HC-One Limited

Dale Park

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Dale park 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. Dale Park is purpose built and can accommodate 46 people who are living with dementia. It is managed by HC-One Limited. There were 44 people in residence at the time of the inspection.

The home was last inspected in August 2017 and was rated 'Requires improvement'. All the previous outstanding breaches of regulation had been met. There was fresh leadership in the home which had provided a positive focus for staff, people using the service and visitors. The service remained 'Requires improvement' because achieving the rating of 'Good' would require good practice being sustainable over a longer period.

On this inspection we found standards and improvements had been maintained. We have rated the service as Good.

A registered manager was in place. 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 found management and overall governance was stable. The registered manager was a consistent and positive lead in the home and had been effective in building a positive staff team and ensuring a consistent approach to care.

Staffing numbers ensured people's care needs were consistently met. We found this had continued to improve. Feedback from staff, people using the service and visitors was positive in that staffing levels had been consistently maintained to ensure safe standards of care.

People's nutritional intake was supported appropriately. Meal times were seen to be a relaxed and enjoyable experience for people. People's nutritional state was very well monitored.

Staff told us there were good systems in place to support them in their work such as training and supervision.

Observations and feedback from people and their relatives evidenced people's dignity was protected and maintained.

Staff were motivated to provide meaningful activities and a more consistent programme of social activities had been developed.

People's risks regarding their health care were being adequately assessed and monitored. There was good referral and liaison with community health care professionals who worked with the home to help ensure people's health care needs were met. We had previously made a recommendation regarding the specific need to ensure best practice around the assessment and monitoring of people who have challenging behaviour; this had improved.

We found medicines were administered safely. We found medication administration records (MARs) were clear and met best practice. People received their medicines consistently.

We looked at how staff were recruited and the processes to ensure staff were suitable to work in the home. We saw checks had been made so that staff employed were suitable to work with vulnerable people.

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. All 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. Planned development / maintenance was assessed and we were made aware of the refurbishment of the home that had taken place.

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.

There were people being supported on a Deprivation of Liberty [DoLS] authorisation. 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 these were being monitored by the registered manager of the home.

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

We observed staff interacting with the people they supported. We saw how staff communicated and supported people. 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.

A complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain. There were records of complaints made and the provider or registered manager had provided a response to these.

The management structure within the home was clear and supported the home with clear lines of accountability and responsibility.

There were systems in place to get feedback from people so that the service could be developed with respect to their needs and wishes.

The registered manager was aware of their responsibility to notify us [CQC] of any notifiable incidents in the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

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

Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

Medicines were administered safely and in line with the provider's policies and procedures.

Risks regarding people's health care were adequately assessed and monitored.

Staff knew how to recognise abuse and the action they should take to ensure actual or potential harm was reported.

There was good monitoring of the environment to ensure it was safely maintained.

Is the service effective?

Good

The service was effective.

We found the home supported people to access support for their health care needs.

People were supported appropriately so their nutrition and hydration needs were met.

Staff said they were supported by the registered manager and there were support systems for staff such as training and supervision.

When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed and people were assessed and reviewed appropriately.

Is the service caring?

Good

The service was caring.

People's dignity was protected and maintained.

Staff showed a caring nature with appropriate interventions to support people.

There were opportunities for people and their relatives to provide feedback and get involved in their care and the running of the home.

Is the service responsive?

Good

The service was responsive.

There were planned social activities for people to engage in and this reflected good practice guidance for people living with dementia.

Care planning showed evidence that people and families had been involved in their care. Care plans were in place and regularly reviewed.

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

Is the service well-led?

Good

The service was well led.

There was a registered manager in place. The registered manager provided a positive focus and leadership.

Management and governance systems were consistently applied and helped to monitor standards in the home. The management structure within the home was clear and supported the home with clear lines of accountability and responsibility.

We found there was a positive and responsive culture in the home and the quality assurance system in place included consultation and feedback from people living at Dale Park and their relatives.

