HC-One Limited

Dale Park

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Dale Park is a purpose built 46 bedded care home offering care for people living with dementia. It is managed by HC-One Ltd.

This was an unannounced inspection which took place on 2 & 3 August 2016. The service was last inspected in September 2014 and at that time was found to be meeting standards.

The service did not have a registered manager in post. 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. The service was in the process of recruiting a new registered manager. Meanwhile the home had been managed by a stand in 'turnaround' manager.

We reviewed the way people's medication was managed. We saw there were systems in place to monitor medication so that people received their medicines safely. We found examples whereby some medicines such as prescribed thickeners for drinks [to help people swallow] and external medicines [creams] were not being recorded appropriately. We told the provider to take action.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We found some anomalies with the staff files we checked and some details were missing such as adequate references. We told the provider to take action.

We recorded some negative comments by relatives and made observations that supported the view that aspects of people's personal care and attention compromised their dignity and could be better monitored. We told the provider to take action.

The manager was able to evidence a series of quality assurance processes and audits carried out internally and externally by staff and from visiting senior managers for the provider. We were concerned that, despite fairly well developed systems in place, some areas had not been effectively monitored and issues had been missed. These included the medication issues we highlighted and the lack of thorough recruitment checks for some staff.

We found that the home had undergone major changes in the past six months and this had caused some unrest in response to the changing culture of the home. We found some improvements had been made but there were many planned improvements that still needed to be implemented. The changes around staffing and management approach needed to be further embedded.

Care was organised so any risks were assessed and plans put in place to maximise people's independence whilst help ensure people's safety.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. Training records confirmed most staff had undertaken safeguarding training and this was ongoing. All of the staff we spoke with were clear about the need to report any concerns they had.

Arrangements were in place for checking the environment to ensure it was safe. For example, health and safety audits were completed where obvious hazards were identified.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity was made and decisions made in the person's best interest.

The managers had made referrals to the local authority applying for authorisations to support people who may be deprived of their liberty under the Deprivation of Liberty Safeguards (DoLS). DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. We found the applications were completed and were being monitored by the manager.

Activities were organised in the home and these were appreciated by some of the people living at the home. Staff were motivated to provide meaning full activities but the programme needed to be developed further.

We made a recommendation regarding this.

We saw written care plans were formulated and reviewed ongoing. We saw that people and their relatives were involved in the care planning and regular reviews were held.

We observed staff interacting with the people they supported. We saw how staff communicated and supported people. Staff were able to explain each person's care needs and how they communicated these needs. Most people we spoke with and their relatives told us that staff had the skills and approach needed to ensure people were receiving the right care. The majority of people were satisfied with living in the home and relatives told us they felt the care offered met care needs. People and relatives we spoke with said they were consulted about their care and we saw some examples in care planning documentation which showed evidence of people's input

Care records showed that people's health care needs were addressed with appropriate referral and liaison with external health care professionals when needed.

We saw people's dietary needs were managed with reference to individual needs. Meal times were, on the whole, relaxed and well-paced with support offered by care staff.

People and relatives told us their privacy was respected and maintained.. When we observed staff interacting with people living in the home they showed a caring nature with appropriate interventions to support people.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain. We saw that a record was made of any complaints and these had been responded to.

You can see what action we told the provider to take at the back of the full version of the report.

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.

We found the provider's arrangements to manage some medicines was not consistently followed.

Staff had not been thoroughly checked when they were recruited to ensure they were suitable to work with vulnerable adults.

There were enough staff on duty to help ensure people's care needs were consistently met.

We found that people had had risks to their health monitored. Assessments and care plans contained necessary detail to help ensure consistent outcomes for people's health.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported.

There was good monitoring of the environment to ensure it was safe and well maintained. We found that people were protected because any environmental hazards had been assessed and effective action to reduce any risk had been taken.

Is the service effective?

Good

The service was effective.

Staff said they were supported through induction, appraisal and the home's training programme.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity was made and care and treatment planned in their best interest.

The home supported people to provide effective outcomes for their health and wellbeing.

We saw people's dietary needs were managed with reference to

individual needs. Meal times were, on the whole, relaxed and well-paced with support offered by care staff.

Is the service caring?

