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?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

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

The service was last inspected in August 2016 when we found three breaches of regulations regarding medicines management, safe recruitment of staff and respect for people's dignity. The service was rated as 'Requires Improvement'.

This inspection took place over three days commencing on 5 December 2016 and following up on 11-12 January 2017 in response to concerns that had been raised with us. During the inspection we found breaches of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014 relating to staffing, dignity and respect, support at meal times and good governance. Respect for people's dignity was a continued breach from the last inspection in August 2016.

Following the first day of the inspection, on 5 December 2016, we found serious concerns and breach of regulations concerning staffing of the home and found this was having an effect on the safety of the care provided. We sent the provider a letter [called a section 64 letter] asking for urgent action to address the concerns. The letter also asked the provider to not admit any more people to the home until the areas of risk we identified had been addressed. We visited again on 11-12 January 2017 to complete a full inspection and check to ensure people were safe.

This report and outcome is based on the evidence we found over the three days of the inspection.

The previous registered manager had not worked in the service since November 2016. A new 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. The new manager said they were applying for registration.

There had been a lack of consistent leadership and management since April 2016 when a previous long term registered manager had left. Some key areas of management such as maintaining adequate staffing levels had not been adequately monitored. This had caused some instability resulting in fluctuating levels of care which exposed people to risk in some key areas.

We found the home had not provided enough staff on duty at all times to help ensure people's care needs were consistently met. This had improved over the past month, following our initial concerns, but consistency of staffing in the longer term remained an issue and we continue to have concerns regarding the sustainability of standards and will therefore continue to monitor the service closely.

We found people were being monitored with respect to their nutritional intake although we saw people

were not always supported appropriately at meal times so there was risk that requirements around nutrition and hydration could be compromised. We told the provider to take action.

Staff said they were better supported by the new manager but we found a lack of consistency since the last inspection regarding support systems for staff such as training and supervision.

At our last inspection we found the service in breach of regulations regarding the need to maintain people's dignity. On this inspection we also made observations which raised concerns that people's dignity was not always protected and maintained.

Limited activities were organised in the home. We were told it had been difficult to organise activities due to lack of staff. Staff were motivated to provide meaningful activities but the programme needed to be developed further.

You can see what action we took with the provider at the back of the full version of the report.

We found medicines were administered safely. This was an improvement from the last inspection when we found the service in breach of regulation. The breach had now been met. We have made a recommendation regarding the recording of some medicines such as creams and thickeners added to drinks so that administration records are clearer and meet best practice.

We made a recommendation regarding this.

We saw that people's risks regarding their health care were being adequately assessed and monitored.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people; this had been a breach at the last inspection. We saw checks had been made so that staff employed were 'fit' to work with vulnerable people. This breach had been met.

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 of the staff we spoke with were clear about the need to report any concerns they had. The home had liaised and worked with the local safeguarding team following a recent referral.

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. Planned development / maintenance was assessed so that people were living in a comfortable environment.

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 who were 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 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. Relatives told us they felt involved in the care.

We observed staff interacting with the people they supported. We saw how staff communicated and supported people. The regular 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. 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 their input.

We saw 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.

We found the new management structure within the home was clear and supported the home with clear lines of accountability and responsibility.

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

The manager was aware of their responsibility to notify us [The 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?

Requires Improvement

The service was not safe.

There were not 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. This was an improvement from the previous inspection.

Medicines were administered safely. This was an improvement from the previous inspection. We made a recommendation for further improvements.

We found people's risks regarding their health care were being adequately assessed and monitored.

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.

Is the service effective?

Requires Improvement

The service was not always effective.

We saw people were not always supported appropriately so there was risk that requirements around nutrition and hydration may not be met.

Staff said they were better supported by the new manager but we found a lack of consistency since the last inspection regarding 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.

We found the home supported people to provide effective

outcomes for their health and wellbeing.

Is the service caring?

Requires Improvement

The service was not always caring.

Some of our observations raised concerns that people's dignity was not always protected and maintained.

Mostly, when interacting with people, staff showed a caring nature with appropriate interventions to support people.

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 was a lack of planned activity for people to engage in with reference to good practice guidance for people with dementia.

Care planning showed evidence that people and families had been involved and were in the process of being further developed so that it would be easier to locate and review information.

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?

Inadequate

The service was not well led.