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 over two days. The inspection team consisted of an adult social care inspector 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 looked at the Provider Information Return (PIR) before 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.

Prior to the inspection we spoke with commissioners such as social services and health care commissioners. They told us there had been no issues with Dale Park since our last inspection.

During the visit we were able to meet and speak with seven of the people who lived at the home and nine visiting family members. We spoke with the registered manager and nine staff including nursing staff, care/support staff, kitchen staff, domestic staff and maintenance staff.

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

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

We carried out a SOFI observation. Short Observational Framework for Inspection (SOFI) is a methodology we use to understand the quality of the experiences of people who use services who may be unable to provide feedback due to their cognitive or communication impairments. SOFI helps us assess and

understand whether people who use services are receiving good quality care that meets their individual needs.

Good

Is the service safe?

Our findings

All the people living at Dale Park who could comment said they felt safe. Our observations were that people were relaxed in the home and in the company of staff. One person we sat by in a lounge area told us, "It's nice here. This is a nice room and very comfy." The person looked relaxed and reassured by their surroundings and the staff who were present. A relative commented, "[Staff] will always keep us up to date. I trust them – it's very safe here." Other relatives also felt the service provided safe care; "Yes, the staff are very alert and on the ball" and "I know [person] is absolutely safe here."

We found that there were enough staff to ensure people were cared for safely. On the first day of the inspection there were some staff who reported sick and did not attend. This meant the home operated for most of the day with a reduction in numbers of care staff from the providers current staffing ratio. Staff told us this had been a regular occurrence in the past but staffing was now much more settled. Staff told us that there was always enough staff to ensure safe care with much less reliance on agency staff cover. One staff said, "Occasionally things likes baths for people have to be put off if we are reduced in numbers and we can't join in social activities; this is not a usual occurrence however." The registered manager advised us that most shifts were covered with a nurse and five care staff for each of the two floors of the service. This was maintained to provide not only safe care but a good quality of care and ensured staff had good support to provide some time and quality.

Our observations on the first day of the inspection confirmed that people were safely care for. A relative said, "It's a big home and residents are very dependant; they need to ensure good staffing." The relative confirmed that most of the time this was maintained. We looked at the staffing rota which also confirmed adequate staffing. We observed that none of the shared public areas were left without a staff member. The Provider Information Return (PIR) told us, 'The plan for next twelve months is to reduce agency usage and continue to recruit permanent staff of the correct skills, ensuring resident needs are met to a good standard and consistency of care'.

There was also additional ancillary staff support such as administration staff, kitchen staff, laundry and domestic staff and a maintenance person. Additional staff hours were allocated for activities and there were designated staff to lead this.

We checked 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 the manager and administrator for copies of applications, references and necessary checks that had been carried out. We saw these checks had been made so that staff employed were 'fit' to work with vulnerable people. We commented that the staff files did not contain a photograph of the staff member; the registered manager told us this would be addressed.

We reviewed the way medicines were managed and administered. We found medicines were being administered safely. We viewed a copy of a recent audit by the supplying pharmacist which reviewed all aspects of medication administration and storage. The audit report evidenced compliance in terms of medicine management. Minor recommendations had been addressed.

There was evidence of good practice in relation to the use of covert medicines [medicines given to people without their knowledge in their 'best interest']. For one person we saw that relevant professionals had been consulted and a' best-interests' decision had been recorded with input from people's relatives; this included an assessment of the person's mental capacity. Advice had been sought from the pharmacist to establish the safest and least intrusive way in which to covertly administer each of the person's medicines.

People had a plan of care which set out their support needs for their medicines, including 'as required' (PRN) medicines. We checked medicine administration records (MARs) and found staff had signed to say they had administered the medicines.