Requires Improvement

The service was not always caring.

We recorded some negative comments by relatives and made observations that supported the view that aspects of some people's personal care could be better monitored. We saw staff failed to respect a person's need for support when they were distressed.

When interacting with people staff showed a caring nature with appropriate interventions to support people. Staff had time to spend with people and engage with them.

People told us their privacy was respected and maintained. There were opportunities for people to provide feedback and get involved in their care and the running of the home.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were some activities planned and agreed for people living in the home but these needed further development and consistency.

Care was planned with regard to people's individual preferences. We saw written care plans were formulated and regularly reviewed.

A process for managing complaints was in place and people we spoke with and relatives knew how to complain. Complaints made had been addressed.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were management systems in place and an acting manager was in place but the home had been without a registered manager for six months.

We found there had been major management changes over the past six months and these changes needed further embedding and development.

There were a series of on-going audits and checks to ensure standards were being monitored. These had not been effective in identifying some issues in the home.

The Care Quality Commission had been notified of reportable incidents in the home.

There was a system in place to get feedback from people so that the service could be developed with respect to their needs and wishes. These included regular meetings and other formal processes.

Dale Park

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 which took place on 2 & 3 August 2016. The inspection was undertaken by two adult social care inspectors 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.

We were able to access and review the Provider Information Return (PIR) as the manager sent this to us as part of the inspection. The PIR 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 also reviewed other information we held about the service.

During the visit we were able to meet and speak with 11 of the people who were living at the home. We spoke with 11 visiting family members.

We spoke with 10 of the staff working at Dale Park including nursing staff, care/support staff, the acting manager and regional operations manager for the provider.

We looked at the care records for seven of the people staying at the home including medication records, three staff recruitment files and other records relevant to the quality monitoring of the service. These included safety and quality audits including feedback from people living at the home and relatives.

During the inspection we observed care by carrying out a SOFI observation. SOFI stands for Short Observational Framework for Inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We undertook general observations and looked round the home, including people's bedrooms, bathrooms and the dining/lounge areas.

Requires Improvement

Is the service safe?

Our findings

During this inspection, we looked to see if there were systems in place to ensure the proper and safe handling of medicines. We found medicines were not being managed safely.

Each MAR (medicine administration record) contained a photograph for identification purposes and any known allergy. For two people who were on respite they did not have a photograph in place; we brought this to the attention of the nurse in charge who said they would rectify this immediately.

We looked at the way external medicines [creams] were administered. Records we saw gave good detail regarding the cream and its use [where to apply and when] but did not consistently record that creams had been applied and were incomplete and confusing.

We reviewed this with one person whose cream chart told us the person was having a cream applied. The record was for the month of May 2016. We saw other creams prescribed for the person kept in their bedside draw but there was no reference to these in the care records available in the person's bedroom. The care staff we discussed this with was not aware which creams [if any] the person was supposed to have applied [the staff member did not normally work in this area]. When we checked with the nurse in charge the creams had been applied in the past but now the person was not prescribed them. The nurse advised us the creams would be removed from the bedroom to avoid any confusion.

Another chart we reviewed was for a person who was on a cream PRN [to be given when needed]. Staff told us if the cream was not needed an entry on the chart 'N' to record this would be made. On the cream chart we saw for the month of July 2016, there was a record for the first two weeks of the chart but then the remaining two weeks were blank.

A third example was for a person on a cream three times daily. In the month of July the chart had no entry for three days. Another cream for the same person had six dates on the chart not recorded.

In the above examples the records were not fully completed and confusing so we were not sure whether the person's cream had been applied.

A number of peopled received nutritional supplements in the form of fortified drinks. For one person we noted that the meal replacement drink they were prescribed was to be given three times a day. The meal replacement drinks were however recorded to be given only twice a day on an administration plan and record for nutritional supplement chart. This chart was signed by the staff when the meal replacement drinks were given; this was not in accordance with the MAR. The care plan from June 2016 recorded the use of a different fortified drink which the person was not currently prescribed. This was confirmed by a member of staff. Our findings meant there was a risk the person was not receiving the meal replacement drinks they were prescribed.

