Caring Homes Healthcare Group Limited

Dormy House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Dormy House is a care home with nursing which is registered to accommodate 88 older adults, some of whom require specialist care for dementia. Dormy House is located in Sunningdale near Ascot, Berkshire and overlooks a famous golf course. There are beautiful landscaped gardens around the building. At the time of the inspection 73 people lived at Dormy House. The service is part of the Caring Homes group, who are an adult social care corporate provider. Dormy House is divided into three units; Surrey unit provides specialist dementia care. Dormy unit provides nursing care and Wentworth unit provides mainly residential care. An extensive refurbishment and redecoration programme continued in 2017 to update bedrooms and communal spaces at the service.

At the time of the inspection, there was a registered manager. 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.

Our last inspection was on 18 August 2016 under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was a focused, responsive inspection following information of concern we received. We inspected key question 'Is the service safe?' which was rated 'requires improvement'. This was because systems were in place to protect people from harm; however, these had not protected all people at the time. The prior inspection did not change the service's overall prior rating of good. The latest inspection found the service had sustained their improvements for protecting people, and the subsequent rating for the key question has changed to 'good'.

People were safeguarded from abuse or neglect. There was a system in place to ensure that people's safety was maintained. Staff were knowledgeable about abuse and how to deal with any allegations.

Appropriate pre-admission and admission risk assessments were recorded. Care plans and evaluations were completed in association with any risks identified for people.

The safety of the premises, equipment and grounds were assessed and managed which protected people, staff and visitors from risk. We viewed maintenance records which demonstrated most required checks for health and safety were completed. We made a recommendation about keeping appropriate documentation related to maintenance works by contractors.

There were sufficient staff deployed to support people. Our observations showed that the staff were occasionally busy but not task-focussed, which led to positive experiences when they interacted with people. Staff worked well together in their respective teams, were flexible with the service's requirements and were willing to assist their colleagues.

Medicines were well-managed. We examined the handling of people's medicines during our inspection and

found that people were safe from harm. Registered nurses demonstrated good practice, in line with that set by national standards and guidelines. Regular pharmacist and GP input was sought and obtained for the management of people's medicines. We made a recommendation about the auditing of controlled drugs.

Staff received appropriate levels of induction, training and supervisions.

The service broadly followed the requirements of the Mental Capacity Act 2005 (MCA). The recording of consent and best interest decisions meant the service did not always comply with the MCA codes of practice. We made recommendations about the documentation used for consent and attorneys. We also recommended that policies be reviewed in line with current industry practice. There were records at the service regarding people's applications, reviews and expiry dates for standard Deprivation of Liberty Safeguards (DoLS) authorisations. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

People received nutritious, appetising food which they had a positive opinion about. Appropriate hydration was offered to people to ensure they did not become dehydrated. Snacks and treats were available if people wanted or chose to have them. Alternative menus were available. People told us they liked the food and had good choices. The kitchen staff demonstrated excellent presentation of texture-modified food for people with swallowing difficulties.

We found the service was caring. People told us staff were kind and patient. We observed staff were warm and friendly when they interacted with people. Staff smiled and laughed with people, and encouraged them to enjoy their stay.

Responsive care was provided to people. Their wishes, preferences, likes and dislikes were considered and accommodated. The service had a robust complaints procedure.

The service was well-led. People who used the service, relatives, healthcare professionals and staff were satisfied with the management of the service. We found the management team were approachable, involved in the care activities and listened carefully to our feedback. A list of audits were used to check the quality of care. Action plans were used to address any areas that required improvement. We made a recommendation about gaining further feedback about the service to aid continuous improvement for people's care experience.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt that they lived in a safe environment and received safe care.

People were protected from abuse and neglect.

People's personal risks were assessed and managed to ensure safe care provision.

Safe staffing recruitment and deployment were in place.

People's medicines were safely managed.

Is the service effective?

Good

The service was effective.

Staff training, supervisions and performance appraisals were appropriate.

People's consent was obtained, but required some improvements to ensure clarity.

People were supported to maintain a healthy balanced diet.

People were supported to have access to healthcare services and receive ongoing support from community professionals.

Is the service caring?

Good

The service was caring.

People were treated by staff with a kind approach.

People and relatives told us they felt staff were always caring.

People's privacy and dignity was respected.

People's confidentiality was securely maintained by the service.

Is the service responsive?

