Dipton Care Home Limited

Dipton Manor Care Home

Inspection report

Front Street
Dipton
Stanley
County Durham
DH9 9BP

Date of inspection visit:
14 March 2018
22 March 2018

Date of publication:
04 May 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 14 and 22 March 2018. The inspection was unannounced. This meant the provider and staff did not know we were coming.

Dipton Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Dipton Manor can accommodate up to 70 people. At the time of our inspection 63 people were using the service, 14 who were receiving nursing care. Some people residing in the home were living with dementia. The home was set in its own grounds with an enclosed garden.

The service had 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.

We visited the home in November and December 2015 and rated the service as 'Good'. At this inspection we found the service had deteriorated to Requires Improvement.

At this inspection we found that there was a breach of two of the Fundamental Standards of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to the lack of awareness of the principles of Mental Capacity Act 2005. We found the quality assurance systems failed to identify the concerns found at the inspection.

You can see what action we have taken at the end of this report.

People who were being deprived of their liberty did not always have decision specific best interests meetings recorded in their care records. Staff did not have a clear understanding of how to apply the Mental Capacity Act 2005.

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

Risk assessments were in place for people; however, these were not always reviewed on a regular basis. Some people's risk assessments were not detailed in order to give guidance for staff on how to mitigate against risk.

Staff supervision and appraisals were not up to date as stipulated in the provider's policy and procedures.

Staff had not received training in specific topics to meet the needs of the people living at Dipton Manor.

The premises were not suited to people living with dementia, there was a lack of signage for people to be able to orientate around the building.
We made a recommendation about providing a more dementia friendly environment.

The provider did not have a robust quality assurance process in place. Audits and reports lacked detail with no clear direction on how to improve the quality of the service.

People and relatives felt the service was safe. Policies and procedures were in place to keep people safe such as safeguarding, accident and incident policies. Staff had received training in safeguarding and knew how to report concerns.

Staff recruitment procedures were robust and included Disclosure and Barring Service checks and references.

Appropriate arrangements were in place for the safe management and administration of medicines.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's right to privacy. Staff supported and helped to maintain people's independence. People were encouraged to care for themselves where possible.

The provider did not use a dependency tool to determine levels of staff. This meant we could not be sure that the provider's system of determining staff levels was robust in order to support people if there was a change in people's care and support needs. Staff gave mixed views on the staffing levels in the home.

We made a recommendation about the providers approach when determining staffing levels.

People had access to a range of healthcare, such as GPs, district nurses and dieticians. Nutritional needs were assessed and people enjoyed a health varied diet.

The atmosphere at the home was warm and welcoming. Relatives felt welcome when visiting with staff offering refreshments and the opportunity to eat with their loved one if they wished. People were encouraged to make choices in everyday decisions.

People enjoyed a range of activities and were supported by staff. The service had positive links in the community with regular visits from the local church. There was a shortage of activities for people who resided on the nursing unit.

The provider had a complaints process in place. Relatives and people knew how to make a complaint.

People and relatives were extremely positive about the registered manager.

Staff gave mixed views about the registered manager.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's risk assessments were not always reviewed on a regular basis to ensure control measures remained appropriate.

The provider did not have a structured process in place to determine staffing levels were appropriate to the needs of the service.

The provider had a robust recruitment process in place.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not have Mental capacity assessments and best interest's decision meeting records in place. Staff did not fully understand the principles of the Mental Capacity Act.

Staff did not always have regular supervisions. Staff had not had training in specific areas such as diabetes awareness.

People had access to health care professionals such as GP's and community nurses.

Is the service caring?

Good

The service was caring.

People who used the service and their relatives felt the staff were kind and caring.

Staff knew people well and demonstrated positive relationships with them.

People had access to advocacy service were appropriate.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were not reviewed on a regular basis.

The provider had an activity coordinator to assist people with leisure and recreational activities.

The provider had a complaints policy and procedure in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider's quality assurance process was not effective in highlighting shortfalls in the service. The process did not identify the concerns found at the inspection.

