Dorrington House

Dorrington House (Watton)

Inspection report

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26 April 2022

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Dorrington House (Watton) is a residential care home providing personal care and support to up to 52 older people, most of whom are living with dementia. At the time of our inspection there were 46 people using the service. The accommodation is built over two floors, with a lift. Bedrooms have ensuite toilets, and there are shared bathrooms and living spaces with an enclosed garden.

People's experience of using this service and what we found
People were not living in a clean, well maintained and comfortable care environment and were not being protected from the risk of harm. This included people living with dementia, having access to unsecured risk items such as denture cleaning tablets. We identified poor infection, prevention and control practices throughout the service.

People were not being supported to have their medicines safely, with lengthy medicine rounds, poor auditing and checks in place, which did not ensure people received their medicines on time. Poor practice had also resulted in one person being given out of date medicine, which placed them at risk of harm.

People at risk of falls, or needing to source additional support from staff, did not all have access to assistive technology that was in working order. People's care records were not being regularly reviewed following incidents such as falls, to ensure staff provided the required levels of support.

Staff were unfamiliar with people's needs, particularly in relation to dietary and choking related risks to keep people safe. If people required pureed diets, they were not offered a choice of different meal options, and food was plated up 30 minutes before eating, increasing the likelihood of the food being cold.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

There was not always sufficient staff to safely meet people's needs. Most people required support and supervision from staff, with tasks including the maintenance of their skin integrity, and the use of equipment to move for example from their bed to a wheelchair. Dependency information provided by the service showed that only one person out of the 46 living at the service was assessed to have low needs and be mainly independent with their own care requirements.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Requires Improvement (published 13 July 2021).

Why we inspected
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The inspection was prompted in part due to concerns received about staffing levels and standards of care provided. A decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of Safe and Well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from Requires Improvement to Inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, governance and oversight of the service, and staffing levels at this inspection.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Dorrington House (Watton)

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
There were three inspectors on the first day of inspection, with support from 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. On the second day of inspection there were two inspectors.

Service and service type
Dorrington House (Watton) is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Dorrington House (Watton) is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
Both inspection visits completed on 21 and 26 April 2022 were unannounced. The inspection completed on

26 April 2022 was undertaken at night time.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We liaised with members of the local authority, quality assurance team, and reviewed information held on our system about this service. We used all this information to plan our inspection.

During the inspection
Across the two inspection visits, we spoke with nine members of staff including the registered manager, regional manager (provider representative) and six members of care staff including those working at night time. We also spoke with the registered provider by telephone.

We reviewed a range of records, including eight people's care records and three medication records. We looked at staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with five relatives about their experience of the care provided by telephone. We provided final inspection feedback to the provider team on 09 May 2022.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- People's needs were not responded to in a timely way. During the day time inspection visit, we regularly were unable to find any staff present on the first floor of the service. We also found assistive technology not in working order, this was another method used by staff for monitoring people and responding to their needs.
- We observed a number of people moving around the service and accessing other people's bedrooms. There were not enough staff to monitor people, or to try to engage people in alternative, meaningful activities.
- Staff told us there were not enough staff on shift. This resulted in areas of care being task focused rather than providing quality, individualised interactions. One relative said, "The staff do seem to be working flat out and I think the home is struggling from a staffing point of view, although I do not think this is impacting on the residents."
- From speaking with staff, and reviewing rotas, the assessed levels of staff were not always in place. There were a number of people who needed assistance of two staff for changing their position, or completion of personal care tasks. We were not assured there were sufficient staff on shift to meet people's needs.
- The service provided evidence that staff accessed group supervision. However, for 2022, only 13 staff had attended one group supervision meeting, with 37 staff having no record to demonstrate they had received supervision. This did not ensure all staff had regular supervision and monitoring of their skills, knowledge and performance.

Sufficient levels of staff were not in place to keep people safe during the day and overnight. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- People's care records were not being reviewed and updated following incidents, such as falls. This did not ensure staff had access to up to date care guidance and risk information.
- Staff were unfamiliar with people's care and support needs. This was of particular concern in relation to meal times, where staff were unsure whether people needed specialist diets or food of a certain consistency to reduce their risk of choking.
- People were at risk of harm from poorly maintained equipment, including wheelchairs, walking aids and from disused equipment being stored in communal bathrooms accessed by people.
- Risk items were not stored securely. People were at risk of accessing, and potentially consuming items including denture cleaning tablets, personal care products, prescribed creams, as well as items such as razors. No risk mitigation was in place, as the units where the items were stored in bathrooms did not lock.

● Assistive technology was in use, but not working, placing people at risk of harm. Equipment used to reduce the risk of people falling, or to enable people to summon assistance from staff was found to not be working. There was no evidence of checks in place to ensure this issue was immediately identified and addressed.
● People were at risk of developing sore skin. People were not being supported to change their position for example when in bed, in line with guidance in their care plans, and from healthcare professionals.
● Staff files did not contain evidence of staff induction periods, and there was limited evidence of competency checks for medicines management provided. This did not ensure staff had the required skills, knowledge and training to provide safe care.

