Care Quality Commission

Dunsfold Limited

Dunsfold

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

Overall summary

We inspected Dunsfold on the 15 December 2014. Dunsfold is registered to provide personal care and support to people living with dementia. The service can accommodate up to 18 people. There were nine people living at Dunsfold during our inspection.

An interim manager was in post, and they had submitted their application to the CQC to be the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider. The home has been without a registered manager for four months.

At the last inspection in April 2014, we asked the provider to make improvements in respect to cleanliness and infection control, supporting workers and quality assurance. An action plan was received from the provider and we found that improvements had been completed. The provider now carried out regular audit and

Summary of findings

monitoring activity to assess the quality of the service and make improvements. Areas for improvement had been identified and action plans put in to place. Such as training and supervision of staff.

People spoke positively of the service and commented they felt safe. Our own observations and the records we looked at reflected the comments people had made.

People were safe. Care plans and risk assessments whilst basic reflected people's assessed level of care needs, action for staff to follow and an outcome to be achieved. People's medicines were stored safely and in line with legal regulations and people received their medication on time and from an appropriately trained care staff member. The home was clean and staff had received infection control training.

Staff received training on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and they had a sound basic understanding of the legal requirements of the Act. They were aware of restrictions posed on some people in the home and why they were in place.

Care plans contained information on people's likes, dislikes and individual choice. Information was readily available on people's life history and there was evidence that people and families had been involved were regularly involved in their care planning.

Everyone we spoke with was happy with the food provided and people were supported to eat and drink enough to meet their nutrition and hydration needs. A communal dining experience was made available to people, and people ate their lunch where they wanted to.

Staff felt supported by management, said they were well trained and understood what was expected of them. There was sufficient day to day management cover to supervise care staff and care delivery. The current management staffing structure at the service provided consistent leadership and direction for staff.

People we spoke with were very complimentary about the caring nature of the staff. People told us care staff were kind and compassionate. Staff interactions demonstrated staff had built rapports with people and people responded well to staff.

Feedback was regularly sought from people, relatives and staff. Residents' and staff meetings were held on a regular basis which provided a forum for people to raise concerns and discuss ideas. Incidents and accidents were recorded and acted upon.

Summary of findings

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

Dunsfold was safe. Staff had received training on safeguarding adults and said they would be to recognise all types of abuse and knew how to report it. Visitors were confident that their loved ones were safe and supported by staff at Dunsfold.

There were systems in place to make sure risks were assessed and measures put in place where possible to reduce or eliminate risks.

Safe recruitment procedures were followed.

There were enough staff to meet people's individual needs. Staffing arrangements were flexible to provided additional cover when needed, for example during staff sickness or when people's needs increased.

Medicines were stored and administered safely.

Is the service effective?

Good

Dunsfold was effective. Mental Capacity Act 2005 (MCA) assessments were completed routinely and in line with legal requirements.

People were given choice about what they wanted to eat and drink and were supported to stay healthy.

People had access to health care professionals for regular check-ups as needed.

Staff had undertaken essential training and had personal development plans, such as one to one supervision.

Is the service caring?

Good

Dunsfold was caring. Staff communicated clearly with people in a caring and supportive manner and it was evident from interaction between them that they knew people well and had good relationships with them. We observed that people were treated with respect and dignity.

Care plans were personal to each person and included detailed information about the things that were most important to the individual and how they wanted staff to support them.

Staff were seen to interact positively with people throughout our inspection. It was clear staff had built a rapport with people and people responded to well to this.

Is the service responsive?

Good

Dunsfold was responsive. A simplified complaint procedure was on display in the main corridor of the home. People who were able to verbally express their views were able to tell us who they would talk to if they had any worries or concerns.

People were involved in making decisions with support from their relatives or best interest meetings were organised.

There were opportunities for social activity and recreational outings. Regular meaningful activities took place or were planned for people.

Summary of findings

Is the service well-led?

Good

Dunsfold was well-led. Quality assurance audits were undertaken to ensure the home delivered a good level of care and shortfalls identified had been addressed. Senior management monitored the home to ensure that this happened.

There were systems in place to capture the views of people and staff and it was evident that care was based on people's individual needs and wishes.

Incidents and accidents were documented and analysed. There were systems in place to ensure that the risk of occurrence was minimised.

Dunsfold

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.

The inspection took place on the 15 December 2014. This visit was unannounced, which meant the provider and staff did not know we were coming. The inspection team consisted of one inspector and an expert-by-experience.

Before our inspection we reviewed all the information we held about the service. We considered information which had been shared with us by the Local Authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the Local Authority to obtain their views about the care provided in the service.