Good

The service was responsive.

People's care planning and support provided by staff was person-centred.

People's preferences and dislikes were understood and respected by staff.

People had access to a good range of activities and socialisation was encouraged.

There was a complaints system in place and issues were addressed promptly.

Is the service well-led?

Good

The service was well-led.

People and relatives provided positive opinions about the management.

Staff worked in a positive workplace culture.

People's care quality and safety was measured and improved by the service's range of audits and checks.

Dormy 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 was planned to check 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.

This inspection took place on 6, 7 and 10 April 2017 and was unannounced. The inspection was undertaken by two adult social care inspectors, a pharmacist inspector, two specialist advisors 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. The Expert by Experience had knowledge of care and support provided to older adults.

For this inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we already held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law. We asked the local authority teams, clinical commissioning groups (CCG), community-based healthcare professionals, fire authority and environmental health officer for information to aid planning of our inspection. We checked information held at Companies House, the Information Commissioner's Office and the Food Safety Authority.

We spoke with 15 people who used the service and six relatives or visitors. We spoke with the provider's management representative, regional manager, registered manager, deputy manager, chef and two kitchen assistants, two cleaners and maintenance workers. We also spoke with three registered nurses, ten care workers, the administrator, the receptionist and an activities coordinator. Healthcare professionals who work with the service sent us written feedback prior to our inspection.

We looked at 20 sets of records related to people's individual care needs. These included care plans, risk assessments and daily monitoring records. We also looked at five personnel files and records associated with the management of the service, including quality audits. We asked the provider to send further documents after the inspection. The provider sent documents to us after the inspection for use as additional

evidence.

We looked throughout the premises and observed care practices and people's interactions with staff during the inspection.

Good

Is the service safe?

Our findings

At our last inspection on 18 August 2016, we rated this key question as 'requires improvement.' This was because we found systems were in place to protect people from harm, however, these had not protected all people at the time. We have checked this at our inspection and found that the service took steps to improve and sustain the protection of people from harm. The subsequent rating for the key question has therefore changed to 'good'.

People told us they felt safe care was provided. One person told us staff did not make mistakes when giving them their medicines and added it was ..."always done by trained nurses." Another person told us about going out and their experience of feeling safe. The person said, "Recently someone accompanies me, friends or family, if I go out [of the service] because it's safer. The carers are very hot on that." Another person told us they previously went out unaccompanied but as their care needs had increased, this is no longer possible. The person commented, "I feel very safe living here." A further person we spoke with also told us of the staff focus on preventing harm. This person stated, "They tell me not to walk on my own in case I fall." A visitor we spoke with also felt the service provided safe care. The visitor stated, "I know [my relative] is safe living here."

People were protected from abuse and neglect. We found staff were trained in the protection of people at risk of harm, during their induction and on a recurring basis. Training included safeguarding and whistleblowing, so that staff knew what to do in the event of an allegation of abuse or neglect. The service had a policy that staff could not use mobile phones during their shift. When we checked, we found no evidence of this; however two staff had their mobile phones in their pockets when we asked. We made the registered manager aware. When we spoke with staff, they knew types of abuse and what to do if they suspected people were at risk of harm. The provider had a good whistleblowing procedure throughout their group, which meant staff could report issues with anonymity (if required). We found the registered manager took appropriate action when there were any allegations of people's harm. We were told the registered manager appropriately liaised with the local safeguarding team to ensure any concerns were fully investigated and action to prevent harm or repetition.

The service ensured that people, visitors and staff were protected from risks related to the building, equipment and grounds. During the inspection, we saw building work was in progress. The service and builders had appropriately blocked off access to areas that may pose danger to people. There was also adequate signage to prevent people inadvertently accessing the building site. We spoke with the maintenance person and checked records of regular checks done. We saw routine checks were conducted for fire safety, Legionella, gas safety, electrical safety and of lifting equipment. Appropriate risk assessments were also present. Some recommendations about repairs to passenger lifts and remedial actions for Legionella safety were required by the provider's relevant designated contractors. We asked to see evidence regarding action taken to manage the potential risks identified. This was provided, although some documents were not readily available.

We recommend the service maintains a clear list of all remedial works to the building and equipment, and stores appropriate records.

