The Dales (Northwest) Limited

The Dales Care Home

Inspection report

6 Marine Park
Wirral
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10 June 2021
16 June 2021

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14 July 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Dales Care Home provides accommodation for up to 31 people who require nursing or personal care. At the time of the inspection 25 people lived in the home. Some people at the home were living with dementia.

People's experience of using this service
At this inspection, we identified serious concerns with the management of risk, the delivery of care, infection control practices, safeguarding people at risk of abuse, record keeping and the leadership and governance of the home.

Staff did not always have sufficient or accurate information about people's needs and did not utilise risk assessments to keep people safe from the risk of harm.

People were not supported to have maximum choice and control of their lives and staff did not support them to make choices about what time they got up each morning.

There was little evidence to show that infection control protocols were in line with government guidance or that they were followed to protect people and staff from the risk of infections such as COVID-19.

The home was visibly dirty and smelled very badly of urine and was unsanitary in some areas. This placed people at increased risk of infection.

Staff did not understand how to manage accidents, incidents or safeguarding concerns safely. This meant that these were not consistently fully explored, and people were at increased risk from harm and abuse.

Record keeping in relation to people's care and the management of the service were poor. It was difficult to see what support people needed and what support they had received.

The systems in place to monitor quality and safety were ineffective. The management of the service was ad-hoc, with little oversight of care delivery. The acting manager did not demonstrate they understood the requirements of the health and social care regulations in respect to providing safe and appropriate care. The registered manager who was also the provider had been absent from the home for around six months and did not have appropriate oversight of the service being provided. This placed people at significant risk of avoidable harm.

The registered manager/provider responded very quickly to the findings of the inspection and when we returned to the service for the second day, significant improvements had already been made. There was a robust action plan provided to CQC and reassurances that action was being taken to address all of these issues.

There were enough staff on duty to support people. Staff were observed to be kind and caring. People told us they felt safe at the home. People and their relatives were generally positive about the service.

Rating at last inspection and update
The last rating for this service was Requires Improvement (published 02 December 2020) and there was a breach of regulation. At this inspection we found that there had been a deterioration in the quality and safety of the service and the provider remained in breach of regulations.

Why we inspected
This focused inspection followed information of concern received by CQC regarding the safety and wellbeing of the people living in the home and the management and governance of the service overall. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.
For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to a failure to assess and mitigate risks in people's care, poor infection control practices, safeguarding adults from the risk of abuse, ensuring staff were suitable to work in social care and poor record keeping and a lack of managerial oversight of the service being provided for people.
Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service.

This will usually lead to cancellation of their registration or to varying the conditions the registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

The Dales Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this focused inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act under the domains of safe and well-led, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team
This inspection was undertaken by three inspectors on day one and two inspectors on day two.

The Dales Care Home is a care home. People in care homes receive accommodation with nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At this home the provider and the registered manager was the same person.

Notice of inspection
We commenced the unannounced inspection on 10 June 2021. We identified urgent concerns and asked the provider to submit an urgent action plan telling us what action they would be taking in response to these. Due to the concerns found at this inspection, we advised the provider we would be returning to the service the following week but did not provide a specific date for the return visit. We returned to the service on the 16 June 2021 to check on progress and complete the focused inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection
On both inspection days we arrived early in the morning to be able to observe the practice of and speak with both night and day staff. We spoke with the registered manager/provider, the acting manager, and seven other staff members. We reviewed a range of records. This included four people's care records, a sample of medication records, four staff recruitment files and records relating to the management of the service.

After the inspection visit
Due to the impact of the COVID-19 pandemic we limited the time we spent on site. Therefore, we requested records and documentation to be sent to us and reviewed these following the inspection visit. We spoke with people at the service and we contacted relatives by telephone to seek feedback about their experiences of the care provided.

We shared our concerns with the local authority during and after the inspection. We also made referrals to the local infection control team, the fire brigade and environmental health following the inspection.

Inadequate

Is the service safe?

Our findings

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

At the last inspection, this key question was rated as requires improvement. At this inspection, this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- The systems in place to protect people from the risk of abuse were not effective. We identified a number of concerns that showed staff did not understand safeguarding processes, including how to recognise and report them and what action they needed to take to keep people safe.
- Senior staff had failed to act and take appropriate action when becoming aware of concerns, some of which were of a safeguarding nature.
- We spoke with the registered manager regarding this and they took immediate action to start to correct these failures.

The provider failed to ensure people were kept safe from potential harm or abuse. This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Relatives told us that staff treated their family members well and they thought they were well cared for. One relative said, "Staff are really lovely, and they are on the ball with [Name]."