During the inspection, we spoke with all nine people who lived at the service, four relatives, the interim manager, the owner, four care staff, the chef and a visiting healthcare professional. We looked at all areas of the building, including people's bedrooms, the kitchen, bathrooms and the lounges.

We reviewed the records of the home, which included quality assurance audits, staff training schedules and policies and procedures. We looked at seven care plans and the risk assessments included within the care plans, along with other relevant documentation to support our findings. We also 'pathway tracked' people living at Dunsfold. This is when we followed a person's life through the home and obtained their views. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Good

Is the service safe?

Our findings

People told us they felt safe, and were confident the providers did everything possible to protect them from harm. They told us they could speak with the interim manager and providers if they were worried about anything and they were confident their concerns would be taken seriously and acted upon, with no recriminations. Relatives told us they had confidence that their loved ones were safe. One relative told us, "Things have improved over the past few months, I know my husband is safe."

At our last inspection we found that the cleanliness of the home needed to improve. At this inspection all areas were clean and fresh, and there were no unpleasant odours. The laundry room was clean, neat and tidy. The washing machine was industrial and had a sluice facility for heavily soiled linen. All laundry equipment was in good working order. Staff used appropriate procedures for dealing with soiled clothes and linens. For example, a staff member told us that flannels were washed every day to maintain safe infection control. People told us they were very happy with the way the home was kept clean. One person told us, "Every day my room is cleaned. The bedding is changed regularly." Where pets lived with their owners, staff had systems in place to ensure litter trays and pet food was kept hygienic and safe. Contract cleaners were employed and they worked five days a week. At weekends care staff added cleaning to their duties. We saw that the cleanliness of the home was checked daily by staff following the contract cleaner's visit. Any shortfalls were acted on immediately. Visitors said the home always clean and smelt good. One said, "Not pristine but homely, lots of pets which is nice."

All staff received training on safeguarding adults. Three staff confirmed this and knew who to contact if they needed to report abuse. They gave us examples of poor or potentially abusive care they had seen in other services which demonstrated their understanding of abuse and how it could be prevented. They were confident any abuse or poor care practice would be quickly spotted and addressed at Dunsfold. Policies and procedures on safeguarding were available in the office for staff to refer to.

People's risks were well managed. Care plans showed each person had been assessed before they moved into the home and again on admission. Any potential risks to people's safety were identified. Assessments included the risk of falls, skin damage, challenging behaviour, nutritional risks including the risk of choking and moving and handling. The files also highlighted health risks such as diabetes. Where risks were identified there were detailed measures in place to reduce the risks where possible. All risk assessments had been reviewed at least once a month or more often if changes were noted.

Information from the risk assessments was transferred to the main care plan summary. All relevant areas of the care plan had been updated when risks had changed. This meant staff were given clear, accurate and up-to-date information about how to reduce risks. For example, one person had been regularly reviewed for weight loss. The latest review had recorded that the risk had reduced, but instructed staff to continue to make sure the person was offered snacks and fortified food. This was monitored daily.

The staff rota showed there were sufficient staff on duty each day to cover all care, cooking and management tasks. The rota showed where alternative cover arrangements had been made for staff absences. The interim manager told us staffing levels were regularly reviewed to ensure they were able to respond to any change of care needs. Staffing levels were sufficient to allow people to be assisted at times they had requested. Individual preferences were recorded in the care plans, for example the times people wanted to get up, go to bed, or have a bath or shower. One to one care delivery for one person was being delivered by a staff member who was additional to the normal staffing levels during the day. Staff were aware of how to support people who lived with dementia and how to manager behaviour that challenged. Staff told us that if more staff were needed the management would arrange it. This ensured that everyone received the care they required.

People told us there was always sufficient staff on duty to meet their needs. One person told us, "There are enough staff. I never have to wait for help." They also told us they had difficulty sleeping at night and took comfort from the knowledge that a member of staff checked on them every hour during the night. They told us the night staff always made them a cup of tea whenever they wanted. Some people told us they used the call bell and never had to wait. Comments included, "There are enough staff – they help me with my cat." We saw staff giving people the time they needed throughout the day, for example when accompanying people to the toilet, and helping people to

Good

Is the service safe?

move to the dining area at meal times. Staff were relaxed and unrushed and allowed people to move at their own pace. We also saw staff checking people who were in their rooms regularly throughout the day.

People told us their medicines were administered safely. Comments included, “I feel confident everything is being looked after.” Most medicines were supplied by a local pharmacy in weekly blister packs. We observed the lunch time medicines round. One staff member administered the medicines safely. Staff checked with each person that they were happy to receive the medicines, and asked “Are you ok to have your tablets?”