For a person who was on thickened fluids (as they had poor swallowing), their plan of care recorded use of a

thickening agent to stage three consistency. Staff were signing the intake and output chart when drinks were given with the prescribed thickening agent rather than signing the MAR. There was however no record of the number of scoops of thickening agent recorded on the person's intake and output chart to ensure drinks were at the correct consistency and in accordance with the person's swallowing assessment. We did see the use of thickening agents were recorded in the kitchen but there was a risk that the drinks might not be at the right consistency to reduce the risk of choking if this was not recorded on their intake and output chart.
We discussed this with the manager and asked how checks were made to ensure MAR's were being accurately recorded. We were sown a comprehensive audit tool but this had not picked up the anomalies we found.

These findings were a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People at the home had their medicines administered by the staff. People had a plan of care which set out their care and support needs for their medicines. Care records we saw confirmed that people were reviewed regularly by visiting GP's and this included medication reviews.

We checked a selection of MARs and found staff had signed to say they had administered the medicines. Numbers of remaining stock were entered following administration of medicines to ensure the stock balances were correct. We carried out a random check of a number of medicines and found the stock balances were correct. This meant the medicines could be accounted for.

A protocol was in place for staff to follow when administering medicines to be given 'when required' (PRN). These were clear and gave staff the required information regarding their use.
Some medicines need to be stored under certain conditions, such as in a medicine fridge, which ensures their quality is maintained. If not stored at the correct temperature they may not work correctly. The temperature of the drug fridge was recorded to ensure these medicines were safe to use.

Controlled drugs were stored appropriately and we saw records that showed they were checked and administered by two staff members. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs legislation. A system was in place to ensure the controlled drugs were checked, counted and recorded each day to ensure the safe management of these drugs.

There were people having medicines given 'covertly' [without their knowledge in their best interest]. We reviewed one of these and saw that the nurse in charge was aware of best practice issues around this and these had been followed. The supporting care plan was clear and issues regarding consent had been clearly recorded.

As well as nursing staff administering medicines in the home other designated staff completed practical competencies in administration of medication course and were regularly assessed for competency and good practice. We saw details of the training completed which was detailed and comprehensive.

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Care records we saw confirmed that people were reviewed regularly by visiting GP's and this included medication reviews.

We looked at how staff were recruited and the processes followed to ensure staff were suitable to work with vulnerable people. We looked at three staff files and asked for copies of appropriate applications, references and necessary checks that had been carried out. We saw checks had been made but these were not thorough to ensure staff employed were 'fit' to work with vulnerable people.

The first staff file evidenced that two references had been sent for but we could only find one on file. The applicant had disclosed a previous caution by the police. This had occurred sometime ago. We could find no reference from the interview records, or any other record, as to whether this had been assessed or questioned with respect to risk.

The second file the second file contained only one reference [although two had been sent for]. The file contained no evidence of identification for the applicant [passport, driving licence or birth certificate for example.]

The third file was from an overseas applicant. This contained two references which were addressed 'to whom it may concern' and appeared to be pre-printed and presented by the applicant as there was no request letter by the provider. The references contained contact emails and phone numbers but there was no evidence these had been checked.

Only one of the staff files contained evidence of a recent photograph to identify the person.

The manager confirmed that two written references were the standard for the provider. The provider information return completed by the provider stated: 'We have robust recruitment and induction processes and we ensure that the relevant checks and documentation are in date and stored securely'.

The staff files had been audited by the provider in May 2016 but these anomalies had not been recorded.

These findings were a breach of Regulation 19 (2) (a) (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to the inspection we had received information that staffing levels were sometimes compromised and inconsistent. We checked to see if there was sufficient staff to carry out care in a timely and effective manner. We were told by the interim 'turnaround' manager and the operations director that there had been some issues with nursing and some ancillary staff leaving following the previous manager leaving and having to be replaced. The difficulties over this period were acknowledged by both managers but they felt they had acted to ensure a continued provision of care for people in the home.

There were 44 people living in the home at the time of our inspection. There was a nurse in charge of each of the two floors on both days of the inspection together with nine [day one] or ten [day two] care staff. These figures fluctuated for late shifts where there was one less care staff and nights where there was one nurse and five care staff. There were ancillary staff such as, an administrator, kitchen staff (all day), and domestic cover. The care was also supported by allocated staff hours for the organising of activities for people.