People and relatives felt the registered manager was approachable.

Staff felt the management in the home was open, honest and supportive.

Dipton Manor 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 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.

The inspection took place on 14 and 22 March 2018, and was unannounced. This meant the provider did not know we were coming.

The first day of the inspection was carried out by two adult social care inspectors, one inspection manager and a specialist advisor. The second day of the inspection was carried out by two adult social care inspectors.

Before the inspection we reviewed other information we held about the service and the provider. This included statutory notifications we had received from the provider. Notifications are changes, event or incidents the provider is legally obliged to send to CQC within required timescales. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We also contacted the local Healthwatch, the local authority commissioners for the service, the local authority safeguarding team and the clinical commissioning group (CCG). Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During our inspection we spoke with ten people who lived at Dipton Manor. The registered manager was not in the service at the time of the inspection. We were supported by the operational group manager and the business support manager who made records available to us. We spoke with the operational group manager, business support manager, the administrator, one nurse, two senior carers, the activity coordinator, the cook, nine care workers and two health care professionals. We also spoke with five relatives of people who used the service.

We looked around the home and viewed a range of records about people's care and how the home was managed. These included the care records of six people. We reviewed staff training and recruitment records. We checked the medicine rooms, laundry and kitchen.

Requires Improvement

Is the service safe?

Our findings

Of the six files we examined three people's files had not had their risk assessments reviewed. Risks assessments help identify where injury or harm could occur and record steps staff can take to support the person in preventing risk. For example, one file contained a moving and handling risk assessment for a person who staff advised used a Zimmer frame, an aid to support their mobility, however, we found no mention of the use of this. The risk assessment regarding personal care did not contain any details regarding behaviour that may challenge which the person could sometimes display on interventions.

Some risk assessments were basic, using a tick box system; these did not clearly demonstrate how the risk had been identified or what was being done to reduce it. Another person required the use of bed rails to maintain their safety whilst in bed. We found no detailed risk assessment on file to demonstrate how their risk of falling from bed had been determined and that the bed rails were the best option.

We spoke with the operational group manager regarding our findings in relation to people's risk assessments. They told us, "We are in the process of changing the documentation in the home. I will speak to staff to make sure these are reviewed and updated as soon as possible. The co-ordinators are working on files now so this can be picked up." Following the inspection the operational group manager provided an action plan which set out that risk assessments had been reviewed and updated. The plan showed staff had also received additional training to support with recording to ensure a better level detail was captured in risk assessments.

Due to the concerns we found with risk assessments and in order to gain assurance that people were being supported safely. We observed staff and spoke with them during the inspection to ensure people received safe support. We found staff had an understanding of how to support people with moving and handling using Zimmer frames and were aware of managing behaviours that may challenge. Observations confirmed the safe practice when supporting people with mobility aids. We observed a member of staff support a person who was displaying behaviours that challenge. The staff member acted swiftly with an approach conducive to enabling the person to become calmer.

The shortfalls we found in relation to risk assessment records had not been identified in the registered person's quality assurance process.

These findings demonstrate a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We asked people and relatives if they felt they or their family members were safe in Dipton Manor. Comments included, "I do feel safe here", "I keep an eye, they are always spot on", "One good thing is that you're safe", "They always give you the medicines, you take it with them (staff) there" and "I would not be here if I didn't feel safe."

We found the provider had policies and procedures which were available to staff for safeguarding and

whistleblowing. Staff we spoke with had an understanding of what constituted abuse and how to act if they suspected or observed any inappropriate practices. Staff had received training in safeguarding and felt the registered manager would act on any concerns they raised.

Staff ensured the visitors' book was available, we saw how staff encouraged visitors to sign in and out. We found staff followed infection control procedures and were seen to use personal protective equipment (PPE) where necessary. Staff told us when and how they used PPE and could explain the processes they used to protect people from the spread of infection.

Risks in the environment were assessed such as slips, trips and falls with measures in place to reduce the risk of accidents or incidents.