There were safe systems in place for ordering new stocks and repeat prescriptions. Medicines were stored securely and safe recording procedures were followed. There was a clinical fridge and staff checked the temperature daily to ensure medicines were kept at the correct temperature. The interim manager carried out monthly audits of the medicines held in the home and those administered to people. Stock levels were checked, during our visit the staff showed us a record book they used for ordering and returning medicines.

Policies and procedures on all health and safety related topics were held in a file in the staff office and easily accessible to all staff. Staff told us they knew where to find the policies. One staff member told us, "Policies are really helpful in ensuring that we use best practice in caring for our residents."

Records of maintenance and regular checks on equipment, including hoists, fire safety equipment, water safety, electricity and electrical equipment showed that all equipment had been regularly serviced, checked and maintained.

People were protected, as far as possible, by a safe recruitment system. Staff told us they had an interview before they started work, that the provider obtained references and carried out a criminal records check. We checked three staff records Each file had a completed application form listing work history as wells as their skills and qualifications.

Good

Is the service effective?

Our findings

People spoke well of the home and staff. Comments included, “It’s a homely place and the care is good, my husband has settled in well and receives support, they keep me updated, “and “The staff are very pro-active, all very good.”

At the last inspection in April 2014, we found the provider was in breach of Regulation 23 of the Health and Social Care Act 2008. This was because provider did not have adequate supervisory or peer support arrangements in place for staff, such as regular supervision meetings. Supervision is a formal meeting where training needs, objectives and progress for the year were discussed. We found improvements had been made.

Staff attended supervision meetings every six to eight weeks. A staff member told us that the manager was, “Brilliant, you can you can say anything to her.” Another staff member said that the manager, “Listens and values our opinions.” In addition, all staff received an annual appraisal of performance. This meant staff were supported in their role and this had improved staff morale.

People received effective care from staff that were appropriately trained. One staff member described the induction programme that enabled them to spend time shadowing staff to observe how support was provided. They said that sufficient time was provided to read documentation, to attend training and to get to know people. Another staff member then shadowed them to ensure they were competent and felt confident to work independently with people. We saw one new staff member being supported by a senior member of the team. We saw that they were appropriately supervised and received direction when needed.

There was a comprehensive training programme in place to ensure that staff had the knowledge and skills necessary to carry out their roles. Records showed that the training the provider required them to do was in most cases completely up to date. Where training had become due, staff had been given a target date that they had to complete the update. A wide range of training was available, such as courses on safeguarding of adults, first aid, moving and handling and understanding dementia. We saw some good management of staff managing people who were frustrated. The staff used diversion tactics that diffused the situation. Staff told us that the training they received was sufficient to meet their needs and they felt well supported.

Staff were working within the principles of the Mental Capacity Act 2005 (MCA). Staff informed us that the majority of people would be unable to consent to care and treatment, and had had a mental capacity assessment completed. We found evidence of mental capacity assessments having taken place and reviewed regularly. Consent to care and treatment had been routinely documented in people’s care plans, and mental capacity assessments recorded the steps taken to reach a decision about a person’s capacity. Training schedules confirmed staff had received MCA and Deprivation of Liberty Safeguards (DoLS) training. Care staff had a basic understanding of mental capacity and informed us how they gained consent from people. staff told us, "We use open questions and wait for them to answer, if they are unsure or refuse, we will go away and then retry later."

The Care Quality Commission (CQC) is required by law to monitor the operation of DoLS. The provider and interim manager knew how to make an application to deprive a person of their liberty. We found individual assessments for people living at Dunsfold on how their freedom may be restricted and how least restrictive practice could be implemented. Examples were the provision of one to one support for up to nine hours a day. We saw that this was also supported by a best interest meeting which family were involved in as well as the GP and community mental health team.

Each person had a care plan and where appropriate, people and families had been involved in drawing this up. People told us that they would talk to staff if they had concerns about their health. They said staff, "Would call the doctor." Care plan’s stated people’s individual wishes in relation to all aspects of their health and welfare. Records showed that within the past year staff had worked closely with a number of healthcare professionals to assist them in meeting the changing needs of people. For example, speech and language therapists, district nurses and dieticians. In most cases the support was short term. There was evidence that the advice obtained was implemented by care staff and had been reviewed and the person no longer needed specialist input. for example weight gain was evident or a wound had healed.

Good

Is the service effective?