Staff interviewed confirmed that things had improved over the past month or so but the staffing situation had been an issue. One staff said, "Its better now and more settled but at one time I felt like leaving myself. Some days we only had three care staff on one floor." Another staff said, "Staffing was all over the place not long ago but It's a lot more positive now. The new staff are coming on board and it's more settled."

The observations we made evidenced staff were available. We observed staff attending to people and

supporting them to eat and drink as well as assisting with aspects of personal care. One staff told us, ''We are not rushed and can spend time with residents.''

During the inspection we made observations in the day area/lounge and spoke with people living at Dale Park who could give an opinion and with relatives and visitors. The feedback was consistent in that people felt there were enough staff currently available. One relative commented "There are enough staff for me.'' Another said, "Staff give good care generally – there is always somebody here.''

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, mobility, pressure relief and the use of bed rails. These assessments were reviewed regularly to help ensure any change in people's needs was assessed to allow appropriate measures to be put in place.

We saw that some more immediate risks regarding people's health were also assessed and care was planned in good time to reduce the risk of further complications. For example, one person who was being cared for primarily in bed was being carefully monitored not motored to ensure any risk to the person's skin integrity was reduced.

We made observations of people living at Dale Park and they appeared relaxed in the company of the staff. People who could express and opinion said they felt safe. One person said, "I like it here, it's very good."

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported to senior managers. Training records confirmed staff had undertaken safeguarding training and this was on-going. The training records seen showed 15% of staff were in need of updates. All of the staff we spoke with were clear about the need to report through any concerns they had. We saw that the local contact numbers for the Local Authority safeguarding team were available in the nursing office and also displayed around the home; for example in the lift.

There had been an example of a safeguarding incident just prior to our inspection concerning inappropriate behaviour by a staff member towards a person living in the home. This had been followed through with the safeguarding team from social services. It was clear the home had worked well liaising with the safeguarding team and investigating the incident to ensure issues were followed up and any lessons could be learnt.

Arrangements were in place for checking the environment to ensure it was safe. For example, health and safety audits were completed on a regular basis where obvious hazards were identified. Any repairs that were discovered were reported for maintenance and the area needing repair made as safe as possible. We saw the general environment was safe.

We saw how accidents and incidents were monitored in the home. All accidents were recorded and sent for review by senior managers. Statistics for accidents and incidents were recorded and discussed at senior management level. The home manager showed us action plans that had been made following analysis of accidents and incidents.

A 'fire risk assessment' had been carried out and updated at intervals. The PIR for the service stated: [Staff] have been trained to identify emergency situations and we have an updated contingency plan in place. 81% of [staff] have completed emergency procedures training and 81% fire training'. We saw personal emergency evacuation plans [PEEP's] were available for the people resident in the home to help ensure effective evacuation of the home in case of an emergency. Following the inspection the manager sent us evidence that safety certificates for electrical safety, gas safety and kitchen hygiene and these were up to date. This

showed good attention with regards to ensuring safety in the home.

Good

Is the service effective?

Our findings

We looked to see if the home was working within the legal framework of the Mental Capacity Act (2005) [MCA]. 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.

We found requirements were being met and people who lacked capacity to make certain decisions were assessed appropriately. For example we looked at one person who was being administered their medications 'covertly'. This meant without their knowledge. We saw that the person had been carefully assessed using the appropriate assessment tool regarding their capacity to consent to their medication administration and assessments had also included input from the family and GP. It was felt the person needed the medicine in their 'best interest' to ensure their health was maintained. This process showed a good understanding of the principals of the MCA and how they should be applied to ensure people's rights are protected.

We saw other examples where restrictions had been applied regarding people's care; for example one person had been assessed for a special chair because of their condition fitted with a lap belt to help keep them safe. We saw this had been carefully considered. A best interest meeting was recorded involving professionals and family members.

We saw examples of DNACPR [do not attempt cardio pulmonary resuscitation] decisions which had been made and we could see the person involved had been assessed regarding their capacity to make this decision and, when necessary, the person's relatives. The DNACPR form we saw contained an assessment of capacity by the GP.

People can only be deprived of their liberty so that they can 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.