There had been changes in leadership and management since April 2016. The new manager was applying for registration.

The changes of leadership in the home had caused instability resulting in fluctuating levels of care which exposed people to risk in some key areas.

We found the new management structure within the home was clear and supported the home with clear lines of accountability and responsibility.

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

needs and wishes.

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 three days. The inspection team consisted of three 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 some previous information we held about the service and this included reviewing the action plan sent to us by the provider following the previous inspection in August 2016. We also asked for and received an urgent action plan following our findings on day one of the inspection.

Prior to the inspection we spoke with commissioners such as social services and health care commissioners.

During the visit we were able to meet and speak with six of the people who were staying at the home. We spoke with seven visiting family members. As part of the inspection we also spoke with, and received feedback from a health care professional who were visiting the home and had knowledge of people's health care needs; the professional was able to give us some information regarding how the service supported people.

We spoke with the new manager and eight of the staff working at Dale Park including nursing staff, care/support staff, kitchen staff, domestic staff, maintenance staff and senior managers.

We looked at the care records for six 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 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/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.

Requires Improvement

Is the service safe?

Our findings

Prior to our inspection visit on 5 December 2016 we had received concerns from a visitor to the home regarding the adequate provision of staff at Dale Park. When we inspected we found staffing numbers were insufficient and this reflected on ability of staff to carry out safe and effective care.

When we arrived on 5 December at 10.30am [day 1 of the inspection] we were told three staff members were off sick on the day. There were no managers present but there were two nurses in charge. We were told there had been staffing issues for some time; two staff members had resigned since the new manager had started. We were told there was a high agency staff usage. We were told staffing levels were supposed to be five care staff on each floor and one RGN; these figures were confirmed by senior managers later in the day.

We found four carers and one RGN on one floor of the home. One staff told us they were to leave at 2pm which meant dropping down to three carers. This was not reflected on the duty rota we saw. Both the senior manager present and the Nurse on duty had not realised a staff member was leaving at 2pm leaving the afternoon shift further depleted.

The new home manager had been aware that there were some shortages of staff on 5 December and had left a note for the office staff to arrange agency staff to cover but this had not been successful as there were no agency staff available. We were concerned that the home was short of staff and the arrangements made to both monitor the home and arrange appropriate cover had been inadequate.

We spoke with six staff on 5 December who all told us there had been insufficient staff on a regular basis over quite a long period of time. All staff said there was three care staff on some days when there should be five. The staffing had been inconsistent since a previous registered manager had left in April 2016. Both nurses' expressed concerns about the lack of staff affecting care standards. We were told there was uncertainty who was coming into work each shift and the rotas on display in the office were often incorrect; they were not accurate as they were not being updated. One nurse said they were concerned about not being able to meet the care needs of people living at Dale Park and although there had been no specific incidents, there had been near misses such as agency staff being sent to provide care who are not trained to use a hoist or in manual handling and the nurse had intervened to stop them from potentially harming a person; this was corroborated by another staff member. One nurse stated they had not had five care staff on shift at any one time for the last five of six months.

These statements were corroborated by all staff we spoke with. A carer said, "We have been really short staffed and a lot of staff have left. Five carers are enough but often we are down to three staff; It's dangerous and we can't give people what they need." Another staff commented, "Staff are stressed and are leaving."

The visitors we spoke with also confirmed poor staffing levels. One relative told us they visit daily and "They are short staffed down to three carers on the ground floor approximately three days a week. This means [relative] has to wait protracted lengths of time to receive care." Another relative commented similarly and said they came daily to assist with feeding their relative, "As staff are struggling."

Our observations of care on 5 December confirmed people's care was being compromised. For example we saw that at 1pm care staff began to assist residents to walk into the dining room. It took staff 30 minutes to seat all the residents. One person who was seated alone on one table was distressed and crying but staff were observed to be too busy and rushed to offer any comfort. Food began to be served at 1.30pm. One person was served a plate of pureed food at 1.30pm, staff then left the dining room; there were no staff in the dining room for 10 minutes. The person was observed to not be able to eat unaided but was not supported as there were not enough staff available. We observed a total of five people in one dining area who had not received appropriate support from staff because they had been left for lengthy periods of time before receiving support to eat. One person was still being supported to eat at 14.20pm.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We wrote to the provider, following our visit on 5 December, telling them to take urgent action to improve the situation. The provider sent us an action telling us how they would meet regulations.