Using medicines safely
● People were at risk from poor medicine management. The medicine room was in a disordered state, and the medicine storage trolley was chaotic and not secured to the wall. This increased the risk of giving people incorrect medicines.
● Medicines management was unsafe. We found a person's medicine was out of date, but staff had continued to give the person the expired medicine. This risk had not been identified by staff or the provider's own audit systems.
● Equipment was unclean. Individual items of equipment were found to be visibly dirty. Equipment to crush tablets contained residue, increasing the risk of people either not receiving their full dose or receiving residue from other people's medicines mixed in.
● Medicine pots, spoons and other equipment was not being washed hygienically. Items were washed in a sluice room; the sink was covered in limescale and the room had malodour. We found poorly cleaned medicine pots ready for re-use.
● As required medicine (PRN) protocols were poor. These did not ensure staff considered all options prior to giving people PRN medicines.
● People living with dementia were not supported to communicate their pain needs effectively. The pain assessments in place were of poor quality and did not support people to ensure their pain needs were accurately identified and addressed.
● Where people could communicate their needs, we observed a person to repeatedly tell staff they had a headache, but no action was taken by staff to respond to their needs.

Preventing and controlling infection
● We were not assured that the provider was preventing visitors from catching and spreading infections. Inspectors were not asked at either inspection, to provide evidence of a recent COVID-19 test result and were not asked any health-based questions prior to entering the service. We also observed visitors to enter the service without encouragement from staff to wear face masks.
● We were not assured that the provider was meeting shielding and social distancing rules. There was a lack of individualized COVID-19 risk assessments in place. Support for people, particularly those living with dementia for example through changes to the layout and seating in communal areas had not been made to achieve social distancing. Items such as seating were not regularly cleaned if used by more than one person, to break the chain of infection.
● We were not assured that the provider was using Personal Protective Equipment (PPE) effectively and safely. Members of the management team were regularly observed to be in the office with colleagues and not wearing masks. They could be seen through glass screens by members of the public on arrival to the service. Staff were observed to regularly touch and readjust their masks while providing care to people.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Cleanliness throughout the service was poor. Equipment and communal facilities were visibly dirty. Discarded PPE was not placed in bins with lids to reduce the risk of the spread of infection.

● We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed. The care environment was in a poor condition, with many damaged surfaces impacting on the ability to keep them clean. There was limescale throughout the service, which impacted on standards of infection, prevention and control.

Risks relating to the health and welfare of people were not assessed or well managed, including a lack of procedures to prevent the risk of the spread of infection and poor management of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider's infection prevention and control policy was up to date. However, inspection findings and observations demonstrated that staff were not implementing training and the provider's policy into their practice.

Visiting in care homes
● Relatives told us they visited the service regularly and could see their loved ones inside or outside in the garden. However, inspection findings highlighted safety concerns and risks for visitors due to poor staff practices, and the overall condition of the care environment.
● Feedback from people's relatives was mainly positive about visiting. One relative stated, "Up until just recently we have had to do a lateral flow test before visiting, but now we do not have to do one. Also, from last week we no longer have to make an appointment to visit, we can go when we want to, so now I feel that I am more like visiting my relative at home as opposed to visiting them in an institution."

Systems and processes to safeguard people from the risk of abuse
● The condition of the care environment and standards of care provided did not protect people from the risk of harm.
● Staff were not found to always be responsive to our concerns or feedback to protect people where risks were identified.
● We made referrals to the local authority safeguarding team, who are responsible for investigating concerns of abuse, as an outcome of this inspection.
● Staff demonstrated an understanding of safeguarding processes, however, poor practices within the service were not being recognised, therefore appropriate and timely action was not always being taken.
● From speaking with relatives, we received no concerns about people's safety. One relative stated, "Within two months of being there [Name] told us how settled they were and that they were not coming home." Another relative said, "[Name] has done well since living at Dorrington House, they seem content and happy, they cannot tell us what is going on, but they seem completely at ease."

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 MCA 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 to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was not always working within the principles of the MCA. If needed, appropriate legal

authorisations were in place to deprive a person of their liberty. However, we identified examples of restrictive practice, and least restrictive options had not been explored.

● People's lives lacked choice and control. This was contributed to low staffing levels, the quality of the care environment, and a lack of understanding of tailoring approaches to support people living with dementia to have a greater level of involvement in their own care.

● People's relatives gave some feedback on people's choice and control. One relative said, "[Name] has not told me if they are given a choice of when to get up or go to bed." Another relative stated, "With [Name's] dementia, the staff allow them to be whoever they wish to be, [Name] does walk around a lot. I have noticed that if one of the residents thinks that they are at work, the staff just go with that."