The PIR informed us that; 'We have 16 Residents that are subject to a DoLS order and they have a relevant representative whose details are clear in the residents care plan. All of our Residents with a DoLS have access to an advocate'.

We saw the applications for one person and saw the application had been made appropriately with the rationale described. We saw the assessment by the local authority was delayed on these applications and the manager was aware of the need to ensure all applications were followed up.

We observed staff provide support at key times and the interactions we saw showed how staff communicated and supported people and asked their consent to care. When we spoke with staff they were able to explain each person's care needs and how they communicated these needs.

We reviewed the care of seven people on our inspection as well as asking about aspects of other people's health care and how effective this was. Each person's care file included evidence of input by a full range of health care professionals. If people had specific medical needs we saw these were well documented and followed through. For example, one person had a very high care dependency needs and was cared for long periods in bed. We saw there was good attention paid to the monitoring of the person's skin integrity and any concerns were referred for health care support. There was a very clear care plan which outlined the care of the person including any risk of pressure ulcers. The person also had difficulty with swallowing and there had been a referral made to the Speech and Language Therapist [SALT] to follow up.

We saw that all care records we saw had been regularly reviewed and updated with reference to any external health support needed.

People we spoke with and relatives told us that staff had the skills and approach needed to ensure people were receiving the right care with respect to maintaining their health. We looked at the training and support in place for staff. The Provider Information Return (PIR) told us: 'All Colleagues including the Home Manager have completed their induction training and new team members are fully supported when they first join HC-One. Staff are allocated a password and username at start of employment and supported to complete Touch training'.

We were shown the 'Touch training' programme which includes a workbook, on line courses and [new] face to face training by the learning and development team. We saw that 75% of staff had completed the face to face training. The course was based on the induction standards in the Care Certificate which is the government's recommended blue print for staff induction.

There was also some attention paid to giving staff more specific training around the care needs of the people living at Dale Park for example the PIR stated: '78% of colleagues having completed the HC-One 'Open Hearts and Minds' training [which] ensures our colleagues know how to intervene effectively and support when residents become agitated in order to keep residents safe and care effective'.

The manager told us that training of staff had been an issue and some staff had not been supported in this area. This was now improving. This was supported by staff interviews. Staff spoken with told us that there had been more of an emphasis on training recently. One staff said; "Things have improved over the past few months with more support around training. We also have supervision sessions which were not happening previously."

The manager informed us that some care staff had a qualification in care such as QCF (Qualifications Credits Framework) and we saw evidence that 25% had completed these courses and attained a qualification. The manager told us that efforts would now be made to increase this number following the recruitment of new staff.

We asked about staff meetings and we were told that issues get discussed at daily handovers and 'flash meetings' with the manager as well as formal staff meetings arranged on a regular basis. We saw there had been a meeting held on 19 May 2016 chaired by the turnaround manager. This had been well attended. Staff we spoke with at the inspection reported they were asked their opinions and felt the managers did their best to act on feedback they gave.

We observed the breakfast and lunch time provision in the lounge/dining rooms over the two days of the inspection. There was staff input in the dining areas and we saw most people were supported appropriately. The new manager had taken time to ensure tables were always laid appropriately and table cloths were used [not used previously]. One relative we spoke with told us that there relative's appetite had improved since moving to Dale Park and they had put on weight.

There were some inconsistencies in the meal time experience which we discussed with the managers to further improve the experience. For example, during breakfast one person was served porridge in the lounge, no napkin was given and consequently some porridge split onto this person's clothing, this person was observed during the course of the day to be wearing the stained clothing. After the breakfast service in the upstairs dining room it was noted that one person remained with half a bowl of porridge and no drink; there were no staff present. We alerted staff to the needs of this person and they quickly responded by assisting with the remaining porridge and provided a drink. Some people did not go to the dining room but were sat in the lounge areas without staff support until after the people in the main dining rooms had been supported. From our observations there appeared to be enough staff one duty to support both areas consecutively. On the whole we saw that meals were a sociable occasion though the allocation of staff during meal times needs to be considered to ensure people receive support in a timely manner.

Requires Improvement

Is the service caring?