The provider had safe recruitment procedures in place which were thorough and included necessary vetting checks before new staff could be employed. For example, Disclosure and Barring Service checks (DBS) and references. These were carried out before potential staff were employed to confirm whether applicants had a criminal record and were barred from working with vulnerable people.

Nurse's personal identification numbers (PIN) were checked as part of the provider's recruitment procedures. The business support manager carried out checks on PINs and kept a record of checks and nurses PIN renewal dates. The Nursing and Midwifery Council (NMC) is the regulator for nurses. The NMC issues nurses with a personal identification number once they are registered. Without a valid PIN number nurses cannot work as a nurse.

We asked people and relatives if they felt there were enough staff to meet the needs of the service. Comments included, "There is plenty of staff about", "There is always someone about if she needs anything" and "If you can't manage there is someone there for you all the time".

We received mixed comments from staff which included, "We asked for more staff as there weren't enough", "[Registered manager] sorted more staff", "Some days only three not five staff, it's not enough.", "It's hard going when only three" and "We have bank staff but can't always get people in." This staff member also told us it that care co-ordinators mainly did paperwork and did not help with care, as senior care workers did. Other staff comments included, "I would like more time with the patients, we are interviewing for another nurse", "Yes, we have enough staff for the job" and "We have enough staff, five for 20 beds and some are empty, I have no concerns".

Following the inspection the operational group manager provided an action plan setting out four new support workers have been recruited, and one of the nurses had been appointed as clinical lead. The operational group manager told us, "This will give more structure and nurses will have a go to person for support, we are also recruiting bank staff. We are starting to have regular meetings with the nurses, revalidation will be part of the meetings. The first one is 17 May."

The provider did not use a dependency tool to determine levels of staff. The business support manager told us, "We use a five to one ratio as a rule of thumb." This meant we could not be sure that the provider's system of determining staff levels was robust in order to support people if there was a change in people's care and support needs.

We recommend that the service seek advice and guidance from a reputable source about the methods of ensuring there are sufficient numbers of staff to meet people's assessed needs.

We observed people's needs were addressed in a timely manner, buzzers were answered promptly any calls for assistance in the lounge were responded to quickly. Staff had opportunities to spend quality time with people, to do some arts and crafts or just to sit and have a chat over a coffee. Staff maintained a presence in the communal and dining area to anticipate needs as not all the people living at Dipton Manor could make their needs known.

The provider had systems and processes in place for the safe management of medicines. We observed a medicine round and found this was well organised. There were no interruptions from other staff members. Medicine administration records (MAR's) were completed correctly with no gaps or anomalies. People told us they received their medicines at the correct time. Comments included, "They give me my medicines on a morning and tea time. I take them with water and they normally watch me take them", "I take one tablet at bedtime and one in the morning, the staff bring them" and "I always get my tablets on time and they always ask if I need painkillers."

We found the lounges, dining areas, toilets and bathrooms were all clean with no odours. Personal protective equipment was used when appropriate and was readily available for staff. We received some negative feedback about the cleanliness of the home but we were reassured that appropriate systems were in place to keep the home clean.

A range of health and safety checks were completed. For example, electrical installation checks, gas safety certificates and hoist checks.

People had personal emergency evaluation plans (PEEPs) in place in case of emergencies. Fire safety was maintained by the maintenance person who carried out regular fire drills with staff both day duty and night staff.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) providers a legal framework for making particular decisions on behalf of people who 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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Three of the staff we spoke with did not know which people were deprived of their liberty and how to support them to ensure the requirements of their DoLS were met. They knew where information was kept but they were not using this to support people on a daily basis.

Where people lacked capacity to make decisions MCA assessments were not in place. Best interest decisions meeting records were not available. For example, one person had bed rails in place to prevent falls from bed, although this decision had been made to keep the person safe, no records of any discussions with health care professionals or other interested parties was on file. We spoke to one staff member about the use of bed rails, they told us who needed these and said; "[Person] has capacity, everything is discussed but it might not be written down."