Learning lessons when things go wrong

● Lessons had not been learnt from the last inspection. The overall rating, and number of breaches of the regulation found at this inspection did not demonstrate that the provider had reflected on inspection findings and feedback or taken on board guidance and advice from other stakeholders.

● Any improvements made to the service as an outcome of this inspection are because the shortfalls were pointed out to the provider, rather than due to them having effective systems in place to identify issues independently.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Medicine audits were of a poor quality. The documents were not dated, to be clear when the audits were completed. The number of concerns identified during the inspection regarding medicines management identified these audits were ineffective.
- The environmental risk assessment identified that only people's own equipment should be stored in their bedrooms and identified in January 2022 that the medicine cabinets were not fixed to the wall. However, when we inspected in April 2022, these risks remained.
- The infection, prevention and control audits were not an accurate reflection of inspection findings. The audits stated that people's personal care products were stored safely but we identified there were no lockable cabinets in place for this to be achieved.
- The infection, prevention and control audit stated bedding, sheets and pillows were in good condition, and bathrooms were clear to enable floors to be kept clean. We found bedding to be in a poor condition, and beds not well made. The registered manager told us new fitted bed sheets were being ordered as an outcome of inspection findings.
- There was a lack of auditing of staff files, to ensure all relevant safety checks were in place before staff started working at the service.
- The health and safety audits were poor and had not identified risks relating to the condition and cleanliness of the environment, and equipment in place within the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Prior to this inspection, the provider did not have their current inspection report and accurate rating accessible for the public. The registered provider was not meeting their legal responsibilities to display accurate ratings.
- Poor documentation of information such as weight records, and repositioning charts was impacting on the quality of auditing being completed. There was a lack of learning from incidents, analysis was not being completed to identify trends, themes and risk mitigation being put in place.
- Documentation relating to accidents and incidents was not stored in any order, and again did not enable lessons to be learnt or analysis and evaluation to be completed. The poor quality of records also impacted on the service being able to demonstrate appropriate actions were taken following incidents.

● Poor documentation did not consistently demonstrate that the registered manager had met their responsibilities and requirements under the duty of candour, for example in the handling of accidents and incidents or where things had gone wrong.
● As an outcome of inspection findings, five people required replacement assistive technology. Whilst awaiting delivery of the replacement equipment, we were told by the provider 15-minute observations would be completed by staff. However, the service was unable to provide any evidence these checks were completed.
● The registered manager was recording the completion of daily 'walk arounds' within the service. However, we reviewed these records against inspection findings and identified these did not reflect the condition of the medicines room, the cleanliness or the condition of the environment or items such as bedding.
● From inspection findings, and our observations, the management and staff team were not recognising poor practice, or the deterioration of the care environment to achieve good outcomes for people living at the service. This was reflected in the overall deterioration in rating, and breaches of regulation identified.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Some people's relatives seemed unclear who the registered manager of the service was, which did not demonstrate regular engagement with people's relatives. One relative stated, "I don't know who the manager is, but someone in charge always keeps us informed." Another relative said, "I don't know who the manager is; I think it is either [Provider's names]."
● The service was not providing high standards of care and was not working in line with their own values, as set out on their website, and in their statement of purpose.
● Care was found to be task focused rather than person-centred, and a lack of provider level oversight of the service did not ensure that people were being empowered to lead meaningful lives as part of their wider community.
● Gaps in provider level oversight of the service did not demonstrate that they had a good awareness of people's quality of life and were not ensuring that good standards of service provision were being maintained.
● Where staff had attempted to raise concerns with the management team, we found evidence that their feedback was not taken seriously, and the response provided did not encourage staff to raise concerns. This did not demonstrate an openness within the management culture, or willingness to learn from suggestions made by the staff team.

Working in partnership with others
● Examples of actions taken by the provider's representatives, following initial inspection feedback, demonstrated a lack of insight into risk, particularly in relation to the management of infection, prevention and control, including COVID-19 management.
● Improvements to partnership working with people, their relatives and with staff was required to ensure people experienced a good quality of life and to make sure going forward, the service made improvements to the standards of personalised care and support provided.
● Maintenance arrangements in place did not offer timely enough responses to address issues with the condition of the care environment.

The provider had poor governance and oversight arrangements in place to maintain standards and drive improvement at the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 HSCA RA Regulations 2014 Staffing The care provider was not ensuring there were sufficient staff to be fully responsive to risks and meet people's assessed support needs, including at night time. Regulation 18 (1)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The care provider was not ensuring that the condition and cleanliness of the care environment and equipment used with people was, and preventing the risk of the spread of infections such as COVID-19. The care provider was not ensuring safe medicines management practices were in place. Regulation 12 (1) (2) (a) (b) (e) (g) (h)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The care provider did not have good governance and leadership in place. Audits and quality checks were not identifying risks and shortfalls. Regulation 17 (1) (2) (a) (b)

The enforcement action we took:

Warning notice