There was information in each person's care plan about their dietary requirements and preferences and we were told that this information was also available in the kitchen. We were able to confirm this on the day of our inspection. Staff told us that some people had healthy eating plans and were able to explain what this meant on a daily basis. One person had a specialist diet. There was clear advice in the person's care plan about how this should be managed. Staff were also clear about what this meant on a daily basis and how they supported the person to maintain a healthy diet.

People told us that the food was good and that they had enough to eat and drink each day. They said that meals were planned but that if they wanted to have something different on a particular day this would be provided. We asked four people what their favourite meals were and noted that these were included in the menus. We observed that people were offered a choice of drinks at regular intervals throughout the day and people told us they could have snacks if they wanted them. We observed the mid-day meal and saw that people enjoyed their food. People that required assistance were supported by staff who sat with them and engaged in conversation whilst they ate.

There was a four weekly rotating menu. We were told that menus changed seasonally and records showed that the last change had been made in the autumn 2014. Two options were always available and people told us that they made additional requests for changes if they did not want what was on the menu.

People were weighed regularly to ensure they maintained a stable weight. Within each care plan each person had a MUST score (malnutrition universal screening tool). MUST is a tool used to assess if people are at risk of malnutrition or obesity. Staff demonstrated an understanding of the importance of hydration and nutrition and knew to monitor for signs of dehydration and weight loss/gain. Where concerns had been raised, for example when someone had been assessed as underweight, this had been discussed with the person's GP. With the agreement of the person, a health goal was put in place which involved ensuring that the person received a diet that was fortified.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. People and their relatives stated they were satisfied with the care and support they received. Comments included, “Oh they are very good – nice and helpful,” “Staff are kind, ” and “They are very good – they are friendly. All of the staff are good.” Visitors comments included, “‘I find it lovely because they are all very welcoming – a top point,” and “They are always very kind.”

We saw that people’s differences were respected. We were able to look at all areas of the home, including peoples own bedrooms. We saw rooms held items of furniture and possessions that the person had before they entered the home and there were personal mementoes and photographs on display. Communal areas had displays on the wall that reflected people’s interests.

People were consulted with and encouraged to make decisions about their care. Throughout our inspection we saw staff consult with people and explain clearly and in a way that they understood what was happening. For example offering to take them to the bathroom before lunch. Care records gave staff information related to people’s requirements and daily records provided information for staff to see how people were feeling and what they had eaten. Individual care plans provided information for staff on how to deliver peoples’ care. Information around people’s personal preferences and requirements had been updated and reviewed. Staff interacted with people in a confident and relaxed way that people responded to. One person said, “They know me well.” This reflected the delivery of care was centred on individual preference and choice.

Care plans were stored securely when not in use. Other information was kept confidential and there were policies and procedures to protect people’s confidentiality.

We spent time with people in the lounge/dining area and sitting in people’s bedrooms. We saw people had been supported to be appropriately dressed. Where required, people wore hearing aids, glasses and footwear of their choice. Most people and their relatives told us they were well cared for and several commented upon the improvements made to the service in the previous few months.

Staff told us they had a good understanding of dignity, privacy and confidentiality and had received training relating to this. Staff knocked on people’s doors before entering. People told us staff were respectful and treated them with dignity. One person said “I think they know what I like and don’t like. I like privacy – the staff respect that.”

Throughout the inspection we saw staff interacting with people in a kind and compassionate way. When talking to people, staff maintained eye contact and knelt down next to the person. Staff had developed a rapport with people and people responded to staff in a positive way. We saw that staff encouraged people to keep mobile and walked with them in the home and gardens. One person was becoming stiff and staff encouraged them to move regularly and be involved in exercise activities sessions in the lounge. Staff spoke positively of the home and confirmed they enjoyed their work. Visitors were welcomed throughout our visit. Relatives told us they could visit at any time and they were made to feel welcome.

Good

Is the service responsive?

Our findings

A staff member said; “We spend with people, really get to understand their needs, I know people really well.” One person told us, “When I was poorly staff made sure I was seen by the doctor and I soon felt better.” Care records contained detailed information about people’s health and social care needs. They reflected how each person wished to receive their care and support. Records were clear and gave guidance to staff on how best to support people with person specific care and were regularly reviewed to respond to people’s change in needs.

People were supported to follow their interests and take part in social activities. For example, one care record stated a person where possible, liked only to join in with activities that matched their interests otherwise they preferred to stay in their own bedroom. Staff told us that they ensured this persons needs were remembered and the person confirmed this. Not everybody could participate in activities and we saw staff sit quietly having a cup of tea with those people and talking with them. During the morning of our inspection we saw people making colourful bird feeders for the garden. Staff supported people and they really enjoyed it. In the afternoon indoor skittles was played by many of the people and staff. One staff member said she was taking over the activity role and was compiling a book of people’s preferences and updating them as people’s needs change. We were told of the success of vegetable growing in the summer and how people had been able to eat their own produce.