We spoke with care coordinators who advised they did not undertake any capacity assessments for people coming to live in Dipton Manor. They relied on the social workers to complete these. They were not checking that relatives had Lasting Power of Attorney (LPA) for Health and Welfare but were taking relative's word about decisions about their family members care. This meant that the systems and processes used in the home did not support the principles of the MCA.

Lasting powers of attorney (LPAs) were created under the MCA. Their purpose is to meet the needs of those who can see a time when they will not be able to look after their own personal, financial or business affairs. The LPA allows them to make appropriate arrangements for family members or trusted friends to be authorised to make decisions on their behalf.

We discussed our findings with the operational group manager. They told us, "I am surprised they did not know, they have done MCA training with me and with Red Crier (the online training course). We will ensure assessments will be completed and care files updated."

These findings demonstrate a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Although staff did not understand the MCA we observed staff supported people to make as many of their

own decisions and choices as possible. These included explaining options to them and anticipating needs by observing facial expressions and body language. We observed staff supporting people to make decisions regarding meal choices and joining in with activities. Staff told us how they supported people with making meal choices and choosing clothes if they were not able to do this for themselves. The staff we spoke to knew people well and made choices based on known preferences.

Following the inspection the operational group manager provided an action plan which set out what action is being taken to ensure staff are more familiar with MCA. The action plan stated all senior staff in the home along with the nurses have since had training at level 3. Care staff are booked to complete face to face in MCA and DoLS training at level 2, this will be completed by July 2018. The training will be on an annual refresher to ensure staff's knowledge is current.

The provider used an online training system and a matrix to track staff training levels. We found gaps in several topics such as safeguarding, moving and handling, dignity and respect, dementia and challenging behaviour. Staff had not received training in diabetes awareness. This meant we could not be sure that staff had the skills and knowledge to support people living in Dipton Manor.

Staff told us they completed training but these were mostly tick box training. We asked staff for their views on training. Comments included, "We get a lot of training but it is mostly tick box but some face to face training would be better", "I do think we get enough training mainly in work books", "I've not been trained in MCA or things like diabetes" and "We get all mandatory training in book form and some in-house like first aid". The nurse on duty told us, "We get plenty of training and opportunities do come up for specialised training in the NHS". Mandatory training was training the provider felt was necessary to enable staff to support people.

Staff told us that dementia training they received in previous employment was more in depth than they received currently. One staff member told us, "You tick boxes and get a certificate. It's a lot different to training I got before." And another staff member told us "At a different company I had six weeks dementia training, not just a booklet in dementia."

We spoke with the operational group manager who told us, "We are looking at staff training and know that the current training is not enough and have started some staff on train the trainer". Train the trainer is a practical course aimed to give staff skills to design and deliver workplace training sessions to other groups of staff. Two staff members had completed the train the trainer course for first aid.

Following the inspection the operational group manager provided an action plan to address staff training needs. The provider is moving to an electronic system to monitor training, the system allows managers to monitor staff progress. Additional courses are being included to meet the needs of the service. The provider is working with Tyne and Wear Alliance to deliver some aspects of the training plan. Tyne and Wear Alliance are an organisation which supports workforce development throughout the independent care sector in the North East.

Staff told us they felt supported and had supervision meetings, although staff were not sure how frequently these should happen. One staff member told us, "I had the last one about six months ago, I'll have one shortly I think." And another said, "Yes I have supervision but I don't know when the last one was, I'd have to check." Another staff member told us, "I had supervision last week." We looked at six staff files and found that three of these did not contain evidence of regular supervision. Staff had received annual appraisals. Staff told us they could go to the people supervising them on a daily basis with concerns and for advice. We checked the provider's supervision policy which stated staff should receive supervision six times a year with

one supervision used as an appraisal.

We spoke with the nurse on duty who told us, "I am supported and attend the training I need". We asked about revalidation and if they felt the provider supported them with this. Revalidation is the process that all nurses and midwives will need to go through in order to renew their registration with the NMC. They told us, "Yes, [registered manager] does my supervision and we discuss it. I can also speak with the other nurses that come in the home".