There were records to track whether people had been administered topical preparations (creams), thickening agents added to drinks for people who had difficulty swallowing and were at risk of choking. With regards to the application of creams, we saw a body map which recorded the areas of the body the cream was to be applied to. We saw that records of creams applied were clear and up to date showing clearly which staff had administered the cream. Similarly records for people prescribed 'thickeners' for drinks (to help reduce any risk of chocking for people with swallowing difficulties) were clear, showing staff were monitoring this aspect of care and recording administration.

Care records contained a range of risk assessments including; dependency, falls, nutrition, continence, moving and handling, pressure relief, use of bed rails and generic risk. Assessed risk showed evidence of monthly review [mostly] in each record. There was evidence in a record of a falls' risk assessment being upgraded following a fall. The person was now to be monitored more regularly and this was specified in the plan. Risk assessments were sufficiently detailed and were reflected in an associated care plan.

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. All the staff we spoke with were clear about the need to report through any concerns they had. Contact numbers for the local authority safeguarding team were available.

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. Any repairs that were discovered were reported for maintenance and the area needing repair made as safe as possible. We walked around the home and did not see any obvious hazards. We spot checked some safety certificates such as gas and electrical safety and fire safety and these were all up to date and well maintained.

A 'fire risk assessment' had been carried out and updated at intervals. 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. Plans were also recorded in a file in the main entrance. In one instance a person had deteriorated in their health over the previous three days and the PEEP required review. This was completed on the inspection.

Good

Is the service effective?

Our findings

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. One relative commented, "Staff are confident and always make sure we are updated with any changes [in people's condition]."

The registered manager informed us that mandatory and other training to all staff helped ensure staff were supported. Mandatory training was through a blend of e-learning and classroom / off line assignments and was aligned with the Care Certificate for new staff. The PIR stated, 'We aim to complete further staff training and complete a six-step programme [for end of life care] to ensure full involvement of relatives and external services in the care and delivery to residents needing specialised support'. When we spoke with staff they confirmed these arrangements had commenced. We saw the latest training statistics f or the home and found staff attendance at training updates was very high. Nursing staff told us they had also completed further training; for example, in the use of syringe drivers (to administer medicines at the end of life) and male catheterisation.

New staff had an induction programme. We were shown the 'Touch training' programme which includes a workbook, on line courses and face to face training by the learning and development team. The course was based on the induction standards in the Care Certificate which is the government's recommended blue print for staff induction. Staff told us the training provided a good background to care and had helped them with their job role.

The registered manager informed us that some care staff had a qualification in care such as QCF (Qualifications Credits Framework). In August 2017 staff having these qualifications was 58% [improved form previous inspections] and this figure had remained constant on this inspection. CQF qualifications evidence a good base knowledge for care staff to carry out and maintain their care role.

Staff told us they now had regular one to one supervision sessions with their line manager. We saw records to indicate this was now being met. One staff told us, "[The registered manager] is very open and we can speak to him at any time but we also have regular one to one sessions with line managers for extra support."

We asked about staff meetings and we were told that issues got discussed at daily handovers and 'flash meetings' with the manager as well as formal staff meetings arranged on a regular basis. Staff we spoke with reported they were asked their opinions and felt the manager listened and acted on feedback they gave.

We found people were very well supported with meals and their general nutrition. Care documents contained routine assessments for any nutritional risks and we found that people who needed referral for extra professional assessment had these. For example, two people we reviewed had difficulties with swallowing and had been referred to the Speech and Language Team [SALT] for further assessment. Staff felt it was important to monitor daily food and fluid intake as this provided a good baseline to assess any changes.

