fluid charts for people identified at risk of malnutrition. Where changes in nutritional intake were noted people were referred to other healthcare professionals.

People were supported to access healthcare services where required although we noted in one instance there had been a delay in requesting end of life support for one person. We saw evidence in records that people were supported to attend hospital appointments and were seen by other healthcare professional such as district nurses dentists, chiropodists when required. We also saw that where required do not attempt resuscitations documentation for people who did not wish to be resuscitated had been discussed with people, their relatives and the multidisciplinary team and documented appropriated to ensure people's wishes were respected.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us they were treated with dignity and respect. However, we observed a few instances where people's dignity was not respected. A person asked for a cup of tea and was told, "Wait for lunch you can have one after lunch." This person was upset by this and waited another 45 minutes before lunch was served and then another hour before they eventually had a cup of tea. Another person was incontinent and needed personal care. However, staff came in the communal area twice without noticing this had happened. The person was eventually supported to the toilet almost an hour later. The above showed peoples dignity was not always preserved and increased the risk of the person developing skin irritation as a result of prolonged sitting on a soiled incontinence pad.

On another occasion we found a member of staff having their break, eating their meal whilst on their mobile phone in a person's room. The interim manager later stated that this was not the norm and that staff usually used the upstairs lounge area but they felt this was out of bounds due to the inspection. Another person was visited by a medicines review officer in the conservatory. Their medicines were discussed, as was their health, in the presence of three other people and without addressing the person in question directly. The interim manager noticed this five minutes later and directed the staff to a private area. The above did not demonstrate an understanding of people's right to confidentiality and privacy and did not show respect for the persons concerns This meant this persons private health condition was discussed in a communal area disregarding their privacy.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People and relatives had access to information which was displayed on notice boards and some within people's rooms. We saw staff talking with people before they supported them with mobility needs or eating and drinking. However we noted improvements could be made on accessible information for people with communication difficulties or other sensory deficits as we found care plans and communication tools were not always made available to support this. For example a person who spoke another language had communication cards within their care plan but we did not see staff use these on the day of our inspection. When asked staff said the person reverted to their original language when they were confused but understood English. This meant that at times staff would not be able to effectively reassure this person when distressed as observed during an incident when this person shouting. We recommend best practice accessible information guidelines are sought and followed.

People and their relatives told us they thought staff were kind. One person when asked about staff smiled and said, "They look after me very well." Relatives also commented, "The staff are very kind." Another relative said, "They try their best to keep everyone happy and clean." We observed that staff were very tactile and there seemed to be a happy atmosphere at times with people responding to hugs and massage by calming down or smiling. Staff told us that the owner joined them for meetings and felt they were "Like a family' and "Loved." They spoke about people using their preferred name and were aware of peoples food preferences and to a degree their medical conditions. They were aware of peoples past and tried to use it to

engage in conversations where possible.

People were supported to be independent. Staff told us they offered choice and enabled people to do what they could still for themselves. We saw staff encourage and support someone to take a few steps before offering them a wheelchair. Staff were mindful of people's religious and cultural preferences. Care plans also reflected people's cultural and religious specific needs which were confirmed by staff we spoke with.

Relatives told us they were able to visit as often as they liked. One person told us, "My [relative] comes to see me all the time." Throughout the inspection we saw relatives come and go and saw people smile when they recognised their visitors and others calm down when their visitors sat with them and at times assisted them to drink or eat. Staff told us some people had relatives who visited on a daily basis. People care plans and reviews confirmed where people had relatives who were actively involved in their care.

Requires Improvement

Is the service responsive?

Our findings

We saw care plans were comprehensive and pictorial and included people's likes and dislikes. However four out of the five care plans were reviewed had not been updated since 2015. This meant that people's current support needs were not always up to date. For example one person's care plan stated they still had a pressure sore however another entry by the district nurse in November 2017 said the pressure sore had healed. Similarly this person's support plan still talked about them having a catheter and pulling it. However when we spoke to staff and asked about this person's needs they confirmed that the person had not had a urinary catheter in place since September 2015. Another person's care plan said the person helped to set the table. However, this person had not been able to do that since December 2017. This meant that although care was assessed and at the time of assessment included peoples personal preferences, these were not always updated as people preferences and needs changed. This meant that care and treatment did not always meet their need or reflect their preferences.