People and relatives we spoke with gave a positive view of staff's ability to provide effective care and support. Comments included, "Staff know what they are doing", "Staff seem trained enough they are all very nice", "They (staff) are well trained, they know what to do, they notice things and one time made sure [person] had medicine to ease a headache" and "I always watch and yes they help [person] in the right way, with walking and eating, that type of thing."

We found people were offered a varied and nutritious diet and told us they enjoyed their meals. Comments from people and relatives included, "The food looks lovely, they always ask if I want a sandwich when I visit", "Meals are good, always plenty on offer", "The food is excellent, too much!" and "The food is nice, not as good as my wife's cooking". We observed people in the dining areas and saw staff supporting people in a safe manner, people were not rushed. People were asked if they wanted a pudding if they had finished their meal. Staff supported people with their meals and offered encouragement to aid independence. Comments included, "You can manage that, you can use your hands", "You can manage that if you get hold of the spoon" and "I will cut that for you if you want."

People were given a choice of meals, with alternatives available. We also observed people being offered drinks regularly throughout the day, along with snacks. Staff understood people's dietary needs and were seen preparing thickened fluids where appropriate. Food was prepared to meet assessed dietary needs, such as soft diets.

The cook told us how food was adapted to meet people's needs and fortified when people were assessed as being at risk of malnutrition. They told us, "I get sheets from each unit so I know who is at risk and who needs special diets." A white board was in place which the cook kept up to date with information relating to nutritional needs.

We found the staff worked alongside other organisations when supporting people. Care records contained input from health and social care professionals, such as dentists, social workers and community services.

The home was not particularly dementia friendly. Bedroom doors were plain with only a door number. Featureless doors which all look the same can be confusing for a person with dementia. Door furniture would brighten the corridors, aid navigation and, by using different colours, would make it easier for people to identify their own room. The provider had removed all the memory boxes from the corridors. Memory boxes store items which are personal, like a favourite ornament or postcard. The memory box should reflect the person's interests or a moment in history that has meaning to them. The business support manager advised that they had been instructed by head office to remove them due to changes in Data Protection. We asked them to revisit this approach as memory boxes were seen as best practice and do not have to contain personal data.

The home lacked signage; we found only two signs on one unit, one for the toilet and one for the bathroom. Dementia signage does what general signage does by helping people find their way around, but is specifically designed to aid understanding for those living with dementia.

Following the inspection the operational group manager provided an action plan which included how the dementia unit had been updated. The plan states, Dementia Care, [a charity which offers support and advice about dementia] has been contacted for advice regarding the environment. More dementia friendly art work is now in place, more touch and feel items have been introduced. Relatives are involved in making people's doors more personalised.

We recommend the provider refers to National Institute of Clinical Excellence (NICE) Dementia – supporting people with dementia and their carers in health and social care September 2016 for advice and guidance

Dipton Manor was spacious with ample space for people who used wheelchairs or mobility aids. Communal areas were set out with easy chairs, televisions and, or radios were available for people to watch/listen to. We saw people had access to a safe enclosed large garden.

The entrance lobby was bright and welcoming with a reception desk for visitors to speak with the administrator. There were regulatory certificates displayed along with notice boards containing information about the home and activities. Armchairs with small tables were available for people to sit and chat. The corridors had shelving containing rummage boxes for people to go through, boxes contained items such as dolls, fabric and games

Good

Is the service caring?

Our findings

People told us they liked the staff at Dipton Manor. Comments included, "They are all lovely, especially them (pointing to a staff member)", "Whenever I need anything they come, we have a chat" and "I am cared for."

Relatives told us they felt the service was caring and spoke about the positive relationships between the staff and people living at the home. One relative told us they had looked at a number of different places and had chosen Dipton Manor because of its reputation. They told us, "I cannot speak highly enough of them, they are devoted here, such a caring lot". Other comments from relatives included, "This home has a heck of a reputation for dedicated staff", "It is such as caring environment" and "It's a lovely place, they (staff) are polite to [person]. We are made welcome too; they (staff) make sure [person] gets her hair done and her nails done."

