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Dover Cottage Rest Home

Inspection report

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Date of inspection visit: 23 July 2015
Date of publication: 08/09/2015

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?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 23 July 2015 and was unannounced. Dover Cottage Rest Home provides residential care for up to 15 older people. There were 11 people using the service at the time of the inspection some of whom were living with dementia.

There was a manager in post; however they were not yet registered with us to manage Dover Cottage Rest 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.

People were not protected from the risk of abuse and people had been abused by other people who used the service. Incidents were not identified as potential abuse; they were not reported or investigated.

Summary of findings

Risks to people's health and wellbeing were not consistently identified, managed and reviewed to ensure the risk of harm was reduced.

People were not always able to have their prescribed medicines when they needed them because there were insufficient numbers of trained staff.

The legal requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) were not being followed. The MCA is designed to protect people who can't make decisions for themselves or lack the mental capacity to do so and the DoLS ensures that people are not unlawfully restricted.

People did not always receive medical support and interventions in a timely way to ensure their health and well-being.

Staff had a good knowledge of people's individual care needs. Risk assessments and care plans did not reflect the current support and care needs of people.

People told us they were happy and they liked the staff. People's privacy was upheld and respected, however people's rights were not upheld.

People's care was not personalised and did not reflect their individual needs and preferences. Most people were disengaged and spent long periods of time with little or no stimulation.

The provider did not have effective systems in place to assess, monitor and improve the quality of care. Poor care was not being identified and rectified by the provider.

We found several breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

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?
The service was not safe. People were at risk of and had been abused by other people who used the service. Potential incidents of abuse had not been recognised or reported because the manager and staff did not know what to do if they suspected abuse.Risks to people's health and safety were not managed and reviewed. People were not always able to have their prescribed medicines when they needed them.

Inadequate

Is the service effective?
The service was not effective. People could not be assured that the requirements of the MCA and DoLS were being followed when decisions were being made by the manager and provider. People could not be assured they were being prevented from leaving the home in a lawful manner. Access to health care services and medical interventions were not provided in a timely manner when people required it.

Inadequate

Is the service caring?
The service was not consistently caring. Staff we spoke with were knowledgeable about the individual needs of the people they cared for. However, staff tended to make assumptions on behalf of people in relation to choices, options and preferences. People's privacy and dignity was upheld and respected, however their rights were not always respected.

Requires improvement

Is the service responsive?
The service was not responsive.People did not receive the care and support they needed in an individualised way. Changes to care and support needs were not reviewed in a timely way. Social and leisure activities were not readily available to support people with their emotional and social needs.

Inadequate

Is the service well-led?
The service was not well led. The service did not have a registered manager. Effective systems were not in place to assess, monitor and improve the quality of care. Poor care was not being identified and rectified by the manager and the provider.

Inadequate

Dover Cottage Rest 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 was 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 on 23 July and was unannounced.

The inspection team consisted of three inspectors.

During the inspection we spoke with six people who used the service and observed their care, we spoke with a relative, a visiting health professional, five members of care staff and the manager.

We looked at six people's care records to see if they were accurate and up to date.

We also looked at records relating to the management of the service. These included health and safety checks, staff files, staff rotas and training records.

Following our inspection we made two referrals to the local authority's safeguarding team and contacted the local commissioners. We did this because of significant concerns we identified with people's care.

Inadequate

Is the service safe?

Our findings

People who used the service were not safe and were at risk of abuse and had been abused by other people who used the service. We saw records and staff confirmed that one person had been assaulting other people who used the service on a regular basis. It was recorded that people had become distressed following the assaults. We asked the manager what had been done to protect people from further abuse and they informed us that they had requested advice from a GP. They confirmed no support had been offered and referrals to the local authority safeguarding team had not been made for the victims of the abuse. The manager and staff did not know that when a person was assaulted by another person who used the service that this constituted abuse and should be investigated. This meant that people were not protected from the risk of further abuse as the manager and staff were not following the provider's and local authority's safeguarding procedures.

We saw that one person had been found to have unexplained bruising. An investigation into how the person had received the bruises had not been carried out. This meant that this person was not being protected from the risk of abuse.