We looked at seven people's care files to check the service satisfactorily assessed, documented and managed risks to people from personal and nursing care. We saw pre-admission assessments were completed in all instances and contained relevant information such as likes and dislikes along with baseline observations and pre-admission weight. People's medical histories were obtained from their GP and recorded in pre-admission assessments.

In all of the care files we reviewed, we found risk assessments included falls risks, the malnutrition universal screening tool (MUST), moving and handling, and risk of pressure ulcers (Waterlow scores). in all instances these were reviewed on a monthly basis. People's weights were monitored on a monthly basis to ensure people were not at risk of malnutrition. MUST assessments ranged from low to high risk, and where needed we saw there was involvement of a GP and dietitian.

Some people who used the service were involved in safety incidents. We reviewed accident and incident records and also audits completed on the records. People's falls and resultant injuries were appropriately documented on paper records by staff, sent to the management team, and then entered into a computerised database. The management team reviewed all of the reported injuries and made notes appropriate to the risks, injuries and staff actions. The provider's head office had access to the computerised records so that they could identify trends or themes about the injuries. We found no patterns in the incidents reports we reviewed. We saw the file of accidents and incidents had monthly audits completed by the registered manager and there was a yearly audit provided. In one person's care file, we found evidence that there were a number of documented falls but these did not correspond with the number of accident forms in the management team's folder. We reported this to the registered manager who provided us assurance that this would be investigated to determine why the records did not match.

People were protected because the service had a robust recruitment process. We spoke with the administrator who explained the procedures. This meant people could be assured that fit and proper checks of new workers was completed. We examined five personnel files of recent staff that had commenced employment. All of the necessary checks were on record. This included verification of staff identities, criminal record checks from the Disclosure and Barring Service (DBS), checks of conduct in prior employment and the right to work in the UK. Staff were interviewed by the management team and selected based on their knowledge, skills and experience.

Staffing deployment was satisfactory. We spoke with people who used the service, relatives and workers regarding numbers of staff on shifts. Overall, the feedback we received was positive. A small number of people told us they requested assistance and occasionally had to wait for the staff to respond. When we spoke with staff, they were aware of this and gave suitable reasons, like the scale of the building. We noted this in particular in the communal lounge area at the front of the building, where staff could be spread out across large areas of the unit at any time. However, during the entire inspection we found call bells were answered by staff promptly. We also found that when an emergency call bell occurred, staff responded quickly. The service used monthly dependency assessments to calculate the required staffing levels. These were reviewed regularly, but ad hoc changes were sometimes needed and staffing was changed to accommodate this. We reviewed rotas and found these were in line with the dependency calculations. The service used some agency staff but we found an ongoing attempt by the management team to fill staff vacancies.

During our inspection we looked at the arrangements for managing medicines (including obtaining, recording, handling, storing, security and disposal) and found that processes kept people safe. A comprehensive medicines management policy was in place and staff had signed to say they had read and understood this. Medicines were checked and recorded when received into the service. We checked some

quantities of medicines against what was recorded and found these to be correct. We saw a letter that one person's medicines had changed on 13 March 2017, but the medicines administration record (MAR) from the 3 April 2017 was not updated by the GP and pharmacy. However, nursing staff responded to this on the day of inspection.

Medicines were stored safely and securely. Medicines fridge temperatures were monitored appropriately. All medicines were within their expiry dates and there was a process in place for recording and disposing of unwanted and expired medicines appropriately.

Controlled drugs (medicines with potential for misuse, requiring special storage and closer monitoring) were stored and recorded in line with relevant legislation. Registered nurses carried out balance checks of the controlled drugs. However, this was not always done regularly. This meant that if a discrepancy was found it would be more difficult to know when it had occurred.

We recommend that the service's policy should specify how frequently controlled drugs balance checks should be carried out, based on frequency of use, medicines incidents and risk assessment.

Medicines were administered by registered nurses and we saw evidence that staff were assessed as competent to manage and administer medicines safely. We observed medicines administered and this was hygienic and safe. The registered nurses were knowledgeable about people's medicines and encouraged people to take their medicines in a caring manner. Medicines were signed for after they were given and there were no missed doses seen on MARs. Some medicines were prescribed on a 'when required' basis, for example for pain relief. There was guidance in place for each person's 'when required' medicine and we observed a registered nurse asking people if they were in pain. Some people were administered their medicines covertly (disguised in food or drink). We saw documentation for one person and the decision for this was in the person's best interests. The GP and community pharmacist had signed assessments and families were informed.

Staff told us that medicines incidents were reported and these were investigated by senior staff. Lessons learnt as a result of investigations were shared during registered nurse meetings and we saw evidence of meeting minutes that contained information about medicines issues.

The service was clean and odour free. We observed cleaning occurred throughout our inspection. We noted the cleaning trolley in the Surrey Unit had chemicals stored on a shelf. At times, the cleaner was not with the trolley during completion of their tasks inside bedrooms and communal areas. There was a risk that people with dementia or people who were confused may perceive the chemical bottles as drinks and inadvertently consume them. We pointed this risk out to the registered manager who told us they would organise a replacement cleaning trolley which contained lockable storage for the chemicals.

Good

Is the service effective?

Our findings

Two relatives we spoke with told us they felt staff were well-trained. Two people we asked also agreed. The first person said, "The carers are well trained. Some young, but willing and very polite and friendly. This person told us she asked for pain medicine regularly and felt the attention and administration by the registered nurses was good. The person continued, "They try to be quick." The other person told us, "They are nice staff… I think there's enough [of them]….Even if they are not from the United Kingdom, they speak very good English. I've never met one who I can't understand and they can understand me too." Whilst we spoke with the person, they complained of pain to a care worker who knew to seek the attention of the registered nurse. The person received some analgesia within five minutes of stating they felt uncomfortable.

The service used Skill for Care's 'Care Certificate' as the basis of their induction for staff who were new to adult social care work. The 'Care Certificate' is a set of 15 standards that care workers are expected to follow in their daily working life and should be covered during their induction period. The management team showed us the provider had recently updated their own version of the 'Care Certificate' with pre-printed volumes of the modules. Ongoing staff training was also closely monitored. We saw most staff were up to date in the training the service considered was mandatory. There were a small number of subjects where the overall rate of completion was lower than projected. When we asked about this, the registered manager told us this was due to staff turnover. We saw mandatory training included: fire safety, basic first aid, moving and handling, infection control, administration of medicines and safeguarding adults at risk. Staff were also provided with training specific to the people they supported. One area that the service focused on was training in dementia awareness. The service commenced a new national training programme that could lead to accreditation as an outstanding provider of dementia care to people. This involved staff completing topics called 'Living in my world', 'Understanding' and 'Supporting'. Successful completion of each topic led to a staff award of bronze, silver and gold. Although a recent introduction at Dormy House, a small number of staff had commenced and the management team aimed to gain the recognition of good dementia care once enough staff had completed the courses.

We saw staff completed appropriate supervision sessions and performance appraisals with their line managers. Some staff were more difficult to engage in regular supervision sessions, for example night workers, but we found the management put effort into ensuring all staff received adequate support.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application 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 were concerned that the service was not acting in compliance with the requirements for consent, MCA and DoLS and the associated codes of practice. Some changes to the adult social care sector's procedures for these areas were not included in the service's documents and processes. We extended our inspection by a day and asked a best interest assessor specialist advisor to review evidence in detail. We initially looked at the service's five policies pertaining to consent, MCA and restriction. Polices about the MCA and advance decision making contained correct information for staff to follow. The DoLS, covert administration of medicines and consent to care and treatment policies required changes to ensure they related to the requirements set by the MCA and associated codes of practice. We provided this feedback to the management at the time of the inspection. We were told a new policy was in production by the provider, but this was not available.

We recommend that the service reviews all policies related to consent, DoLS and covert administration of medicines in line with the MCA, associated codes of practice and relevant recent case law.

Staff showed an understanding of the consent process. They were able to explain the principles of implied and verbal consent, and the basic requirements for written consent. A tool designed to record consent to the various elements of care was not satisfactory. The form included aspects that were not necessary and made completion and interpretation by staff more complicated. For people with capacity to consent, some forms were signed and others were unable to be physically signed by the person but staff recorded their verbal consent. The form did contain a section to record if people had an enduring or lasting power of attorney (EPA and LPA), Court of Protection Order or advocate. We spoke with the deputy manager and administrator, who had the knowledge of which people had EPAs and LPAs. The administrator, who was new in their role, had already established a list and contacted people and relatives to determine whether attorneys or deputies were appointed. They had managed to obtain copies from a number of family members and told us they intended to continue working on this. We examined all care files in the service with the deputy manager for presence of EPAs, LPAs and the corresponding documents. These did not match with the administrator's information but the information was shared so that the care files and list could both be accurate.

We recommend that the service ensures documentation pertaining to all people's attorneys and deputies is obtained, stored appropriately and the information shared with relevant staff.

DoLS applications were appropriately completed and submitted to the relevant local authorities. The registered manager kept a list of people's DoLS application and approval statuses. The service's records showed that 14 people were subject to a standard DoLS authorisation at the time of our inspection and that a further 10 were awaiting the determination by a best interest assessor. Following a check with one local authority, we found that one of these applications was not submitted. We pointed this out to the registered manager who organised the submission of the application. It was noted that statutory notifications in respect of people with approved DoLS authorisations were appropriately received by us.

We looked at the DoLS outcomes of eight people and the best interest decisions records of one person. Some people's DoLS authorisations were subject to conditions. For example, one authorisation was subject to a condition that the service notified the DoLS team if there were any changes to the restrictions put in place specifically in relation to the administration of medication covertly and a restriction in the doorway to the person's bedroom. We discussed this condition with the registered manager who informed us that no changes had been made in these two areas. We found this supported by the care plan documentation we reviewed. There was both a medicines administration care plan and mental capacity assessment in the care

documentation. Both documents showed evidence of a best interests decision involving relevant professionals and family in relation to the covert administration of medicines. There was also evidence that staff had considered whether covert administration was the least restrictive way of dealing with this matter.

The deputy manager told us that consideration would be given to the introduction of a separate DoLS care plan so that matters arising from a DoLS authorisation may be more adequately recorded and managed. This would also ensure all staff that provided personal or nursing care could readily access pertinent information about restrictions and conditions of people's DoLS authorisations.

Consistent praise was provided by people and visitors regarding the nutrition and hydration. One person stated, "The food is good. The cooks are brilliant." This person was so impressed with the kitchen, catering staff and the quality of the meals that they wanted us to see them. We spoke with the chefs and kitchen assistants as part of our inspection. The second person we asked gave us the 'thumbs up' when we asked what the food is like. Another person said, "I vary where I eat; in my room or in the dining room. You can ask what is for lunch and they tell you. I can't complain about the food." Another person said, "The food is always very nice… I go downstairs to eat." A further person said, "We can have something else to eat if we don't like the main choices."

We found people were provided with adequate food and drinks that catered to their likes. One of our inspection team sat with people during in the main dining room. Everyone was offered and had drinks. We saw the meal service was efficient but relaxed. We observed a care worker talking a person who used the service about the choices available, going to great lengths to explain exactly what a particular dish was and how it had been cooked to make sure the person could make an informed choice. The person told us afterwards that was a typical example of how staff took time to make people were served what they liked to eat. We noted the chef circulated amongst the tables and talked with people about the menu to check if they were happy. One person told us they always attended meals in the dining room and talked to the chef, adding "He's nice."

We examined the presentation of food that was texture-modified, which was offered to people with swallowing difficulties. Instead of serving spoons of the food on a plate which did not resemble the original vegetable or meat, the service had invested in moulds. The moulds allowed the food to be shaped into a format that looked appetising and encouraged people to eat it. We were provided with a demonstration of the food used in the moulds. There were several meals shown to us, which looked inviting and appeared attractive. The chef then gave an explanation of how the moulds worked, how they were used and the training staff attended to learn about their use. We found a number of people required texture-modified foods, and each person had their food presented using the moulds. The service's efforts with the presentation of pureed foods were recognised in the provider's newsletter. This method of meal presentation meant that people were encouraged to consume the food, and reduced the risk of malnutrition.

People had ongoing support from multidisciplinary healthcare teams. Health professionals like GPs, dietitians, speech and language therapists and district nurses attended to people within the service regularly. People were also taken into community settings for their appointments or health tests. We observed a contemporaneous log of healthcare support was maintained and stored by staff in each person's care file.

Good

Is the service caring?

Our findings

People told us Dormy House was caring. One person told us, "You won't find better than this. I'm staying here 'til the end of my days. If I say to them 'Wake me at 7 in the morning', they do so. Always…..nothing here could be improved upon." A second person commented, "The staff are marvellous, very good, [though] some are better than others. Everything is done that needs to be done. If I've got to be somewhere like this, this is absolutely the best place to be. I can't think of anything bad to say." Other people we spoke with said, "Absolutely. Yes, they are [looking after us well]. I've no complaints..." and, "The carers learn to know what you want so you don't have to tell them. They know."

Relatives we spoke with were also positive that staff were caring. One relative told us about their concern for their loved one. They said that for two day their family member was tired and went to bed in the afternoon without eating breakfast or lunch. The relative said they wanted to know the person was eating normally again and a care worker they asked knew, and immediately confirmed what the person had food and fluids the person consumed in the prior to days. The relative commented that this demonstrated staff were caring and the care worker on the shifts was aware of the person's situation. Another relative we spoke with commented, "It's early days. The staff seem very caring. I've just sat and watched [my family member] having lunch and it's very good. He is not sleeping at night so they are trying to keep him awake all day so he can sleep at night. All he wants is a comfortable place where people are kind to him." When we asked the relative if the care experienced was good, they told us that the service provided the care the person and themselves expected.

The service aimed to include people and their significant others in care planning and review. Some people were unable to participate in decisions about care, treatment and support and we found staff made the best choices for them, Relatives (some of whom were appointed attorneys), healthcare professionals and friends people were involved in decision-making at each step, even before people started to live at the service. When we spoke with staff, they knew relevant information about people and their relatives. Staff knew people's social history and encouraged them to think about their past and what they had accomplished or experienced in their life. The activities coordinator made particular use of this task as a routine part of the support provided to people. As there were two vacant posts in the activities team, this could be expanded further when new staff are appointed to the relevant roles.

People's dignity and privacy were preserved. We observed staff always addressed people by their preferred name, and often laughed and joked with them. People we spoke with and observed in communal spaces were well-groomed and dressed. We saw some people liked to use make-up and staff assisted them every day to have this applied. When personal care took place, this was behind closed doors and staff were observed to knock when any door was closed before they entered the room. Staff that cleaned the premises were also mindful of people's care.

Confidentiality of people's information was maintained, including electronic records and communication. We noted that all computers required a user password to log in. Personal information was protected by computer systems because they promptly logged off if left unattended. Computers were at staff stations and

paper-based records were locked away appropriately. Records were only used by staff when they recorded information about care, and we observed documentation was always immediately stored in the correct place.

At the time of the inspection, the provider was registered with the Information Commissioner's Office (ICO). The Data Protection Act 1998 requires every organisation that processes personal information to register with the ICO unless they are exempt. This meant the service ensured that confidential personal information was handled with sensitivity and complied with the legislation.

Good

Is the service responsive?

Our findings

At a prior inspection on 3 February and 10 February 2015, we rated this key question as 'requires improvement.' This was because we found care plans did not always accurately reflect people's needs and records were not always completed promptly. We have checked this at our inspection and found that the service has improved and sustained people's care plans and daily records. The subsequent rating for the key question has therefore changed to 'good'.

We saw that care between staff and people who used the service was person-centred and responsive to people's needs. People's experiences indicated that the service encouraged people to socialise in communal areas and also enjoy the local community. The main lounge on the ground floor was continually lively, with numerous people sitting, chatting, enjoying food and drinks and speaking with staff who accompanied them at various intervals. We also observed visitors happy to sit with their relatives in the area and often included other people who used the service in their conversations. We noted some children visited and the positive effect this had on people's behaviours. We asked people and visitors whether care provided was individualised. We received positive feedback from all those we asked. One relative told us, "...they get the best care possible. The staff are all good and they seem properly trained. The staff are good at anticipating [my loved one's] needs."

We noted one person who used the service enjoyed walking and talking to anyone throughout the building. On their own accord, they undertook to show one of the inspection team members around. We observed that during our tour, the activities coordinator asked the person to collect a list of names of people who desired manicures on that day. As we spent time with the person, they were pleased they were given the role to undertake and this was one of the things they liked to do. This was an example of good practice.

We also observed other staff interaction with people who used the service. We found a person-centred approach through the entire inspection. We saw one relative visited a person in the main sitting room. They told me they visited every other day and felt welcome. We observed that the care workers chatted with the family member in a helpful manner about a pair of the person's slippers which could not be located. They helped the person to fit a replacement pair the relative had brought with them. The registered manager walked past and greeted the person, who was pleased to see her. The registered manager discussed with the person the possibility of getting their fingernails trimmed as the activities coordinator continued to complete manicures.

We asked staff about interactions with people and observed their process of personalised care provision. One person we visited was in their bed, and consumed a cup of tea. They were pleased to see us and spoke with us about their care. They provided a positive account of staff interaction during care or when staff answered their call bell. We then spoke to a care assistant on the unit to ask them how they usually provided assistance to the person. The staff member said, "He is calmer when he is on his own. He can get aggressive when he is with other people. But he is our [first name]. We know him and like him, whatever his behaviour is like." This experience showed that staff were recognisant of how each person's care was different and should be provided in a responsive manner to the person's needs.

We visited one person person's room, with their consent, to ask their experience of the care. We saw the bedroom was highly personalised, with a lot of communication equipment available. They told us this was important to them. We saw a landline phone, 'old style' mobile phone, smart mobile phone for e-mail and a modem for Wi-Fi. The person liked to keep in touch with others. The person said they had an active social life at Dormy House. They told us they liked to visit local restaurants with friends and sometimes attended activities downstairs such as exercise classes. The person said, "If it's a nice afternoon I can go down and sit outside and talk to a very nice gentleman...they have cushions on the seats outside and a parasol."

We observed another person sitting in a communal lounge area listening to music. We asked the person what they liked to do on a daily basis. They told us, "I like the music they play." Another person who used the service commented to us, "Actually, it's not bad here. I think we are quite lucky to be here… we have a dog that comes round here…. I am hoping we can introduce healing [therapy]. If you ask them for anything they usually provide it. We get what we want." We also spoke with the volunteer who told us they visited once a week with the dog. They had commenced this after their relative had lived at the service. They told us that when their family member had passed away, the service was very supportive to them and the end of life care was very good. At the time of the inspection, they had visited the service for two years with the dog for people's enjoyment.

In one unit, we observed a further a person with dementia had been quite tearful in the morning. We noticed that care workers paid particular gentle attention to the person and by noon, they had cheered up and chatted with us in a positive mood. The person said they had a manicure between our chats with them, and said they felt pleased with that. They told us their mood improved because staff had noted their feelings, and used techniques that would cheer them up.

Each person had a named registered nurse and key worker. We found care plans were comprehensive with clear and detailed information on particular health needs, likes, dislikes and preferred routines. Care plans were evaluated monthly by staff and any changes incorporated. All care plans we reviewed were up-to-date and monthly assessments were clearly recorded. There was good evidence of response to changes in people's needs. For example, we saw there was detailed documentation on dietary preferences which included physical requirements or impairments such as assistance to eat or the need to have modified food textures. Daily notes were detailed and relevant and it was possible to see that care needs and preferences recorded in the care plans were delivered correctly.

People's right to choice in their care was maintained at the service. We found a number of examples when we reviewed the care files and spoke with people. For example, one person had a pressure ulcer but had asked not be disturbed at night to turn or change their position. This choice was respected and was documented in the care plan with a reasoned assessment of risk. The person was found to be able to move sufficiently and that an undisturbed night was not seen as a significant risk. We also saw one person had lost weight and the care plan recorded that they were switched to a softer diet, to make food more palatable. This person had gained weight as a result, which lessened their risk of malnutrition. Another person had used bed rails at night but changed their mind and no longer wanted them. The care plan recorded that bed rails were removed in response to the person's own decision.

The complaints, suggestions and compliments procedure were clearly displayed in the reception areas. We reviewed the complaints log and documentation for complaints received since our last comprehensive inspection. We looked at the complaints process to check how they were investigated and managed. We saw the complaints log registered the date of a complaint, name of the complainant (and person who used the service), how the complaint arrived, the subject of complaint, and whether the complaint was resolved, including what action was taken to ensure closure. There was a small number of complaints, with no trends

or themes listed. The management team told us they took complaints seriously, and ensured each one was investigated. There was the possibility to escalate the complaint to the provider or external organisations if a satisfactory outcome could not be reached with the complainant.

Good

Is the service well-led?

Our findings

As part of our inspection, we received a variety of positive feedback from various sources about the care, leadership and management of Dormy House. This included feedback from people who used the service, families, healthcare professionals, contractors to the service, local authorities and healthcare agencies who worked with the staff and management to manage people's care. For example, one healthcare professional wrote to us and said, "From our perspective Dormy is always a pleasure to visit. They are prepared for our visit and help organise which clients we are seeing. Most importantly the nurses are actively involved in the...process and help ensure that we...maximise each client's quality of life...I wish I could say the same about all the homes we visit!" Another healthcare professional submitted comments to us as part of our inspection process. They stated, "This home has had a different home manager on each of my visits and on my last visit a newly appointed clinical lead, who had clearly made improvements to the management on the units he looks after. I spoke with the manager, deputy manager, clinical lead and nurses. I saw care staff attending to residents around the home whilst conducting my visit. I saw nothing to indicate they were not caring. The home manager and deputy have always been very receptive to any feedback given."