One visiting health care professional told us, "I have not seen anything that worries me about the care."

We observed staff showed kindness throughout their interactions with people showing genuine fondness. There was an atmosphere of trust and calm, families were encouraged to visit and staff welcomed them with a smile and a quick word. Staff had a clear understanding of people's needs and had developed positive relationships with them. We saw staff were friendly and caring in their conversations with people, crouching down to maintain eye contact, using gestures, facial expressions and touch to communicate. When communicating with people we saw staff waited patiently for people to respond. Staff clearly explained options which were available to the person and encouraged them to make their own decisions. For example, whether they wished to join in activities or have a drink and snack. People enjoyed the company of staff and appeared comfortable in their presence.

Staff told us, "Everything is important to me, the care, working with outside agencies, everything. It's more than just a job." And another told us, "The best thing here is the residents. I love the residents." Another staff member told us, "We have happy residents. We know their traits, preferences. We know their families and have good relationships."

We saw when one person become upset and tearful staff understood the best way to support them at this time providing them with kind words, warmth and understanding. We observed staff having a laugh and a joke with people who by the very nature of their responses enjoyed the interaction.

We joined people in the dining room at lunch time. We observed staff treating people with dignity. People were asked if they wanted to have protection for their clothes during lunch and were supported with napkins or protective aprons. We observed staff demonstrating respect for people by asking what they preferred for lunch, offering choices and alternatives. Staff supported people to eat and drink in a pace appropriate to their needs which ensured people were supported to be as independent as they could be. Time was taken when supporting people to eat by ensuring they had finished one mouthful before being given another. One staff member explained how they supported people to remain as independent as possible; they gave an example of supporting someone with dementia to have a bath. The staff member

then supported other staff and shared learning about how to encourage this person to have a bath.

People's privacy and dignity was respected by staff closing doors when supporting people with personal care and ensuring people were supported to eat and drink when appropriate. All of the people we saw were cared for, appeared content and had all of their needs met by staff. We saw staff also had a good relationship with relatives and friends who visited the home. We saw visitors were offered refreshments when they arrived. We saw a sense of appropriate humour between people, relatives and staff.

The provider had information relating to advocacy. Advocates help to ensure that people's views and preferences are heard.

Requires Improvement

Is the service responsive?

Our findings

We reviewed six people's care files. We found care plans contained several sections covering physical, social and mental health needs. The care plans were simple, direct and easy to understand, clearly written with no jargon or abbreviations. However, we found care plans were not always personalised and had not been reviewed since December 2017. For example, one person's care plans for nutrition, diabetes and the use of the medicine Warfarin had not been evaluated.

We found a community psychiatric nurse had visited one person due to a change in their behaviour. However, the person's care plan did not contain any risk assessments or care plan for staff to follow when the person displayed behaviours that may challenge in relation to personal interventions and administering medicines. We also found the person suffered from oedema. Oedema is a build-up of fluid in the body which causes the affected tissue to become swollen. There was no care plan or risk assessment in place to provide staff with the appropriate guidance on how to support the person.

We spoke to the operational group manager about the care plans. They advised care records are in the process of being updated and new documents introduced. They told us, "All care plans will be reviewed and where needed updated." Following the inspection the operational group manager provided an action plan which advised, 'care plans and evaluations are now being monitored and actioned on a monthly basis. New monitoring forms have been put in place.'

These findings demonstrate a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We discussed people's care needs with staff to ensure care was being provided in a personalised way. Staff were able to tell us how they supported people in a personalised manner. Such as, how people's personal hygiene needs were met in a way the person preferred. Examples also included how people's health needs were supported by contacting GP's and community nurses, where people required positional changes or additional welfare checks.