Some care plans were not person centred as they did not always outline people's current routines in great detail. For example some night care plans did not always specify peoples sleep routines such as people who preferred to sleep in a chair and the guidance for staff to make the person comfortable. Others still mentioned people's old habits that were no longer current. Fluid charts where in place did not include the individual's daily intake calculated based on their weight. We spoke to the registered manager about care plans and they told us they were responsible for them and were in the process of updating care plans to ensure they reflected people's current preferences and needs. Staff told us they were mainly involved in completing daily records and food and fluid charts and did not get involved in writing care plans.

We observed that people were not always supported to engage in meaningful activity that met their individual preference or ability. Throughout the inspection ten people were in the main lounge which was poorly lit. They received minimal stimulation or engagement. A staff member switched on the TV on the first day of inspection without asking what people wanted to do or which channel they wanted to watch. Five out of ten people were slouched in their chairs or bent forward, asleep. One person told us they could only see "Blurs." They mentioned that they could no longer read. We asked if they might be offered an audible version of a book for example, on a CD. We were told this had never been discussed. This persons care plan confirmed they had enjoyed reading in the past but there was no detail in the care plan to say how this could be facilitated as the person's declining sight was now stopping them from reading.

Despite the presence of the activities schedule on the walls, people told us and records showed these were not always followed. One person told us, "I prefer to go out for walks if I am honest." People in the conservatory during our visit had some colouring books and puzzles but were left with intermittent checks from staff or occasional one to one interactions. When we asked a person why they were not doing the puzzle they shook their head and said, "It's too much for me." The above showed people were not always supported to engage in activities they enjoyed and were left for long periods of time without any stimulation thereby negatively impacting on their morale and well-being

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014

We saw evidence that regular feedback was sought and positive comments given by family members. This included a 'Tell us about your day' form for ad-hoc feedback from visitors, which contained a box for comments and suggestions. Feedback included, "Staff excellent at all times" and "Always find the staff most helpful, efficient and understanding." There were also a number of thank you cards in the file. The interim manager told us that feedback was shared with staff and we saw some feedback displayed on the notice board to recognise what was going well as well as work on areas of improvement.

People and their relatives thought the service was responsive to their needs. On the day of our visit we observed that people chose when to get up. For example one person chose to stay in their bed till 11:00am and staff went back to assist them when they were ready.

Only one person could talk to us about complaints and they told us they were able to express any concerns. Relatives told us they did speak to the management but felt regular meetings to discuss issues were non-existent at present due to change of management. One relative felt concerns reported were yet to be fully addressed. These related to communication about changes of staff and management.

Complaints procedures were in people's bedrooms, but not in communal areas of the service. Staff told us they would pass on any complaints to the interim manager. We looked through the complaints log and found no complaints recorded since September 2017. One complaint recorded prior to this lacked detail about how it was handled or resolved. The interim manager was unable to explain further as they said that was dealt with by the previous manager. This meant that the complaints were not always logged and investigated in accordance with the services' policy. We recommend that the policy is followed to ensure all complaints are dealt with transparently.

Staff had no specific training in relation to end of life care. The interim manager did know the process to follow to get assistance from the district nurses when people were towards the end of their life although for one person there had been a delay in making a referral. Care records showed people's last wishes were recorded. We heard the interim manager speaking about arranging for a person's last rites in accordance with their religious preference. We recommend further guidance is sought in relation to end of life care delivery.

Inadequate

Is the service well-led?

Our findings

We found significant shortfalls in the way in which the service was managed. There was no registered manager in place. Although there was an interim manager in place they did not yet have the necessary skills, experience and training to enable them to manage the service effectively. The interim manager was yet to start a management course and spent a significant time working a routine shifts as a team leader. This meant that they did not always have the time to carry out comprehensive audits. We spoke with the provider about these concerns. They told us they had not yet recruited since the last manager left in November 2017.

The service had inadequate quality monitoring systems in place. Systems were not operated effectively to ensure care was delivered safely. The current assessment and monitoring systems in place had failed to identify and rectify the issues and concerns we found relating to medicines management, risk assessment and fire safety. We found personal emergency evacuation plans were out of date. This meant existing systems had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of people and others who may be at risk.