When we returned to complete a full comprehensive inspection on 11-12 January 2017 we found action had been taken to address the concerns around staffing and standards had improved. We found that over both days of the inspection there were sufficient numbers of staff and the provider's staffing ratios were being met. Staff we spoke with told us 'things had improved'; One staff commented, "There's been a big improvement in staffing. We've got more time to spend with the residents. I've got no concerns about people's safety. We've got enough staff to keep an eye on people. We have one nurse and five carer's morning and afternoon." Another senior staff said, "There's been a massive improvement in staffing levels. Staff are happier now; everything is more relaxed. Agency staffing has improved because it's more planned and consistent. Agency staff get an induction pack. We also have a file with information about each person."

We found comments from relatives were more varied but they generally recognised the improvement in staffing. One family member said, "Yes I think staffing is better"; another commented, "Currently there is enough staff, there was a problem before." Two other visitors commented positively saying, "They have quite a few of their own (staff); 90% of agency staff are fine" and "Yes they're the same staff; the most I've seen are three (agency) on each shift, but they seem to be keeping the numbers up."

We made observations of care over two days and saw that there were enough staff present to help ensure people's needs were being met.

We spoke with manager who told us that maintaining staffing levels had been a priority over the past month. The duty rotas confirmed consistent numbers of staff on shift. The manager was conscious of the fact that there remained a high number of agency staff [for example two to three on both days of our visit] but the overall usage was being reduced as more permanent staff were being recruited. We saw the agency staff hours had reduced from 26 December to 15 January by nearly 90 hours. The manager recognised consistency of staffing was required over a longer period of time.

At the last inspection in August 2016 we found the home in breach of regulations with regards to recruitment of staff. We checked, on this inspection, 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 for copies of appropriate 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. This was an improvement from the previous inspection and the breach had been met.

We reviewed the way medicines were managed and administered. In August 2016 we found some areas of concern that needed to improve to ensure medicines where administered safely. On this inspection we found improvements had been made and medicines were being administered safely.

We viewed a copy of a recent external review by the local Clinical Commissioning Group [CCG] which reviewed medicine management and controlled drugs. This provided us with an overview of how medicines were being managed at the home. The report showed 'compliance' and any recommendations made had been taken on board by the management team to help assure the safe management of medicines.

A medication policy was in place to support staff practice and we saw medicines were administered safely to people. Staff [nurses] responsible for administering medicines had attended medicine updates [in-house training] to update their practice for administering medicines. We saw the nurse administering medications had protected time and wore a designated tabard so that they were not disturbed.

We saw controlled drugs were stored appropriately and records 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. We checked a number of medicines, including a controlled medicine and found the stock balances to be correct.

We found medicines to be stored safely when not in 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 daily. This helped to ensure the medicines stored in this fridge were safe to use [no medicines stored at the time of the inspection].

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']. We saw that relevant professionals had been consulted and a' best-interests' decision had been recorded with input from people's relatives. 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 and meal replacement drinks. Meal replacement drinks are prescribed for people when they have lost weight and are not eating. 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 made some suggestions as to how the record could be made clearer. For example some charts recorded 'as required' but we were told the creams were being applied, and where needed, daily. We also discussed with the manager the fact that the record for the application of the cream was being completed retrospectively and not at the time of application which would be best practice and meet the provider's policy guidance. The manager said they would consider this further.

We found one discrepancy regarding records for a person on a thickening agent. It was not clear from records what stage thickener was being administered in drinks; this was corrected. Best practice would be for each drink given to also state what stage thickener had been used.

We would recommend that both topical application records and records for thickening fluids are further reviewed to ensure best practice is maintained.

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 in each record. There was evidence that a Waterlow score [for assessing risk of pressure ulcers] had been adjusted following a change in a person's weight. There was evidence in a different record of a falls' risk assessment being upgraded following a fall.
Risk assessments were sufficiently detailed and were reflected in the associated care plan.

There was no evidence that people had been actively involved in risk assessment processes, but there was evidence of family and healthcare professional involvement.