Our findings

We made some observations of lounges over the two days of the inspection. Staff were seen to have very positive relationships with people and encouraged a good communal atmosphere. The interactive skills displayed by the staff were positive and people's sense of wellbeing was evident when being supported. Throughout the inspection we made many observations of staff supporting people who lived at the home in a timely, dignified and respectful way.

However, we did hear some comments and made some observations that raised issues around attention to people personal care at times and reflected on aspects of their dignity. This evidenced some inconsistencies at times with care standards that should be addressed.

For example, one relative was very concerned with regard to the appearance of their loved one and said, "(person) is wearing pyjama bottoms again, there are trousers to wear and they have not put on a vest. [Person] feels the cold, this happens at least once a week. They went on to say the person had lost dentures, spectacles and a wrist watch. Also, staff do not always make sure the person was wearing shoes or slippers.

Another relative also commented that their loved one had lost their dentures. While another commented that their relative was sometimes wearing clothes belonging to others. One relative said when they visited they brought with them an iron so that they could remove the inevitable creases from clothing as it came back from the laundry. One person's relative told us that bras and bed socks often went missing but no one offered to cover the cost of replacements. One relative commented that their loved one regularly misses a morning shave but has an electric shaver which he can manage himself with support; the feeling was staff do not have the time to offer this support.

We followed this up with staff and we received an update following the inspection that one person's belongings [glasses and watch] had been found but the dentures hadn't.

Our observations of care on the inspection included a number [at least five] people who were not wearing shoes / socks and men who had not had shaves and did not look at their best. Staff and managers stated that some people did not like wearing foot wear and continually took shoes off and this was in their care plans. The care plans we saw however did not offer a positive approach to improving this [merely recorded it as a choice]. Staff commented that some people could be difficult and resistive when they attempted support with personal care.

One observation of concern showed a lack of respect for a person who appeared in distress. The person was heard to be shouting in distress for a prolonged period [at least ten minutes]. When we investigated we found the person in one of the lounges with the door closed. Two other people [residents] were also in the room and seen also to be in distress because of this person. Staff were in the adjacent lounge and had not responded to the person's distress. Staff responded only when we raised this and reassured the person.

These findings were a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

All relatives spoken with agreed that there were no restrictions to visiting, some indicated they arrived at meal times so that they could assist with supporting their relative. One relative spoken with was familiar with the care planning system used in the home and had been consulted when their relative was first admitted. They stated that a review had been completed the previous week. They went onto say, "The care workers are excellent."

Most people spoken with and relatives told us they felt they were listened to and staff acted on their views and opinions. We saw that resident and relative meetings had been held. One relative was able to tell us that there was a relatives' meeting about a month ago, it had been arranged by the temporary manager. We saw the notes from this meeting which had been well attended.

Surveys were also sent out to canvass opinions. We saw the most recent survey form relatives which received 14 respondents. 100% of relatives thought the home overall was 'good' or 'outstanding'. The strongest ratings were for 'care' and 'kindness'.

Requires Improvement

Is the service responsive?

Our findings

We felt that the provision of meaningful activities was still an area that was being developed. On the first day of the inspection, for example, there was an issue with staffing levels and the activities co-ordinator was assigned to care duties during the morning and reverted to activities in the afternoon. The activities notice board showed evidence of past events during July 2016 and a planned visit by the Zoo Lab scheduled for 5th August 2016. It appeared that the daily activities were the same every day and the following were noted; A.M. Cleaning, polishing, folding, setting tables, sweeping and watering plants. P.M. Exercise based activities and games.

On the first day of the inspection we were told the activities for the afternoon would be dominos but after lunch the activities co-ordinator arrived at one of the upstairs lounges with a large inflatable hoopla game. A few people took part but many were watching TV or sleeping.

One person said, " The activities are not my scene but if there is a picnic out in the garden I will go" They went on to say, "It's a long time since I have been out, I stay in my room watching TV."

Another resident said after breakfast, "I don't like dominoes." Another person told us, "We used to go to Blackpool but there's nothing now." A relative commented, No one takes (person) out."

The lounges were all equipped with TVs which were constantly on during the inspection, staff were observed changing channels without consulting the people in the lounges. The chairs in the lounges were predominately arranged around the sides of the rooms which did not promote interaction.