During the inspection we found the service failed to ensure that staff had the qualifications, competence, skills and experience necessary for their role. The interim manager was currently studying for a qualification which was not at the appropriate level for a management role. The interim manager told us when they completed the course they would go for the management course. We asked the interim manager about any time scales for this and they told us there were no time scales. This showed the provider had not made the necessary arrangements to ensure a person with the necessary skills and experience was in day to day management of the service. The systems in place were not effective to ensure the quality of care delivered was meeting people's needs or that staff were appropriately skilled.

We found equipment checks completed were not robust. Systems in place had failed to identify and address concerns. We raised our concerns regarding a fire extinguisher that was not easily accessible and emergency lighting that was not working .This left people at risk in the case of an emergency as it would take longer for staff to get access to a locked extinguisher which had no key.

The service did not identify that the current water checks were not comprehensive. Although regular water temperature checks were completed, there was no guidance for staff on action to take if temperatures were outside of the correct range. There was a risk of staff not knowing when to escalate or report issues to ensure remedial action was taken to protect people from the risks exposure to legionella.

We found gaps in the monthly checks of wheelchairs and bedrails. Checks had not been completed since November 2017 when the previous maintenance staff member had left. This meant people were at risk of harm from the use of poorly maintained equipment.

There was no system for checking the safety of window restrictors in place. We found the system to check this had failed to identify that the window restrictor in one bedroom was broken. We asked the interim manager about this and they could not explain how this had not been identified. This failure to ensure

health and safety checks were completed left people at risk of potential harm of falling through the window.

Cleaning checks were in place but not completed since 9 February 2018 and had not been identified. The current cleaning schedules in place were not always followed leaving people at risk of exposure to dust and an unclean environment potentially negatively impacting their health.

Checks regarding infection control and checking the environment were in place but not completed on a regular basis. There was no documented evidence of actions taken as a result. We asked the interim manager about this and they did not have any records. This showed the systems in place had failed to identify and rectify the record keeping and quality assurance shortfalls we found.

Governance systems in place did not identify that some policies such as the safeguarding and complaints policy were not up to date. Policies were not always followed as the current governance systems in place had failed to maintain oversight of the overall running of the service. Although the provider visited the service, they admitted they did not complete any audits and the external auditors were concentrating more on supervision for the interim manager. The complaints policy referred to outdated CQC guidance and policies were not particular to Dothan House but had other service names included. The safeguarding policy also had out of date details about the local safeguarding team. This meant the current governance structures in place had failed to keep policies up to date and had not addressed the fact that they were not specific to this service. Therefore, staff were not always signposted to the latest guidance they required when referring to the policies which left people at risk of delayed care

Audit systems for records were not robust as all care plans were currently completed by the interim manager. There was no oversight or audits by the provider of the records they had created. There were no systemic daily checks completed and recorded to ensure the premises were safe and fit for purpose.

The multiple failures described above showed inadequate monitoring systems had failed to ensure concerns we found relating to poor medicines management, inadequate risk assessment and poor fire safety were identified and rectified. Furthermore there were inadequate systems in place to check equipment, premises and records to ensure they were up to date and fit for purpose.

The above were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had also failed to ensure the latest CQC ratings of their previous inspection were displayed on their current website, although we noted the ratings were displayed at the main entrance of the service. We spoke with the interim manager and the provider about this and they said they did not use the website. Services are required to display inspection ratings.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider had failed to ensure the Care Quality Commission had received all notifications as required by law. We found two safeguarding issues and multiple deprivation of liberty safeguarding incidents that we had not been notified of. Although we noted that the local authority had been notified.

This was a breach of Regulation 18 Registration Regulations 2009 Notifications of other incidents.

People and their relatives had mixed reviews about the way in which the service was run. Some people and

staff told us they thought the service was well -led. They reported a "Warm and friendly atmosphere." One person told us, "It is good here, they are all good to me and get us all what we need." Other relatives told us since the last manager had left there had been no residents meetings and they found communication difficult. One relative cited communication difficulties with some staff as their competency in English was not always proficient.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to ensure we received two safeguarding notifications and five DoLS notifications.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users did not always meet their needs nor reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure that care and treatment was provided with the consent of the relevant person. They had not always acted in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises and equipment used by the service provider were not always clean or properly maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not established and operated effectively to ensure that persons employed had the qualifications, competence, skills and experience which are necessary for the work to be performed by them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive appropriate support, training, professional development as is necessary to enable them to carry out the duties they are employed to perform.