People and relatives felt the service was responsive and provided a good level of support. Comments included, "I am involved in my care", "They always get the Doctor when [person] is not well, and let me know", "[Person] is well cared for I have no concerns", "If I wasn't well I would report it to the girls and they would get whoever needed to come" and "The GP does a weekly round, the chiropodist comes and the specialist diabetes doctor has been."

One visiting health care professional told us, "I have no concerns at all, it's a good home. They refer appropriately as they should."

People received support in accessing activities as part of their support at the service. The provider had employed an activities co-ordinator. During the inspection they were spending time showing people different flowers and asking if they knew the names. People were really enjoying the activity and interacted

well with each other. One person told us, "I do a lot of knitting and sewing to occupy my time, I planted all those bulbs up yesterday". Another said, "School children come on a Wednesday afternoon and sometimes we have a thing on a Saturday."

We spent time talking with the activity co-ordinator. They told us they took time to speak with people to find out their preferences, likes and dislikes about entertainment. The activity co-ordinator advised, "Coffee mornings are held every Monday and up to 36 attend including relatives and friends. The connection with the community has grown which is good for the home." They also told us, "We take photographs whenever anything is on, that way I can show relatives what they [person] has been doing. We are also doing some intergeneration with school children and did a project on world poetry day." Intergeneration is about bringing generations together within the home which can enhance quality of life of older people while expanding the knowledge of both young people and the older person together.

We found there was a lack of activities for people on the nursing unit. One staff member told us, "We need more activity up here, it is so quiet and people get lonely, we get forgotten as we are out of the way." One person told us, "I sit here and can see what is going on (in the corridor) it gets lonely sometimes, people are so busy. We spoke with the activity coordinator to find out how people who either preferred to stay in their rooms or were not able to spend time in the communal areas were supported with activities. They told us "I do a lot of one to one with people in their bedrooms. I always make sure everyone is invited to what is going on. There is a lot you can do, such as reading or playing board games. Even just a chat."

No one was receiving end of life care at the time of the inspection. We spoke with the nurse about end of life care. They advised that some people were receiving palliative care and had been prescribed anticipatory medicines as they were at risk of their health deteriorating. Anticipatory medicines are prescribed end of life symptom control is available and can be given without unnecessary delay. Staff had received training in end of life care so had the skills and knowledge to support people when necessary. We saw several compliments had been made by relatives about the care provided to people at this time.

We saw people who used the service were encouraged to raise any problems or concerns they had through individual discussions with staff or through resident and relative meetings. There was a formal complaints policy and procedure in place. People and relatives felt that the registered manager would act if they had a complaint. The service had also received several compliment cards to demonstrate people's and their relative's satisfaction with the care and support provided in Dipton Manor.

Requires Improvement

Is the service well-led?

Our findings

We found the provider's quality assurance systems and processes did not identify the issues found at this inspection.

The provider's training plan did not include specific areas of training necessary for staff to provide safe care and treatment to the people living at Dipton Manor.

The provider had a monthly checklist which was used as part of the quality assurance process. The last record on file was from December 2017. Not all of the sections of the document were completed. The section relating to checking staff files did not detail whose file had been reviewed. The monthly quality audit for the laundry had not been completed monthly; records were dated September, November 2017 and February 2018. The infection control audit stated the next audit was due to be completed February 2018, this had not been completed. The accident and incident analysis did not contain any detail on how the information was used to monitor for themes or trends.

Audits of people's care records did not identify the lack of capacity assessments and best interest decision records. This resulted in the provider not identifying staff's lack of knowledge of the MCA and the need for associated records. No checks were in place to identify if people had LPA in place.

We found the operational group manager visited the home on a monthly basis to carry out an inspection. We reviewed a selection of monthly inspection reports. These were not detailed and contained statements such as satisfactory, completed or a tick in the yes or no box. The comments were brief and did not contain any detail of which person's care file had been reviewed or which staff file had been reviewed. Where gaps or anomalies had been found no actions were included in the report. This meant we could not see how these records linked in to the overall quality assurance process.