A nurse said, "We inspect skin at least monthly or more often if required. We use Waterlow and observe people during personal care. I've not got anyone with a pressure sore on the unit. We actually managed to heal a long-standing pressure wound for someone who was admitted with a problem." We were told that recently a person showed signs of redness to their skin. The person was supported to get out of bed and encouraged to eat more; skin improved within a week. One staff was allocated as 'Lounge Supervisor' which helped with the risk of falls. We saw records which showed people had been referred to the falls team for review when required.

We asked people whether they felt safe in the home. Relatives had mixed comments with negative comments related to the lack of staff. One relative told us they felt unsure as to staff attention and monitoring of their relative as they were mainly cared for in bed. The relative commented that staff went for long periods without checking the person concerned. Other comments reinforced the more consistent staffing over the past month and relatives reported they felt more reassured.

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 of the staff we spoke with were clear about the need to report through any concerns they had. We saw that the contact numbers for the local authority safeguarding team were available. There had been a recent safeguarding investigation in November 2016 following a relative being concerned about the lack of staff in the home. The home had liaised with the safeguarding team at the time.

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 conducted a tour of the home and saw that planned upgrading of some areas was in progress. The manager showed us a development plan for the decorating and upgrading of some areas of the home. We spot checked some safety certificates such as gas and electrical safety and fire safety and these were all up to date a well maintained.

A 'fire risk assessment' had been carried out and updated at intervals. We saw personal 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. We asked the manager to check the accuracy of the information in the PEEP's file kept in the main entrance as we found a possible discrepancy. This was completed by the manager and a new audit tool introduced to ensure information was cross checked and updated accurately.

Requires Improvement

Is the service effective?

Our findings

Prior to the inspection we had received concerns that because of staffing issues people were not being supported appropriately at meal times and there was a risk their nutrition was being compromised.

On the first day of the inspection on 5 December we observed meal times and were concerned that this was founded. For example we found people were not being provided with assistance to eat food placed in front of them and were waiting for assistance due to the low numbers of staff to assist them. People were not receiving assistance to eat their food until as late as between 1.30 to 2.20pm. We told the provider to address meal time concerns.

We visited again on 11 January and the manager discussed the provider's action plan with us. Because staffing was more stable we were told that support for meal times had improved. Extra support from the kitchen staff at meal times had also supported this.

We found that people's nutritional state was being monitored effectively. People were weighed routinely on a weekly basis if required and monthly as a standard with fluctuations recorded and adjustments to diets made as appropriate. There was some concern about the accuracy of measurement as some people showed large gains or losses across each month. None of the results indicated a significant, sustained loss. One person's care plan for eating stated, '[persons] appetite has changed recently and is more variable. We are continuing to offer snacks, milky drinks and puddings as advised by the dietician'. The plan also referenced a decline in swallowing function and a change in the use of thickeners to drinks. The person's weight had fluctuated over the previous six months, but had remained at a healthy level. We saw that most people had put on weight over the last few months. We saw that care staff recorded people's fluid intake and these records were up to date.

Our observations on 11 January confirmed that meal times were overall a better experience for people than a month previous on 5 December 2016 although we made some observations evidencing the support for people could be further improved.

In one of the dining areas we made observations. When we went into the dining room at 12.30 everyone was already sitting down. The food was served at 12.55, with two people asking when they were going to get their dinner. Staff were observed to wear cloth aprons and one was stained before the staff started serving; we asked staff how often the aprons were changed and were told at every meal. This carer also told us, "If the resident's aprons are not dirty they are re-used'. We were told these are not individualised for people.

We saw there were no menus displayed and none of the residents knew what they were having prior to it being served. In this dining area the meals were observed to be very large and only one out of eight people finished their meal.

Meals were put in front of people and they were left to manage themselves. One person ate most of what they had with their fingers and a knife. A carer came to help at 13.25 and then asked if the person had had

enough and took the plate away.

The chef did come round and offer to cut up the food and also brought a plate guard for another person, however by the time the person got this, most of the meat was on the table which a staff member took away. Another person was observed to be pushing the food onto their fork with their fingers.

We did make other observations in other areas and at breakfast times and found improved standards in these observations. From our observations it was clear however that some inconsistencies persisted. The manager explained that at the time of the above observations the unit in question had been particularly busy with a new admission and also a discharge from the home. The manager said they would continue to audit the meal time experience to make improvements and ensure people were supported appropriately.