We carried out our SOFI observation over the dinner time. We saw very good support provided by staff. The meal time experience for people was positive and relaxed. Staff took time to support people positively; independence was encouraged whilst staff monitored carefully how much diet people had. We saw the meals offered were of good quality and were well presented. There was good choice available; for example, a choice of two main meals and during the breakfast meal there was a cooked breakfast available. Some people had specially prepared meals such as pureed diets and these were also well presented. People in need of assistance were supported by staff; there were sufficient staff to provided support when needed. The meal was well paced and relaxed. The expert by experience, who accompanied the inspection, sat with people during lunch and reported, "Lunch was served in a small dining room that day to myself and four dinner companions. The room was bright, warm and clean. The main course was a very nice pork stroganoff with fresh veg. One resident was quickly brought a freshly made chicken sandwich as they didn't want the pork. A [person] was served chips with a sausage roll as that was what they preferred. Hot and cold drinks were offered too. Lunch was served in a kindly way with no fuss and in a pleasant way. I enjoyed mine very much."

We reviewed the care of five people. 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. Care records had been regularly reviewed and updated with reference to any external health support needed.

We looked if the home was working within the legal framework of the Mental Capacity Act (2005) (MCA). The MCA provides a legal framework for making 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 and Community Mental Health Team. It was felt the people 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 three examples of DNACPR [do not attempt cardio pulmonary resuscitation] decisions which had been made and in one we could see, when necessary, the person's relatives had been involved.

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 and found that they were.

Good

Is the service caring?

Our findings

We received very positive feedback from relatives and visitors to the home regarding the general approach and caring culture within Dale Park. One relative commented, "The staff are so caring, the manager as well; they are very approachable." A recent on-line review of the care in the home stated, "Needs have been fully met with kindness, compassion and good humour. Staff genuinely care and go out of their way to improved [person] wellbeing."

Other relatives gave examples of the caring nature of staff: "When [person] had to go to hospital, the senior carer stayed with them until late at night," "When [person] was taken to hospital they did a full "body map" and told me [person's] skin was fine with no sores which really reassured me that the home was doing a great job" and "You can visit any time and the night staff are just as kind as the day staff."

The PIR for the service gave a good example of where staff had gone the extra mile in supporting a person and their relative who had communication difficulties and anxiety because they were away from their relative for a period: 'After discussion with the family, it was thought a small laptop would be a good idea so they could face time each other and at least have a face to look at. This was organised and gave both the resident and [relative] support to reduce their anxiety'.

Our general observations included positive care interventions. We also carried out a specific period of observation in one of the lounges and over lunch time. The people involved in our observations all received support and positive interaction from staff. Staff were seen to be caring and courteous in their interactions with people.

The manager told us about resident / relative meetings that had been arranged. Relatives we spoke with said the meetings were informative and positive. The PIR stated: 'Relative and resident meetings are held regularly and items including any complaints/concerns are discussed openly and relatives are fully included in the running of the home. We have a tablet in reception for providing feedback and receive a monthly report where we can identify themes if there is any dissatisfaction and respond'

Another feedback format came from regular surveys for people to complete. We saw the results of the last survey given to relatives in June 2018 when 10 respondents rated the home either good or excellent. The rating for 'kindness' was 80% positive. We saw in the foyer of the home that Dale Park has recently received a regional kindness in care award from the provider and had also been nominated for a national award in kindness and care.

Good

Is the service responsive?

Our findings

People we spoke with and their relatives told us activities were provided to engage people and provided some focus to people's day. One person we sat with said, "We get people entertaining us; we have a nice time."

Two activity coordinators each worked 16 hours a week. Care staff also involved themselves in activities such as karaoke with people on the morning of our visit. This was very popular with people and some people who had difficulties communicating or don't wish to speak much became quite animated and involved in the singing and really seemed to enjoy themselves.

There was list of daily activities including Karaoke, dominos, minibus 'adventures' [outings], arts and crafts, 'one to one' memory lane and bingo. One activity staff was spoken with and knew all the people living at Dale Park very well and seemed popular.

Relatives told us that staffing had been consistent since the registered manager had been running the home and now had more time to socialise and people received a higher level of individual attention. All felt this had improved and was consistent. 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 given by the staff and input from external health and social care professionals to oversee people's health and wellbeing.

