Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Dalvey House

35 Belle Vue Road, Southbourne, Bournemouth, BH6 3DD

Tel: 01202423050

Date of Inspection: 13 September 2013

Date of Publication: November 2013

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Management of medicines	✖	Action needed
Assessing and monitoring the quality of service provision	✖	Enforcement action taken

Details about this location

Registered Provider	TAM Carehomes Ltd
Registered Manager	Mrs. Joanne Smart
Overview of the service	Dalvey House is a care home that does not provide nursing care. The home is registered to accommodate up to 19 people.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Dalvey House had taken action to meet the following essential standards:

- Management of medicines
- Assessing and monitoring the quality of service provision

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 13 September 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

What people told us and what we found

We carried out this inspection on the 13 September 2013, to follow up on compliance actions made at the last inspection of the home in April 2013.

We spoke with the manager, three people living at the home, one relative and one visitor. There were 19 people living at Dalvey House at the time of our inspection.

People that we spoke with were positive about the way the home was run and managed. No complaints or concerns were raised with us during our visit.

People were not protected from risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

We found the home did not have a robust quality assurance system in place to ensure standards in the home were maintained.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 21 November 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have taken enforcement action against Dalvey House to protect the health, safety and welfare of people using this service.

Where providers are not meeting essential standards, we have a range of enforcement

powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Management of medicines ✖ Action needed

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke to people using the service but what they told us did not relate to this standard.

We saw that medicines were stored appropriately in secure lockable cupboards.

Staff told us about the procedure for ordering, administering and disposing of medication. We looked at a sample of medication administration records (MAR) of two people who lived in the home. We saw that there were details of any known allergies on people's MAR charts. All medicines given had been signed for. We found that the balances of medication stored was in accordance with the medication records.

However, we found that where eye drops were being used, two vials we looked at had not been dated when opened in accordance with Royal Pharmaceutical Guidance and manufacturers' guidance on use. We also found a vial that had been dated when opened had passed its use by date. This could mean there could be a risk of bacteria contaminating the liquid which could cause damage to the person's eye and the drug in the eye drop may not be effective.

We checked the controlled drugs storage cabinets and controlled drugs records. We identified that according to the controlled drugs records there was a medication that was not in the controlled drugs cabinet. We also found loose medication in the cabinet that was not labelled with the person's name for who it was prescribed. This meant that medication errors had not been identified by Dalvey House staff.

We noted there was a system in place that ensured medication was disposed of safely. For example, there was a dedicated box for medicines to be returned to the pharmacy.

Assessing and monitoring the quality of service provision

✖ Enforcement action taken

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider had systems for reviewing and monitoring the quality of service provided to people, but these had not always been implemented effectively to ensure that people were not at risk of unsafe or inappropriate care.

We have judged that this has a moderate impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

Our inspection of 17 April 2013 found the provider had some systems for reviewing and monitoring the quality of service provided to people, but these had not always been implemented effectively to ensure that people were not at risk of unsafe or inappropriate care. The provider wrote to us with an action plan outlining improvements that would be met by the 17 June 2013.

On our inspection of the 13 September 2013, we found that the provider had systems in place for reviewing and monitoring the quality of service provided to people. However the provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on.

People we talked with and their relatives spoke positively about the home and the way it was run. One visitor told us that they had felt the manager listened to them when they requested any changes. They told us that any changes requested were always carried out.

The home had sent a questionnaire to people who used the service, their relatives or representatives to obtain their views in July 2013. We saw that the responses had been analysed and the provider had written to people to clarify some feedback received. An action plan had been put in place to address any low scoring areas identified by the survey. For example, it was identified that a further call bell would be placed in the communal area of the home to make it easier for people to notify staff when they required assistance.

We saw the provider conducted regular staff meetings. We looked at the minutes of the

last staff meeting held on the 04 July 2013. We saw that topics included medication and activities in the home.

We found that whilst the home had some systems for reviewing and monitoring the quality of service provided to people. These had not always been implemented effectively to ensure that people were not at risk of unsafe or inappropriate care in a way that protected people from harm.

We saw that the medication audit only checked quantities of stock. This did not ensure that people were protected from the risks associated with medicines. For example there were no records to show that periodic checks had been undertaken to ensure that people had received their medicines as prescribed. We saw no records to show that medicines had been audited to check that they were still within their use by date.

We saw that the home completed an infection control audit. We noted that the last audit took place on the 25 August 2013. However, when we checked the providers cleaning records, we found that there were a number of gaps. For example we saw that some of the monthly cleaning tasks such as cleaning the blinds in people's bedrooms had not been completed. This meant that there was not an effective system in place.

We looked at the homes accident policy and recording system. The accident policy stated that "accidents and incidents are followed up to ascertain outcomes and identify training opportunities", and "accidents and incidents are routinely analysed for trends and patterns".

We found that whilst some accidents and incidents had been analysed and followed up, this was not consistent. We saw that there were no checks to identify trends and patterns. For example, we saw records that showed the last accident audit took place on the 24 August 2013. However when we checked one person's care plan, we saw that the person had a total of five accidents that took place from the 22 July 2013 to 19 August 2013. We noted that these accidents had not been analysed and there was no evidence where the home had implemented revised practices.

We saw that for another person who had an accident, an analysis had been undertaken. We saw that to prevent reoccurrence staff were to ensure that the person had their walking frame next to them at all times. However we observed the person sat in the lounge and noted that from 12:30 to 14:00 the person did not have their walking frame next to them. This meant that the home had not implemented the changes to prevent reoccurrence.

We noted the provider had a complaints policy, we saw that this was displayed in the main entrance of the home. We looked at the provider's complaint records; we noted that there were no recent complaints on file.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: People were not protected against the risks associated with medicines because there was no medication auditing. Eye drops were not handled in accordance with manufacturers' guidance on use. There were loose controlled drugs in the cabinet and there was a controlled drug discrepancy.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 21 November 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 14 October 2013 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others. This was because the medication audit, infection control audit and accident audits were not robust.

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk