Care Quality Commission

The Dales (Northwest) Limited

The Dales Care Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement	
Is the service safe?	**Good**	
Is the service effective?	**Requires improvement**	
Is the service caring?	**Requires improvement**	
Is the service responsive?	**Good**	
Is the service well-led?	**Requires improvement**	

Overall summary

The Dales is a residential home providing accommodation and support for up to thirty people. It is an adapted detached house based in a residential area of the Wirral. Accommodation is provided over three floors with a passenger lift available to the first and second floor. The majority of bedrooms are single rooms with people sharing adapted bathrooms and shower rooms and a large lounge and dining room.

At the time of our inspection there were 27 people living at the home.

The home has 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.

At this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

We last inspected the home in April 2013. At that inspection we looked at the support people had received with consenting to their care, welfare and medication, the support provided to staff, the premises and how complaints were responded to. We found that the provider had met regulations in these areas.

The registered provider did not meet the requirements of the Mental Capacity Act 2005 (MCA). They had not always assessed people's capacity to make individual decisions and ensured decisions were only made on the persons behalf when they were assessed as in the persons best interests and the person was unable to make that particular decision.

Records were not stored safely and securely. This meant that people's right to privacy was not protected.

People's right to dignity and respect was not always protected by the staff team.

People received the support they needed to eat and drink and this was provided in a way that promoted a social occasion people could enjoy.

Activities were available during the day that people could choose to join in with.

Care plans provided sufficient information to inform staff about people’s support needs. This included information about their health, nutrition and personal care.

Medication practices at the home were safe. People received their medication on time and it was stored correctly.

Staff had received training and understood their role in identifying and reporting any potential incidents of abuse. People felt confident to report any concerns or complaints they had to a member of the staff team.

A system was in place for recruiting new staff to work for the organisation. This included carrying out checks to help ensure the person was suitable to work with people who may be vulnerable.

There were enough staff working at the home to meet people's needs.

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 safe.

Good

Staff had undertaken training in safeguarding adults and were aware of the procedures to follow if they suspected abuse had occurred

Safety checks on the building had been carried out to ensure it was a safe place for people to live.

Medication was safely managed within the home.

Recruitment polices were in place and followed to ensure appropriate information was available about staff before they started working at the home.

There were sufficient staff available to provide people with the support they needed.

Is the service effective?

The service was not always effective.

Requires improvement

People's right to be assessed to consent to their treatment had not always been followed. Decisions made on behalf of a person had not always been made following clear procedures to ensure they were in the individual's best interest.

CQC monitors the operation of the Deprivation of Liberty Safeguards which applies to care homes. Procedures for ensuring people were not unduly deprived of their liberty had been followed.

People were provided with the support they needed to manage their health and nutritional needs.

Staff had received the training they needed to support the people living at the home.

Is the service caring?

The service was not always caring.

Requires improvement

People's privacy and dignity was not always respected.

People received support at mealtimes to make meals a relaxed and enjoyable occasion.

People liked the staff who supported them and staff spent time talking with people well as meeting their care needs.

Is the service responsive?

The service was responsive.

Good

Summary of findings

Care plans were up to date and comprehensive. Staff had a good knowledge of the support people needed and support was provided to people as described within their care plan.

People had the choice to take part in arranged activities and socialise with others if they wished to do so.

A system was in place for dealing with any complaints received. People knew how to raise a concern or complaint and said they would feel confident to do so.

Is the service well-led?

Requires improvement

The service was not always well led.

People's records were not maintained securely. This compromised their right to privacy.

The home had a registered manager in post.

Quality assurance systems were in place to check the quality of the service provided and plan improvements required.

Care Quality Commission

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

This was an unannounced inspection carried out on 29 June 2015. The inspection was carried out by two Adult Social Care Inspectors. During the inspection we spoke with six of the people living at the home and met with several others. We spent time observing the support provided to people. We also spoke with three relatives of people living at the Dales Care Home, six members of staff, including the registered manager and with a visiting health professional. We looked at shared areas of the home and visited people's bedrooms. We also looked at a range of records including care plans, medication records, staff records and records relating to health and safety.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the manager since our last inspection in April 2013.

Good

Is the service safe?

Our findings

People told us that they felt safe living at The Dales Care Home, with one person explaining, "I'm happy here" and another person telling us, "I am amongst a good crowd." Relatives also told us they thought it was a safe place to live.

Before we visited we looked at records we held about the home. We saw that potential incidence's of abuse had been reported appropriately. This showed us that the registered provider was taking action to protect the people living there.

Staff had undertaken training in recognising and reporting abuse and they demonstrated an understanding of the indicators of abuse and their role in reporting this. A policy was available to provide further guidance and staff knew how to report to external authorities if they needed to do so.

Staff told us that they were aware of the provider's whistle-blowing policy and knew how to use it. Whistle-blowing protects staff who report something they think is wrong in the work place.

People told us that they got their medication when they needed it with one person explaining, "Oh yes they make sure I take them."

Medication was stored safely in locked trollies and cupboards. We checked a sample of Medication Administration Sheets (MARs) against stocks held and found that these had been signed correctly and tallied with stocks held. Medication that was prescribed for short term use or as a weekly or variable dose had been clearly recorded and stocks of these tallied with records. Prescribed creams and ointments had been recorded when used. This all helped to ensure people had received their medication as prescribed.

A lockable fridge was used for storing some medications. We checked a sample of these and found that the medication had been stored correctly. The temperature of the fridge had been regularly checked to ensure it was within the correct range.

A locked cabinet contained medication for returning to the pharmacy. No record of the medication held in this cupboard was in place. This meant that the medication could be mis-used. We brought this to the attention of senior staff who told us they would arrange for the medication to be returned and for a stock check system to be implemented.

General risk assessments were in place to reduce the risk of accidents occurring. These covered areas including trips, falls, hazardous substances and intruders and had been reviewed regularly. Staff were aware of the location of first aid boxes, the action to take if the fire alarm sounded and their role in supporting people who had had an accident including falls.

Fire safety checks had been regularly carried out including a fire risk assessment, testing of emergency lights and fire alarms, and checking of fire exits. Small electrical appliances had been tested for safety and satisfactory certificates were in place for the gas and electrical supply.

One person told us that they sometimes had to wait for staff to answer their call bell, other people we spoke with said it was usually answered promptly. During the inspection we saw that there were sufficient staff available to meet people's needs in a timely manner.

The manager explained that the home had rarely used agency staff, any staff shortages had been covered by members of the permanent staff team. This had helped to provide the people living there with more consistent staff support. Staffing levels were set at three care staff during the day, one of whom was a senior member of staff and two care staff at night. A fourth carer was often available between 8 am and noon to support people getting up. In addition the home employed domestic and kitchen staff 7 days a week and laundry and administration support 5 days a week. The manager worked at the home 2 - 3 days a week and told us she was always on call. We checked a sample of staff rotas for the weeks prior to, during and following our inspection and found that these staffing levels had been maintained.

Staff said there were sufficient staff available to meet the needs of the people currently living at The Dales Care Home and to enable them to carry out their role effectively. One member of staff told us they were confident the manager would increase staffing levels if needed.

We spoke to two members of staff who had recently started working at The Dales Care Home. They explained they had

Good

Is the service safe?

completed an application form and undergone a formal interview process. They registered provider had then obtained references and a Disclosure and Barring Service (DBS) check before they had commenced work.

Staff records contained this information along with proof of the person's identification. The checks carried out on staff before they started work helped to ensure they were of good character and suitable to work with people who may be vulnerable.

Requires improvement

Is the service effective?

Our findings

People living at The Dales Care Home told us they liked the meals provided, their comments included, "Smashing," and "The foods great." People told us they had enough to eat and drink and that they had a choice of meals. They also told us that they got the help and support they needed from staff. One person commented, “They’re all good, they help me.”

One person was given their medication covertly, this meant they did not agree to taking the medication and it was therefore concealed in their food. Records showed that health professionals had decided this was in the person's best interests and their GP had agreed to it. However no assessment of the person's capacity to make this decision had been undertaken. Neither had a best interest meeting taken place. Before a decision is taken to given a person covert medication the person's ability to make this decision needs to be assessed. If the person can understand and make the decision then this must be respected. If the person is assessed as unable to understand and make that particular decision then a best interest meeting needs to take place to discuss the specific decision and medication and take into account the person's expressed views.

Care records for two people contained ‘Do Not Attempt Resuscitation’ Records which had a capacity assessment stating they were able to make that decision. Their files also contained consent forms covering trips, care plans and photography. These forms had been signed by the person's next of kin. If a person has capacity to make a decision then they should be consulted or asked if they give permission for their next of kin to sign on their behalf. If the person has capacity to make a decision on resuscitation it is probable they can make other decisions such as agreeing to having their photograph taken and it is therefore not possible for others to give permission on their behalf.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have suitable arrangements in place for people to consent to their care or follow legal requirements when people could not give their consent.

The registered provider had acted lawfully and in keeping with the latest guidance around Deprivation of Liberty Safeguarding (DoLS). These laws and safeguards are a legal way to ensure people are not deprived of their liberty unduly. Senior staff had undertaken training on and had an understanding of, the laws around DoLS and had applied to the local authority for a DoLS for people who may need this protection.

The day of our inspection was a hot day. People had a jug containing a cold drink available in their bedrooms and were served a choice of drinks and offered lolly ices throughout the day.

Staff had a good understanding of people's nutritional needs and the foods they could and could not eat. We saw that special diets were catered for and staff routinely remembered this information when serving meals.

A relative told us that they were aware staff were monitoring their relatives food and drink intake as they had been unwell. We saw that records of this had been completed and a referral made to a dietician for more specialist advice on how to support the person with their nutrition. Care plans contained nutritional assessments and people's weight had been monitored regularly .Where a concern was identified with the person's nutrition then their intake was monitored and a referral made for health advice.

A visiting health professional told us that the staff team made appropriate referrals to them and followed guidance to improve the person's health.

People's health had been monitored and appropriate action taken where a concern was identified. Regular checks and assessments had been made on people's weight, temperature and pulse and referrals to health professionals had been made appropriately. We saw a note that one person needed an injection and later saw that the relevant health professional had been contacted. Another person's file contained a referral to a dietician. However this had been made several months ago and it was unclear if this had been followed up. Senior staff agreed to follow this referral up to ensure the person received the support requested.

Staff said they had been given the training they needed to carry out their role effectively. They explained there were specific timescales for completing training and that the manager monitored this. A newer member of staff was clear about the training they had to complete within the first four

Requires improvement

Is the service effective?

weeks of commencing work at the home. Other staff said that the manager had supported and encouraged them to complete a nationally recognised qualification relevant to their role.

Records showed that staff had completed training in areas the registered provider considered mandatory. This included fire safety, health and safety, moving and handling people and abuse awareness. We also saw that staff had completed training in more specialist areas including supporting people with dementia, stroke awareness and end of life care.

Records showed and staff confirmed that they had received regular one to one supervision from a senior member of staff. One to one supervision provides staff with the opportunity to discuss their work, how they can improve in their role and any training needs they may have.

Staff had a good understanding of their role and were able to explain the day to day support they provided as well as the action they would take in the event of an emergency or if someone became unwell.

The Dales Care Home is a large adapted detached house in a residential area of Wirral. The majority of bedrooms are single rooms with one room large enough to be shared, although this was used as a single room at the time of the inspection. The home had three floors with bedrooms available on each floor. A passenger lift provided access to the first and second floor with a stair lift also available between the first and second floors. Adapted bathrooms and shower rooms were available to make it easier for people to receive support with their personal care. Call bells were situated in each room and we saw these were easily accessible for people sitting in their bedrooms.

A large dining and living room was located on the ground floor, this was split into sections so that people could sit in smaller groups or engage in different activities. Some parking was available to the front of the house with more parking on the street outside. An enclosed back garden with seating was being enjoyed by people during our inspection.

Is the service caring?

Our findings

People living at The Dales Care Home told us that they liked the staff team and that they had received the care they needed. Their comments included, "Staff are great," "Everybody is very kind to me," and "Can't ask for anything more."

Relatives were also satisfied with the care people had received. One relative commented staff, "Can't do more for her." Another relative described the care as, "Superb - you can't ask for more than that."

We saw one person having a rest in their bed and staff told us the person was not feeling particularly well that day. At the same time as they were resting in their bed a hairdresser was in the person's bedroom with three other people who lived at the home having their hair done. We looked at the person records and could not see any record that they had consented to this use of their bedroom. The use of someone's bedroom in this way, particularly when they are resting in bed compromised their privacy and dignity. We brought this to the attention of the registered manager who said that she was aware this practice shouldn't be happening and staff had previously been instructed that hair dressing services should not be provided in this person's bedroom.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have suitable arrangements in place to ensure service users were treated with dignity and respect.

Throughout the day we saw staff spending time talking with people as well as meeting their care needs. Staff spoke respectfully to people and communicated in a way the person understood.

The lunch time meal was a pleasant unrushed occasion that provided people with the opportunity to socialise as well as eat their meal. People were encouraged to eat their meal at their own pace and to take their time. Tables were nicely laid with weekly menus displayed. We saw the chef asking people what they would like to eat and people confirmed they had always been offered a choice of food and drink.