We met with an activities organiser who told us about the social activities programme offered to people living at the home. These were arranged by two activities organisers and a member of the ancillary team. They also informed us of the proposed plans to refurbish the activities room so that people could come together in one designated area to enjoy a range of activities, including arts and crafts and use of a sensory area. They told us they wanted the room to become an immersive room, where by people using this room were fully engaged with the surroundings. Some themed art work had been completed in preparation for the use of this room though at the time of the inspection the activities room was being used for general storage. This meant people living at the home were unable to use it. The manager informed us this was a temporary measure whilst other areas of the home were being decorated. The manager agreed that the room needed to be cleared as soon as possible so it could be used to its full potential.

The activities organiser gave us examples of the activities people had been engaged with. This included activities in respect of promoting daily life skills and also recreational pursuits, such as, cooking, reminiscence therapy, flash cards, poetry, reading, hand massage, singing, dancing, gardening and creative art work. There were no designated drivers for taking people out on trips at this time though the activities organiser told us they took people out one a one to basis for weekly shopping trips. Musical entertainment was provided by external organisations and some people at the home had taken part in a cognitive stimulation group. A person told us how much they enjoyed taking part in the music sessions.

We were shown the new activity care plans which were being introduced and this included people's life story, social background and preferred social activities and pursuits. These had yet to be completed for the majority of people though the activities organiser told us how they were compiling these records by talking with people about their past life and gathering information from families to build up a detailed picture of the person. It is important to have this information recorded for staff as often people with dementia are not in a position to either recall or verbally articulate this information.

We recommend that the proposed activity programme for people is developed with reference to good practice guidance for people with dementia and activities are promoted consistently.

We asked people and their relatives how their care was managed to meet their personal preferences and needs. Most people spoken with were satisfied with living in the home and felt the care offered met their needs. Relatives said they felt involved in their care in that staff asked them regularly how they felt and whether their care needed changing in anyway.

People living at the home had individual care plans. These contained information and guidance for staff on people's health and social care needs, their preferred routine, daily records of the care and given by the staff and input from external health and social care professionals to oversee people's health and wellbeing.

We saw care plans for areas of care which included mobility, nutrition, personal hygiene, falls, people's routine, medicines and continence management. Clear and detailed care plans are important to ensure consistency of approach and to assure people's needs are met. The care plans we saw provided this assurance. They recorded good detail so that staff support was provided in a way the person wanted and needed to maintain their health and wellbeing. For example, for a person whose mobility was poor, staff had described their gait and how this could have an impact on their safety. Their plan of care showed how the staff supported the person but also how they encouraged the person with their independence. For another person we saw that a change in medication has helped to relieve a person's anxiety and reduce their pain.

Care plans were reviewed each month and these reviews provided an over view of the person's care and reflected any change in care or treatment. For a person who needed monthly clinical observations these had been undertaken in accordance with the person's plan of care and staff were monitoring the findings. Where equipment had been assessed as needed to ensure people's safety, for example, risk of falls this was in place and recorded. Body maps were used to record skin tears or bruising as part of monitoring people's skin integrity with a plan of care should a person require pressure area care or wound care.

We saw evidence of care plans to support people with behaviours that may challenge when caring for a person with the dementia. This included potential triggers and guidance for staff on how to support the person. Significant behaviours were recorded and positive strategies were in place to support people as part of assuring their comfort and wellbeing.

We saw care files were being reviewed by nursing and care staff regularly. We saw evidence of people, where possible, being involved in their care planning. For example we saw that in some instances people had signed their care plan and in others they had signed to say they had seen their care plan or it had been discussed with them. We also saw entries to say care had been discussed and updated with relatives where necessary. All of the relatives we spoke with told us they were always kept well informed regarding any issues with their relative. They had been involved in care reviews with staff from the home at various stages and these had sometimes included formal reviews of care with social workers input.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of

how they could complain. There was also a computerised feedback system in the foyer of the home for visitors to feedback any issues if they wished.

We saw there were good records of complaints made and these were audited and discussed at senior management level if needed. We saw that complaints had been investigated and responded to by the managers of the home.

Requires Improvement

Is the service well-led?