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Care plans did not contain adequate information or guidance for staff about people's needs, risks or the care they required in order to ensure their health and safety was maintained. This placed people at significant risk of receiving inappropriate and unsafe care.
- People's care was not properly monitored to ensure their needs were met. It was impossible to tell if people had received the care they needed to keep them safe and well. For example, one person was at very high risk from falls. They had experienced regular falls that were not recorded, or the appropriate response taken to keep them safe. The CQC raised a safeguarding referral in relation to these concerns.
- A person had an identified personal risk to their health and well-being. Records showed that they needed support on two occasions to address this risk in recent weeks and no action had been taken. This person was subject to a CQC safeguarding referral following the inspection.
- The oversight of risk in the home was very poor. Accidents, incidents and safeguarding concerns were not recorded in the correct format, so they were missed by managers and no action taken in response to them. We identified 17 concerns in the last three weeks that had been missed resulting in people being placed at risk from potential harm and abuse.

The provider had not ensured people's risks were adequately assessed, monitored and managed to prevent avoidable harm. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The registered manager provided an urgent action plan and took prompt action to address all of the above issues.

Preventing and controlling infection

At our last inspection the provider had failed to ensure that staff were consistently wearing PPE in line with government guidance. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection staff wearing PPE had improved. However, there were significant failings in infection prevention and control practices at the home. The provider remains in breach of Regulation 12.

● The home was visibly dirty. It smelled very strongly of urine in almost every part of the home. Carpets in most of the home were worn, threadbare, sticky and heavily stained.
● We found significant evidence that staff were not supporting people to live in clean and sanitary conditions, especially within their own bedrooms and bathrooms.
● Appropriate Infection prevention control (IPC) policies and procedures in respect of COVID-19 were not in place. Testing was not being carried out in accordance with government guidance and visitors were not instructed by staff to follow guidelines to keep people safe.
● PPE was in use but was not disposed of safely. We observed discarded PPE in a number of places around the home including bathroom and bedroom floors and in wastepaper bins. Clinical waste bins for the disposing of used PPE were available but were not always used appropriately.

Infection control practices at the home did not adhere to government guidelines to protect people from the risk of, or, spread of infection. This was a continued breach of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager provided an urgent action plan and took prompt action to address all of the above issues. However, the governance arrangements had failed to recognise the issues prior to our inspection which had led to a significant deterioration in the environment of the home.

Staffing and recruitment
● Two staff had been recruited in the last six months and no references had been sought.

Safe recruitment practices had not been followed and people were at risk from staff who may be unsuitable for the role. This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were adequate staff on duty to meet people's needs during the inspection and staffing levels appeared to be maintained.
● There was some use of agency staff and we raised concerns about the induction and management of these staff and how this impacted on people living in the home.
● The provider was recruiting new staff to reduce the number of agency staff needed.

Using medicines safely
● Medicines were stored, recorded and administered safely.
● Staff responsible for the management of medicines had completed training and had access to up to date information and guidance about the safe management of medicines.

● Medication administration records (MARs) detailed people's prescribed medications and instructions for use. Staff initialled MARs after people had taken their medicines.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated requires improvement. At this inspection, this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The registered manager who was also the provider had been absent from the service for some time and had failed to ensure adequate oversight of the care being provided and the maintenance of the home's environment.
- The acting manager was not able to demonstrate that they had the skills or knowledge to manage the service safely.
- The governance systems in place were not robust and had not picked up on concerns highlighted during this inspection. For example, care plan audits failed to identify that people's needs and risks were not properly assessed or managed. The condition of the carpets, equipment and cleanliness had not been acted upon and the environment had been allowed to become unsanitary and unsafe.
- Provider and managerial oversight of the service were inadequate. As a result, the provider and acting manager failed to ensure the service met its regulatory requirements and failed to ensure risks to people's health, safety and welfare were properly mitigated.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;

- There was limited record keeping in respect of people's needs and the care they required. Records kept were not contemporaneous or accurate. Staff relied on a handover book and did not record specific incidents and issues in people's care plans, so at times they were missed and not acted upon.
- There was no evidence that the manager or provider reviewed the care and support people received to ensure it met the standard required. This increased the risk of people experiencing poor outcomes. There were examples where staff had tried to raise concerns, but they had not been listened to.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

- There was little evidence that there was any clear audit system and the management team had not recognised the significant issues identified in the home.

The governance arrangements in place were not robust, managerial oversight was poor and record keeping was not always adequately maintained. This was a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager/provider acknowledged the failures within the service and promptly started to take action to address all of the concerns found at the inspection. At the second day of the inspection there was evidence that many of the matters were already being addressed and plans put in place to ensure that the mistakes were not repeated.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Feedback from professionals was positive and the service was engaging with local systems to support people's needs.
- Relatives told us that they had good communication with the home and that throughout the past difficult year and COVID-19 lockdowns, this had been invaluable.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured people's risks were adequately assessed, monitored and managed to prevent avoidable harm. Infection control practices at the home did not adhere to government guidelines to protect people from the risk of, or, spread of infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure that people were kept safe from potential harm or abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The governance arrangements in place were not robust, managerial oversight was poor and record keeping was not always adequately maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment practices had not been followed and people were at risk from staff who may be unsuitable for the role.