Staff were unrushed and took the time to explain to people the contents of the meal, for example we saw one person being supported to eat and the member of staff took their time explaining the contents of each forkful to the person.

A service user guide was available in all bedrooms. This provided people with information about how the home operated including the services they could expect, and who to contact if they had a concern or complaint.

Good

Is the service responsive?

Our findings

A relative explained staff had been responsive to their relative's needs, this had included calling a doctor if the person was unwell or getting them a fan when it was hot.

Care plans contained assessments of the person health and personal care needs and a history of their life. Where an assessment showed that the person needed care or support a care plan was in place to guide staff. We noted that where the plan identified equipment such as a pressure cushion or walking frame was needed then this had been provided and the person supported to use it. In discussions with staff they had a good understanding of people's individual support needs and how to provide the support in a way the person preferred.

One care plan contained information that was different from the information staff provided about the current care needs of the person. We discussed this with senior staff who explained the person's care needs had changed. The manager agreed to review the care plan and ensure it contained accurate and current information regarding the person's support needs. However we saw and confirmed with the person that they were getting the right care.

The home employed an activity coordinator who worked four hours a day Monday to Friday. During the morning of our inspection we saw people being supported to sit in the garden and socialise. A hairdresser was also available to do people's hair. After lunch outside entertainers led a music session which people appeared to enjoy.

Advertised activities included bowling, singing, trips to the shops and pet therapy. The activity coordinator explained that she also spent time one to one with people engaging them in conversation. A communion service was held once a month.

Throughout the day people appeared occupied, time was spent enjoying meals or drinks and snacks people were able to choose where to sit and whether to spend time alone or socialising and staff spent time engaging people in conversation.

The complaints policy was readily available to people living at and visiting the home. This provided information on who to raise a complaint with and the timescales they could expect a response within. A copy of the complaints procedure was displayed in the entrance hall and included within the service user guide, available in people's bedrooms.

People said they would feel confident to raise any concerns they had. A relative explained they had raised an issue and felt they had been listened to and their concern dealt with. Staff knew about the complaints procedure and their role in dealing with concerns and complaints. We asked the manager for a copy of their complaints records and she explained they did not have any as they operated an open door policy and had not received any formal complaints. Recording any informal complaints or concerns received would provide a clear audit trail of the actions and help to identify any patterns that may emerge.

Requires improvement

Is the service well-led?

Our findings

A corner of the lounge area was used as an office area by staff. We saw some of the people living at The Dales Care Home sitting in this area. We walked over and sat down at the desk. An open communication book on the desk included information such as, '(name) refused doctor'. 'Has a break on her bottom.' 'Don't think he is getting washed.'

A printed list hung on the wall above the desk was titled, 'The Dales Resident List'. This list contained pre-printed information including the person's name, whether they had a 'Do not Attempt Resuscitation' agreement in place, whether they were receiving end of life care and information on their medical history, for example, 'schizophrenia,' 'mastectomy,' 'dementia.' Information had then been written daily including, 'wet the bed' and 'breathing not good.'

This meant that personal, private information about people living at The Dales Care Home was visible to others living there, staff who did not need to know and visitors. This meant people's privacy and dignity was not being respected by ensuring their records were maintained securely.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have suitable arrangements in place to maintain service user's records securely.

Staff said they had found the manager approachable and supportive. They said they felt confident to express their views and that they would be listened to.

Accidents and falls had been regularly audited to check for patterns emerging such as the time of day these occurred. A note had been made of the action taken to reduce future risks, for example referring the person to external health professionals.

A number of systems were in place at The Dales Care Home to check the quality of the service provided. This included regular checks on equipment including wheelchairs, commodes and walking frames. Water, fridge and food temperatures were also checked and recorded regularly. This helped to ensure temperatures were within safe limits and any anomalies could be quickly noted and addressed.

A 'senior audit' had taken place every three months. This involved a senior member of staff auditing the care provided to people including their care records. Where areas for improvement were noted an action plan had been put into place to address these. A three monthly audit of medication had also been carried out, again this provided an action plan to improve any areas of concern noted.

There were no records of any consultations formal or informal with the people living at The Dales Care Home or their relatives to demonstrate that their views had been obtained and used to improve the service provided. The manager told us she had an open door policy and therefore had not held recent meetings with the people living at the home or their relatives.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider did not have suitable arrangements in place for people to consent to their care or follow legal requirements when people could not give their consent.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider did not have suitable arrangements in place to ensure service users were treated with dignity and respect.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not have suitable arrangements in place to maintain service user's records securely.**