We checked the supervision policy which stated that staff should receive supervision '6 times per calendar year with the sixth meeting being an appraisal'. There was no plan in place to demonstrate supervisions had been arranged or to show that the registered manager had oversight of the supervisions completed. We discussed this with the business support manager, who acknowledged that supervisions had not been completed in-line with policy and they implemented a document to plan and track supervision going forward.

We found records to demonstrate that resident and relatives meetings had been held. The meeting minutes dated 27 June 2017 stated that meetings would take place every four weeks. We found no other meetings had been held until 7 December 2017.

The provider did not have a structured process in place to review the staffing levels in the home. We could not see how the needs of the people using the service were assessed to ensure the level of staff on duty was appropriate to peoples assessed needs. A general ratio of five people to one staff member (care staff) was used.

We spoke to the operational group manager regarding the concerns we found at the inspection. They were surprised that so many issues had been found and assured us they would address the shortfalls.

Following the inspection we spoke again with the operational group manager who told when reviewing our findings they believed some of the records had either been tampered with or removed as they were in place previously. This is being investigated internally.

Part of the action plan submitted by the operational group manager set out how they intended to address the quality assurance in the home. A new quality assurance file has been set up to included quality checks such as, inspections, monitoring reports, surveys and audits. A full care management system is in place to ensure care records are kept up to date. They told us, "I will be overseeing the new process and work with [registered manager] and the business support manager when reviewing the plan.

These findings demonstrate a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The operation group manager told us of their plans for the home. They advised about a new staffing structure in the home, there was to be a new role for co-ordinators who will manage care workers and senior care workers. There will be a change in job title with care workers being called support workers. There were also plans to use champions in the home for example, dementia champions. Champions attend specific training and meetings on a particular subject and they cascade their specialist knowledge to other colleagues in the home leading to an all-round response to people's needs.

The operational group manager said, "I want to make staff feel valued, we have links with the McMillan nurses to assist staff to support people living with cancer. We are putting a self-help file together for staff, it's important that we make sure staff are looked after as well. It will include support for staff's mental health, a link to free counselling and learning and development support." The operational group manager also told us they were planning to implement a new quality assurance database, following concerns that some key documents could not be located at the time of the inspection. This system would ensure the service could operate effectively in the absence of the registered manager and improve data security.

The registered manager submitted statutory notifications in a timely manner. Records relating to people and the service were held securely.

We received positive feedback from people and relatives about the registered manager. Comments included, "I can go to see her anytime and have a chat", "[Registered manager] is always popping about, always a smile", "If it was not right here I would go and tell her" and "She is great, one word superb, absolutely superb. I don't know how she does it".

Staff felt the registered manager was open and approachable and supportive to the people who used the service. Comments from staff included, "She is really good, I can go to her with any concerns", "It is a nice home we have a good manager" and "The managers are very supportive and kind." The nurse on duty told us, "The manager is very supportive and understanding; we get what we need from the owners, no problem."

Staff comments about the registered manager were mixed. Most staff we spoke with found the registered manager supportive, and told us, "[Registered manager] is approachable. You can go to [registered manager] with concerns, they'd sort it." And "I trust 100% that what [registered manager] says is the right thing." We also received comments including, "[Registered manager] is approachable sometimes, it

depends on the day." And another staff member told us, "Sometimes our concerns are addressed."

Staff meetings were held on a regular basis which gave staff the opportunity to raise concerns or views on the service. The meetings were also used for the registered manager to share information. One staff member told us, "We do get asked if there are ways we can improve the home." Other staff told us, "We're not asked for feedback, there was one survey but nothing came of it though. Staff meetings are not really our input, we just get told new rules.

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 11 HSCA RA Regulations 2014 Need for consent The registered persons did not ensure people who lacked capacity had Mental Capacity Assessments and Best Interest Decision meeting records in place. Staff were not following the principles of the Mental Capacity Act in terms of decision making. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had not ensured systems and processes were operated effectively to assess, monitor and improve the quality of the services provider. Regulation 17 (2) (a)(b)(c)