These fluctuations in the support people received were also commented on in the last inspection report in August 2016 and on day one of our inspection on 5 December 2016 and, although not evident on this inspection, could pose a risk to people's nutritional state.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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) was completed in May 2016 and told us: 'We provide mandatory and other training to all colleagues to ensure that Residents, Visitors and Colleagues remain safe and free from harm and discrimination. Our mandatory training is done through a blend of e-learning and classroom / off line assignments and is aligned with the Care
Certificate'. The PIR also stated: 'We aim to have 95% compliance on all training within 6 months'.

We were told at the last inspection in August 2016 that training of staff had been an issue and some staff had not been supported in this area but this was now improving. On this inspection the new manager said that there had been a lot of staff turnover since the last inspection and this had made it difficult to plan effective training updates for staff. We saw the overall statistics for completion of mandatory training for staff had remained at 58-60% since the last inspection despite the aim to improve this.

New staff were inducted through 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. We spoke with on staff who had undergone this and had nearly completed. They told us the training provided a good background to care and had helped them with their job role.

All of the staff spoken with confirmed that they felt better supported since the new manager's appointment but said that they had not received a formal supervision for some time. Each said that they could access informal supervision and support on request but there had been nothing planned; this had been noted on a provider audit carried out in October 2016. Two senior staff told us they had not undergone a recent annual appraisal.

The manager told us about some updates planned, for example moving and handling training was booked

for staff. Planned dates for supervision and appraisal were currently being reviewed however and needed to be addressed.

The manager informed us that some care staff had a qualification in care such as QCF (Qualifications Credits Framework). In August 2016 we had seen evidence that 25% of staff had completed these courses and attained a qualification. The manager, at the time, told us that efforts would now be made to increase this number following the recruitment of new staff. On this inspection the current figure for staff having these qualifications had improved to 54%. The manager told used this figure would be higher if not for the staff turnover being high. CQF qualifications evidence a good base knowledge for care staff to carry out and maintain their care role.

The overall training profile and skill base of care staff together with a lack of planned supervision of staff requires further development.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 the new manager had held meetings with night staff fairly recently to discuss and provide feedback from audits. Staff we spoke with at the inspection reported they were asked their opinions and felt the manager, although early days, did their best to act on feedback they gave. Senior staff felt that overall communication had improved since the new manager had arrived.

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 two people who were 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. In another example, a person had a best-interests decision regarding the use of bed-rails. There was a good level of detail included and a clear rationale. The record included a 'Best Interests Consultation' document. A similar process had been followed for a person for the use of a support chair.

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 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 forms 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.

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

We spoke with a visiting care professional who was reviewing a number of people living at the home. We were given positive feedback and told nursing and senior care staff were knowledgeable regarding people's health status and always spent time to make sure up to date information was available. We were told, "There is good continuity and staff seem organised."

We had been made aware of a recent visit and audit carried out in December 2016 by the clinical care nurse for the local CCG. This had highlighted areas of clinical care that required improvement including, tissue viability, nutrition and hydration and end of life care. The manager showed us the action taken to date to improve these. The home was due to be re audited in the near future.

Requires Improvement

Is the service caring?

Our findings

At the last inspection in August 2016 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. The provider sent us an action plan following our inspection which outlined support for staff including training in dementia care and staff supervision regarding dignity in care. Some of this was being carried out; for example 63% of staff had undergone the dementia care online training.

On this inspection we found that most staff approached people in a caring manner and carried out positive support but there were still some observations we made that evidenced further consistency and improvement were needed.

Some of our general observations included positive care interventions. We witnessed a care staff speaking with a person and encouraging them to whistle when their mood declined. We noted from care records that the person liked to sing and whistle. The staff told us this it was something that offered a distraction and helped to improve the person's mood. We also saw a care staff attending to a person who was distressed and offered a blanket as this was a planned intervention to help calm and reassure that particular person. Most of the interventions we saw were positive and supportive. Although there were periods where care was task-led (lunch in particular) the majority of staff took time in the delivery of care and interacted reasonably well with residents.

We saw another incident, however, where a resident offered to assist staff to move a walking frame but they were ignored by staff on two occasions. One staff member was observed to be remote and disengaged during lunchtime. They did not respond when the person they were supporting showed signs of confusion and distress; this was reported to the manager. On another occasion we observed a person who had removed their clothing exposing themselves inappropriately. This was observed by staff but there was no immediate attempt to intervene.