Our findings

We found that the home had undergone major changes in the past six months and this had caused some unrest, particularly amongst staff, who had had to make adjustments to the changing culture of the home. We found some improvements let had been made but there were planned improvements that still needed to be implemented. The change of culture needed to be further embedded.

The service did not have a registered manager at the time of the inspection. The home had been without a registered manager for six months, since February 2016. The home had been managed by a 'turn around' manager for the provider over this period. We were advised that a new manager was due to commence in the home the following week to the inspection. Following the inspection we were advised this was now not the case [the proposed manager had been placed elsewhere at another service] and the company were advertising for a new manager for Dale Park.

Prior to our inspection we had received a number of concerns from staff who were thinking of, or had, left the service following the previous registered manager leaving and the appointment of the new turnaround manager. These staff raised concerns around the support for staff and the changing culture of the home. We spoke with staff, people living at Dale Park and their relatives, as well as the manager and senior operational manager for the organisation. It was clear that there had been a change in management approach over the past six months and this had affected some staff. The operational manager and the turnaround manager told us this change was needed to meet certain corporate objectives that were not being met previously. For example, standards around hygiene in the home, staff training and support and the fact that the general environment needed improving. Both felt that the home had, overall, improved over this period and staff were 'now on board', although admitted this had been a difficult process and there was more to do.

We spoke with many of the staff in the home over the two days of the inspection. The interviews were consistent in that the home had gone through a difficult period after the previous manager left as there had been a very different approach following this. Staff had left and this had caused some disruption, possible affecting care in the short term. All of the staff spoken with, however, told us that things were now improving and the home was more settled.

Most staff we spoke with had been in the home for a number of years and were able to comment on the changes. One staff said, "Things were all over the place following [the previous manager] leaving. Things are getting better now and staff seem very good and are on board." This was echoed by other comments. A staff member told us, "Overall I'm happy with the changes – it was needed." Another commented, "We can still be short of staff sometimes but overall it's improving and getting better. It was chaotic at one time but I'm willing to give the new management a go."

The general feeling was that there had been improvements to the home, particularly in terms of the planned environmental upgrade and staff training but these were still on-going. Staff felt the culture of the home had changed and needed to be further embedded. A staff said, "Were used to the new approach now but it's vastly different than the last manager and time is still needed."

Relatives spoken with felt the manager was approachable and helpful and felt there was a positive culture in the home. Some realised there had been changes and commented on lack of staff on occasions but, again, all felt this had improved overall. One relative told us, "[The manager] has done well. The last manager was good but there have been further improvements. I've been to the relative meetings and things are discussed."

We reviewed some of the current quality assurance systems in place to monitor performance and to drive continuous improvement. The managers were able to evidence a series of quality assurance processes and audits carried out internally and externally from senior managers in the organisation. These processes had helped monitor, maintain and generate a series of developments over the recent months to improve the service.

The PIR stated: 'Our quality assurance framework, Cornerstone, consists of daily, weekly and monthly tasks and audits to help us assure good quality care. We use Cornerstone along with the HC-One Policies and Procedures. Every audit has an action plan to drive improvement'.

We reviewed some of these. For example, we looked at how accidents were recorded and reviewed and found a good audit trail which included review at senior management level to look at trends. We saw medication audits, care plan audits and various health and safety and environmental audits. This had helped to ensure the home was being monitored in key areas. Some of these audits were supported by external audits carried out by senior quality managers in the organisation. For example a recent health and safety and environment audit had highlighted issues to address.

We were concerned that, despite fairly well developed systems in place, some areas had not been effectively monitored and issues had been missed. These included the medication issues we highlighted and the lack of thorough recruitment checks for some staff. The staff files had been audited by the provider in May 2016 but these anomalies had not been recorded.

The managers were aware of incidents in the home that required The Care Quality Commission to be notified of. Notifications had been received to meet this requirement.

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 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	We recorded some negative comments by relatives and made observations that supported the view that aspects of some people's personal care could be better monitored. We saw staff failed to respect a person's need for support when they were distressed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	We found the provider's arrangements to manage some medicines were not consistently followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed
Treatment of disease, disorder or injury	Staff had not been thoroughly checked when they were recruited to ensure they were suitable to work with vulnerable adults. 19 (2) (a) (3) (a) (b)