This is a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw there had been incidents that had put people who used the service at risk of harm. One person had been escorted into the community by a relative. Later in the day the person was seen alone by a member of staff. They had been assessed by the manager as lacking capacity to access the community alone and a DoLS referral had been made to restrict them leaving the service. The manager had spoken to the safeguarding authority about this incident; however they had not updated the person's risk assessment. The manager and staff could not tell us how they planned to minimise the risk of this occurring again. This person posed a risk to themselves and to other people by continuing with a specific life style choice within the home. We saw staff recorded when this had occurred but nothing had been done to minimise the risks. The manager told us that they tried to stop the person with their life style choice but without reaching a mutual agreement.

Another person required the use of specialist equipment to maintain their health. We asked staff and the manager if they knew how the equipment should be maintained. Neither were able to tell us whether the equipment was set correctly or if it was safe and effective. This meant that this person was at risk of harm due to their equipment not being maintained or monitored for its safety.

This is a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were sufficient numbers of staff to meet people's needs during the day; however people were not always able to have their medicines when they required them due to a lack of suitably trained staff at night. Staff who worked during the night had not received training in the administration of medication. The manager told us that people were not able to have their prescribed medicines after 8pm and they were unaware that anyone had requested medication during the night. We saw that several people had been prescribed 'as required' pain relief and inhalers which they may have required during this time. No plan was in place to ensure that people would be able to have their medication if they required it.

Inadequate

Is the service effective?

Our findings

Some people who used the service lacked mental capacity to make some decisions for themselves. We saw that the manager had completed DoLS referrals for everyone who used the service due to the doors to the exits and stairways being locked. Some people were being restricted of their preferences without legal consideration. A relative told us: "My relative has capacity to decide for themselves what they want, but staff won't let them do what they would like to do". This person was being restricted from doing something they wished to do; this had not been agreed by them or recorded in their DoLS referral as a required restriction. We saw and staff told us that they were searching the person's room without their consent or agreement and removing items relating to the activity from them. We asked the manager why the person was being stopped from participating in this activity; we were told that it was the provider's policy. This had not been agreed at the time of their admission and the manager and staff were restricting this person of their liberty to participate in their chosen activity.

This is a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order which had been put in place in 2014 when they were unwell and in hospital. We saw that the district nurses had alerted the staff in October 2014 to the fact that it had been incorrectly completed and would not be legally binding in the event of a medical emergency. The person themselves or their representative had not been involved in the decision making process. This had not been reviewed and the DNACPR was still in place. This meant that this person was at risk of not receiving care that was safe and proper.

This is a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of care that was not safe, effective or that met their needs. One person required medical intervention every three months to maintain their health. We saw records and it was confirmed by the manager and the health professionals involved that within a six month period this person had not received the intervention they needed. This had left them at risk of becoming seriously unwell. The manager and staff had not ensured that the person received the medical intervention they required at the time they needed it.

We saw records that two other people who used the service had been showing signs and symptoms of being unwell for up to a month. The manager told us that they knew that medical intervention should have been sought for both people, however it had not. This meant that these people were not receiving timely medical intervention to ensure their health and wellbeing.

This is a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they liked the food they were offered and had enough to eat. A relative told us: "My relative eats well". At lunchtime we saw there were two choices on offer and the food looked appetising and well presented. Drinks were offered throughout the day at set times and we observed one person asked for a cup of tea and a biscuit at a different time and staff quickly accommodated this request. When people required specific food monitoring this was completed. Nutritional risk assessments were completed and where there was a specific risk was identified we saw a corresponding care plan had been completed. People's cultural nutritional needs were identified for example a person did not eat a specific food on a certain day. Staff confirmed an alternative was offered to the person to comply with their requirements. People's nutritional needs were being met.

Requires improvement

Is the service caring?

Our findings

People who used the service told us they were happy with the care and support they received from the staff team. We observed interactions between staff and people were kind and compassionate.

Some people on occasions became upset, distressed and aggressive towards others. Although staff told us they supported people at these times, their care plans stated that their behaviour was 'being controlled by medication'. The manager told us that they recognised that the terminology used in people's care plans was not respectful and dignified.

Relatives and visitors were free to visit at any time. One relative told us: "I visit about twice a week and I can come at any time, they keep me informed of what's going on". However the manager confirmed and we saw records of incidents that had occurred that had not been reported to people's relatives. There were no opportunities for people to discuss their care or the running of the service. Regular reviews or meetings did not take place to give people the opportunity to be involved in their care planning. People were not being kept informed of events that had affected the wellbeing of their relative and were not involved in the planning of their care.