A SOFI observation on one unit was completed in the build-up to lunch. Four people were observed. There were a total of 36 interactions observed; all were with people and staff interacting. 21 were categorised as good, 12 neutral and three poor. Positive examples included; asking if a person preferred the radio to the TV and making the change and a resident who hugged a staff member when she was asked if they were alright. One person was left with no staff contact or interaction over the thirty minute observation period. There was a five minute period before lunch was served when none of the residents in the lounge received any staff interaction. Mood was recorded as zero/neutral or negative for 19 of the 20 time frames.

During meal times we made some observations were people's dignity was not always preserved and people were not offered timely support. This resulted in people carrying out inappropriate behaviour, such as eating with their fingers, which undermined their dignity.

This was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

We did receive many positive comments from relatives who felt that most staff were very caring and kind. One relative commented, "They're very good". Another relative said, "I think they're very good; there is some excellent staff with a lot of empathy and patience." Other comments included, "In the main, they do a very good job – they are very patient" and "When the staff give care they are kind and very patient."

We asked how the home involved people in its running and provided information to people. The manager told us about resident / relative meetings that had been arranged. We saw a meeting held in November 2016 so relatives could be updated and also provide feedback about how the home was run. We also saw the results of the last survey given to relatives in June 2016 when 14 respondents rated the home either good or outstanding. The rating for 'kindness' was 86% positive.

Requires Improvement

Is the service responsive?

Our findings

Following the last inspection in August 2016 we made a recommendation that the provision of meaningful activities was still an area that needed developing. On this inspection we found there had been very little progress in this area.

The staff we spoke with were keen to interact and develop activities but told us that the lack of staff had meant that it had been difficult to plan. A key staff who had been previously involved in planning activities had also left. During the three days of the inspection activities were limited to a trip out to a garden centre in the afternoon. There was an activities' resource cupboard, but nothing was available for people to use. A senior staff who had previously been involved in planning activities told us, "I haven't had much time to do activities because we were short staffed. The other activities coordinator has just left. We're planning to meet soon to develop person-centred activities. We have an activities' file to record their preferences and we speak to families."

We spoke with another staff member who had recently started working at the home. They had an interest and background in developing activities for people and organised a trip out on one of the days.

Our observations were similar to the last inspection. For example, on one floor the television was on in both lounges all day. None of the residents were taking any notice of the television. There were carers in both lounges, but they were either completing paperwork on or one occasion just watching television. We didn't see any one to one activities and little interaction between carers and residents unless they were assisting with food or drinks. The chairs in the lounges were predominately arranged around the sides of the rooms which did not promote interaction.

The lounges weren't particularly 'dementia friendly' as apart from the television there was nothing for the residents to do. Although we were told one person read the daily paper or a book, but they did this in their room. We spent more time in the small ground floor lounge than the large one and although the television wasn't on again there was nothing for the residents to do over the course of our observations.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people and their relatives how their care was managed to meet their personal preferences and needs. Most relatives had mixed opinions. We were told that due to lack of staff it was difficult for people to receive a high level of individual attention. All felt this had improved however over the last month due to better staffing levels being maintained. 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 and an advocate had been involved in the assessment process. There was also evidence that family members had been invited to reviews of care, although this varied with some care files showing no evidence of this.

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. They recorded good detail so that staff support was provided in a way the person wanted and needed to maintain their health and wellbeing.

We were advised that the care records were being reorganised so that it would be easier to locate information. In one example, due to information not being in one place, it took 30 minutes to clarify one piece of care for a person [regarding thickeners in drinks]. On the ground floor the unit manager was working through all of the care files and auditing them to help ensure easier access to information.

Each of the care records we reviewed contained a good standard of person-centred information which detailed their personal, medical and care histories. For example, 'I had pet dogs as a child.' People's personal preferences were clearly recorded for example, '[person] likes The Times newspaper' and 'Likes strong tea with no sugar'. One person's favourite foods were recorded and a staff member was able to tell us what some of them were. The staff confirmed that this information had been used when the person's appetite had dipped to encourage them to eat and avoid foods that exacerbated any health conditions.

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. 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 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.

Inadequate

Is the service well-led?