Care records we reviewed showed that people had limited capacity to be meaningfully involved in the assessment process or planning of care. However, there was evidence that family members or advocates had been involved in the assessment process. There was also evidence that family members had been invited to reviews of care.

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, in the main, provided this assurance. Each of the care records we reviewed contained a good standard of person-centred information which detailed their personal, medical and care histories. A good example of how people's communication difficulties were assessed and supported was one person who speech patterns were described fully to assist staff when interacting, '[Persons] speech is clear and can be well understood…… pattern of speech can be repetitive and can forget what you have asked … may need support and guidance in relation to the environment'. There was more information about the need for hearing and other aids such as glasses to aid vision as being important to aid good communication.

The PIR stated, 'We respect diversity by providing person-centred care and treat the individuals we support as unique rather than treating all individuals in the same way and ensure we work in a non-judgemental

way'.

Care plans were reviewed each month and these reviews provided an overview of the person's care and reflected any change in care or treatment. 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.

The approach to care was also evidenced for people at the end of their lives. One person we reviewed was under regular review involving the palliative care team and we saw that some advance care planning was in place with respect to anticipatory medicines which were available in the home for use when needed. We spoke with a relative who told us that the staff were "Well on top of things" and were managing the care well. We saw some recent feedback by another relative which stated, 'Dale Park bought happy days for [person] at the end of [their] life. The expertise helped [person] pass away peacefully'.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain. We found the complaints policy and procedure was only displayed in the main foyer and then was only part of an information booklet – the 'Service User Guide'. We discussed ways in which key information could be more accessible for people, including easier formats for people to access; this had been achieved with the display of information regarding activities. The registered manager agreed to look at this and include more accessible and easy read formats for information displayed.

There was a computerised feedback system in the foyer of the home for visitors to feedback any issues if they wished. There were good records of complaints made and these were audited and discussed at senior management level if needed.

Good

Is the service well-led?

Our findings

The registered manager had been in post for over 18 months and was seen by staff, relatives and health and social care professionals as being the key reason for the maintenance of consistently good standards in the service. A relative commented; "The manager really does listen. Everything I've spoken about in the last year or so has been actioned."

Staff spoken with also agreed that the registered manager provided an effective lead and was extremely approachable and friendly. One staff commented, "I'm fairly new but I've been supported to settle in well; a lot of this is down to [the registered manager]."

The feeling on the inspection was a very positive and a caring culture was evident at all levels. The registered manager stated they felt there was a positive culture of learning at Dale Park and any person was free to contribute ideas and have a say. The PIR, sent by the registered manager, prior to the inspection, stated: 'Dale park is now registered as a learning centre for student nurses from Edge Hill College and we are also registered with Queens Court Hospice regarding the six-step process. Both regularly give feedback, which is positive, and audit the home. This promotes good communication and supports the staff team at Dale Park'.

The registered manager was a registered nurse and held a Level 5 in Leadership for Health and Social Care. In addition, there was a management team in the home consisting of unit managers who were both registered nurses. Externally the registered manager was supported by senior managers who visited and supported the service on a regular basis.

We reviewed some of the current quality assurance systems in place to monitor performance and to drive continuous improvement. The registered manager could evidence a series of quality assurance processes and audits carried out internally and externally from senior managers in the organisation. These processes were seen to be fully formed and focussed on key performance indicators such as clinical issues including hospital discharges / admissions, staffing, wound care, falls, and nutritional risk. The registered manager explained the quality assurance framework, 'Cornerstone', consisted of daily, weekly and monthly tasks and audits to help assure good quality care. We were also told about the daily management of the home and the routine 'walk around' and 'flash meeting' with key staff, to both monitor and communicate key issues. Staff spoken with evidenced the value of these processes.

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

From April 2015 it became a legal requirement for providers to display their CQC (Care Quality Commission) rating. The rating from the previous inspection for Dale Park was displayed for people to see and was also on the provider's website.