People's comments about the management of the service echoed those of healthcare professionals. On a care home review website in 2017, one person commented, "I have been here for about one year and the treatment I have been given has been excellent. I could not have had a better bedroom; I hope to stay here until I die. All the staff are caring and helpful. The lady who runs the entrance is excellent and the home manager is absolutely excellent and works so hard for us as does the deputy manager." Another person on the review service stated, "We liked the feel of Dormy House from the start, it has a very homely atmosphere. We visit most days and there is always plenty of staff supporting and assisting residents. The nursing care is second to none we feel very reassured that dad is being looked after extremely well indeed..." We noted the service encouraged people and others to provide feedback. There was signage and cards available for the care home review website and also signage about how to provide feedback to us using our national customer service centre.

We asked for any feedback obtained via surveys or questionnaires to people. Although a survey of the quality assurance was completed in 2016, the results were not available at the time of our inspection. We looked at the September 2015 results instead. There were just four submissions from relatives or friends, which was a low response rate given the scale of the service. We noted the survey of relatives asked questions using our 'five key questions' approach. For example, the survey asked whether relatives felt their family member was safe and whether they were consulted in care planning and review. The overall satisfaction across all 'five key questions' was positive. One relative wrote, "Some staff [are] really good at notifying me of problems. There was a higher response rate to the survey from people who used the service; 11 people took part. The same format as the relatives' survey was used. When asked if they felt comfortable contacting a manager regarding comments or concerns, 100% of those surveyed felt they could do so.

We recommend that the service increases recording of people's opinions and implements further methods of capturing feedback, to use in ongoing quality improvement.

In 2016, the service dealt with a safety concern professionally. The provider and management invited people and relatives to regular meetings and provided updates about actions taken and strategies they had implemented to prevent the matter from recurrence. The event had however had a temporary impact on staff morale. However, all of the staff we spoke with had a positive opinion of the service and of management at the time of our inspection. The management team recognised that the workplace culture may have been affected by the incident. They organised a team-building event, which focussed on what staff enjoyed about working at the service, and what they felt required improvement. We reviewed the records from the activity and spoke with the management team about anything learnt from the experience. The management team acknowledged the areas that could be improved for staff and workplace conditions, and had a plan in place to continue engagement with staff. This was a positive step in ensuring the service was well-led.

Staff said they knew how to raise concerns and report poor working practices ('whistleblowing'), and felt confident to do this. Leading up to our inspection, there were no whistleblowing allegations made to us. A whistleblowing policy and procedures were in place to support staff and guide them of the steps to follow when reporting poor work practices. Staff had the ability to report their concerns anonymously to an external agency and be afforded protection under relevant legislation. The service had not received any reports from the external agency.

The service had established effective quality assurance systems to assess, monitor and improve the quality and safety of people's care. We found audits undertaken covered areas such as infection control, care plans, medicine audits and health and safety. We noted recommended actions were followed up and completed by the relevant staff.

Services are required to comply with the duty of candour regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' in relation to care and treatment. It also sets out some specific requirements that services must follow when things go wrong with care and treatment. This includes informing people about the incident, providing reasonable support, providing truthful information and providing an apology (including in writing).

The service had an appropriate duty of candour policy in place which gave clear and specific instructions for management to follow when the duty of candour requirement was triggered by safety incidents. Duty of candour requirements were met in the event of safety incidents. It is also a legal requirement for providers to submit statutory notifications to us when events that affect people's health and safety had occurred. We reviewed the accidents and incidents which resulted in serious injuries and saw the relevant statutory notifications were submitted to us in a timely manner. In conjunction with notification requirements, the management team also developed a good working relationship with us and the local authority to keep all parties informed of the progress of any relevant cases. We noted transparency in matters with the local safeguarding team, police and healthcare professionals.

We saw the service's prior inspection ratings were conspicuously displayed throughout the service, and on the provider's website.