Our findings

We identified concerns regarding governance and leadership by the provider at Dale Park. There was a failure to meet regulatory requirements and provide safe care and treatment. The service had met two of the three previous breaches from the previous inspection in August 2016 but has not met another one and has now breached three additional regulations, potentially putting people at risk.

We found that the home had undergone major changes since a previous registered manager left in April 2016. This had caused some unrest, particularly amongst staff, who had had to make adjustments to the changing culture of the home. The service did not have a registered manager at the time of this inspection [another registered manager had stopped working at the home in November 2016] although the new manager was applying. The home had been managed by three managers for the provider over this period.

Prior to our inspection we had received a concern that there were inadequate numbers of staff and this was having an effect on the delivery of care. We visited, for day one of our inspection, unannounced, and found the staffing was insufficient and this was affecting some of the care delivery such as supervision and support for meals. Although a new manager had started and there had been an on-going programme of staff recruitment, the daily management, including attention to accurate duty rotas and assessment of care need, had failed to provide sufficient staff to maintain care.

Such was the concern that we wrote a letter to the provider asking for an urgent action plan to address the concerns.

For the second part of our inspection on 11-12 January 2017 we found the new manager had been instrumental in addressing the main staffing issue and the numbers of staff on duty had stabilised. Feedback from staff and visitors was more positive. One staff commented, "The atmosphere is a lot better. People are happier." Another staff said, "I feel more positive because staff are feeling better. We've got a lot to do, but [the new manager] is very approachable. They put on extra staff to help with an admission. Communication is lot better." A nurse and a senior unit manager both agreed that the home had stabilised over the past month. Our observations evidenced that whilst there remain quality issues with the home, people were having their basic personal care needs met.

The two unit managers and the home manager had worked as a team to meet more immediate objectives and goals. These were primarily the issues specified in The Commission's letter following the visit on 5 December, and the recent audit by the CCG also in December 2016. An example of this was the assessment and monitoring paper work that had been set up around tissue viability which had been highlighted by the CCG audit, as well as the improvements in staffing highlighted in the CQC letter.

However, the last report of our inspection in August 2016 made similar comments about the transition of the home under, the then, 'Turnaround' manager; to quote the last report:

"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, "We're used to the new approach now but it's vastly different than the last manager and time is still needed."

Since then the evidence would be that there has been little progress and staffing numbers and support for staff had deteriorated and had remained inconsistent which reflected in some of the care. The management and governance by the provider had failed to effectively maintain and improve standards in the home.

We reviewed some of the current quality assurance systems in place to monitor performance and to drive continuous improvement. The manager was able to 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 provider information return (PIR) for the service 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 to help deliver quality and consistency in the way we support residents'.

The manager explained that daily management consisted of a routine 'walk around' and 'flash meeting' with key staff, to both monitor and communicate key issues. We saw examples of these and how they worked in practice. From staff feedback these more immediate management tools had not been consistent before the new manager had started.

We were concerned that, despite fairly well developed corporate systems in place, some areas had not been effectively monitored and some issues we identified on inspection had been missed. These included the lack of effective monitoring and allocation of staff, standards at meal times and support for staff through well-developed training and supervision. In addition we found key areas such as activities for people and consistency around attention to protecting people's dignity also required further improvement.

Some of these had been highlighted on management audits. We saw an audit carried out by a senior manager for HC-One in October 2016 which mentioned, staffing at meal times and support for people needing improvement as well as planning of staff supervision needing more clarity in terms of future planning; we found there had been no effective progress in these.

These findings are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

From April 2015 it became a legal requirement for providers to display their CQC (Care Quality Commission) rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate. The rating from the previous inspection for Dale Park was displayed for people to see.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care There was a lack of planned activity for people to engage in with reference to good practice guidance for people with dementia.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Some of our observations raised concerns that people's dignity was not always protected and maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs We saw people were not always supported appropriately so there was risk that requirements around nutrition and hydration may not be met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff on duty to help ensure people's care needs were consistently met. Staff said they were better supported by the new manager but we found a lack of consistency since the last inspection regarding

support systems for staff such as training and supervision.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There had been changes in leadership and management since April 2016. The changes of leadership in the home had caused instability resulting in fluctuating levels of care which exposed people to risk in some key areas. Existing audit tools and systems had not effectively provided adequate monitoring of the service.

The enforcement action we took:

We served a Warning Notice.