Staff knew people well and spoke about people in a kind and caring manner. Staff were very familiar with people's care and support needs, their likes and dislikes, however people were not always offered the opportunity to choose and make decisions for themselves. Staff chatted and laughed with people and had a good rapport. People were offered privacy at the times they needed it. We saw one person required support with their personal care and they were discreetly supported to their bedroom so staff could help them.

Inadequate

Is the service responsive?

Our findings

People who used the service did not always receive care that met their personal needs and preferences. One person was being cared for in their bedroom, this had been advised by a health professional in 2014 due to their 'unpredictable behaviour' when being supported to mobilise. However, this person had since been prescribed medication to support them with their behaviour, staff told us this had been effective and the person was less unpredictable. Their care plan stated 'behaviour is controlled by medication'. The manager confirmed that this person's needs had not been reviewed following the medication change and consideration to the person now being able to spend time out of their room had not been made. The provider was not responding to a change in this person's assessed needs.

We saw that this person's care plan stated that they liked to listen to music and sing with staff. However the person did not have a music system in their bedroom. The manager confirmed that this person spent the majority of time in their bedroom and was at risk of social isolation. No activities or equipment were available to reduce the risk of the person feeling isolated.

People who used the service were not offered any recreational or leisure activities and were not encouraged to pursue their hobbies or interests. People sat and slept in the lounge area. Only one person occupied themselves by dusting the dining room. A relative told us: "There is a lack of activity, lots of sitting watching TV". The manager confirmed that there were no activities available to people to stimulate and meet their emotional and social needs.

This is a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people who used the service had physical and sensory needs due to their disabilities. Consideration to people's sensory needs had not been made. There was no signage or visual prompts to support people to find their rooms or facilities within the home. This meant that people were not being supported to be as independent as they were able to be.

We saw there was a suggestions box available in the reception area and the provider's complaints procedure was on the wall. A relative told us that they would speak to the manager if they had any concerns. However we were made aware that relatives were not kept fully informed of incidents that affected their relative. This meant that they would not be in a position to complain about these incidents and other events that affected their relative as they would not have this information.

Inadequate

Is the service well-led?

Our findings

The service does not have a registered manager; however since June 2015 a staff member from another home owned by the provider had taken over the role as manager. Staff told us they felt well supported by the manager and they worked well as a team.

Effective systems were not in place to assess and monitor the quality of care. For example, no audit systems were in place to assess and monitor the quality of the information contained in people's care records to ensure information was current and appropriate in order to meet people's needs. We saw conflicting information in a care plan and risk assessment of the equipment to be used to support a person with transferring from area to area. Another person had not received the medical assistance they required at the time they needed it due to there being no system in place to remind staff when the intervention was required. People were at risk of harm due to the lack of effective monitoring of care plans and working practices.

Risks to people were not being consistently identified, managed and reviewed by the manager or provider. Some people's welfare and safety was not promoted and their current care needs not taken into consideration. For example, people at risk of developing sore skin and pressure areas were not being monitored to ensure they received the support they needed. Checks on equipment were not made to ensure they were safe and kept in good working order.

Care plans and risk assessments lacked clear, concise information to enable staff to care for people. Reviews of people's care were not regularly undertaken to ensure the care they were receiving reflected their current needs.

The manager had not raised safeguarding referrals with the local authority when there had been incidents of suspected abuse and did not recognise the need to so. Investigations were not carried out to reduce the risks to people and lessons were not being learned to ensure people were protected from further harm.

This is a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had started to implement some health and safety checks, but confirmed more rigorous and regular checks were needed to ensure the quality of the service.

This section is primarily information for the provider

Enforcement actions

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

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 to service users was not appropriate, met their needs or reflected their preferences.**

The enforcement action we took:
The service was placed into special measures and an urgent notice of decision was served on the provider to suspend all new admissions into the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Care and treatment of service user must only be provided with the consent of the relevant person. If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act.**

The enforcement action we took:
The service was placed into special measures and an urgent notice of decision was served on the provider to suspend all new admissions into the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment was not provided in a safe way.**

The enforcement action we took:
The service was placed into special measures and an urgent notice of decision was served on the provider to suspend all new admissions into the service.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not safeguarded from abuse and improper treatment.

The enforcement action we took:
The service was placed into special measures and an urgent notice of decision was served on the provider to suspend all new admissions into the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems were not established and operated effectively to ensure compliance with the requirements.

The enforcement action we took:
The service was placed into special measures and an urgent notice of decision was served on the provider to suspend all new admissions into the service.