People were encouraged and supported to maintain links with the community and their families to help ensure they were not socially isolated or restricted due to their disabilities. People enjoyed shopping trips, and visits to the local pub. One person said, “We can have guests – I’ve had friends popping in and we can have pets – I’ve got my cat.”

People were supported to have as much choice and control as possible. One person told us of how they cared for her cat, and how much the cat meant to them. One person told us the pets were part of the “family” at Dunsfold and how much it had meant to them all. “We all love the pets, we get to share them.”

People received personalised care that was responsive to their needs. Individual needs were regularly assessed so that care was planned to provide people with the support they needed, but ensured people still had elements of control and independence. Staff told us they not only identified problems during in-depth assessments, but were empowered to help solve them. For example, maintaining people’s independence and mobility. We saw that one person’s mobility had decreased and staff had devised a plan that ensured they were supported and encouraged to move around during the day. People’s personal preferences for care and support were responded to by staff. One visitor said, “He likes to stay in bed so they leave him to get up when he wants.” We were also told, “They let you alone – they let you do your own thing.”

The provider had a policy and procedure in place for dealing with complaints. This was made available to people, their friends and their families. The policy was placed in each individuals service user pack and clearly displayed in several areas around the home. People knew who to contact if they needed to raise a concern or make a complaint. People who had raised concerns, confirmed the issues were dealt with to their satisfaction without delay. A relative told us; “I would be happy to talk to someone about a problem – but I’ve never had to do it.’ People told us,

“I’d be happy to mention it if I had a complaint. I’d talk to any of them – they are all very nice.”

A district nurse said; “I really have no concerns but I would talk to the staff in the first instance.”

We looked at one formal complaint made to the home. The complaint had been responded to in a timely manner and thoroughly investigated in line with Dunsfold's own policy. Appropriate action had been taken and the outcome had been recorded and fedback. The provider told us, they used monthly audits to monitor concerns and complaints. Appropriate action was then taken to improve their service and raise standards of care. For example, concerns had been raised about the security of the home in the evenings when staff had been living on the premises. This facility had been withdrawn by the provider and alternative arrangements for staff made.

Good

Is the service well-led?

Our findings

There was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. The registered manager had resigned 4 months ago and we had been informed. The provider had recruited and interim manager who had submitted her application to become registered manager.

The provider and the manager took an active role within the running of the home and had good knowledge of the staff and the people who used the service. There were clear lines of responsibility and accountability within the management structure. The service had notified us of all significant events which had occurred in line with their legal obligations. The provider confirmed that the service measured their performance against recognised quality assurance schemes. These included the dementia quality mark. This helped ensure best practice was used when staff carried out their duties.

People, friends and family and staff all described the management of the home to be approachable, open and supportive. People told us; “Always available and very approachable.” and “So understanding and ever such a lot of help.” A relative said; “The management have time for you, they will stop and talk and most importantly listen.” A staff member commented; “The management are supportive, they work with us, they’re not just stuck in their office.”

The provider told us one of their core values was to have an open and transparent service. The provider sought feedback from people and those who mattered to them in order to enhance their service. Friends and Relatives meetings were regularly held and surveys conducted that encouraged people to be involved and raise ideas that could be implemented into practice. For example, relatives had been involved in the development of activities and meals. People and relatives told us they felt their views were respected and had noted positive changes based on their suggestions. One person told us, “There are opportunities to make suggestions. But I’m quite happy so I leave things alone.”

Staff meetings were regularly held to provide a forum for open communication. Staff told us they were encouraged and supported to question practice. If suggestions made could not be implemented, staff confirmed constructive feedback was provided. For example, one staff member told us they had recently questioned the necessity to complete so much paper work during their working day. They said; “I felt listened to, although the process could not be changed, and I now I have a better understanding behind the reason we need to do certain things.” Another member of staff commented; “I raised a concern, the manager took my comments on board, spoke with staff and I’ve noticed change already.”

Information following investigations, accidents and incidents were used to aid learning and drive quality across the service. Daily handovers, supervisions and meetings were used to reflect on standard practice and challenge current procedures. For example, improving staffing levels and introducing more training in dementia.

The manager inspired staff to provide a good service. We were told, “She leads by example and works alongside us.” Staff told us they were happy in their work, understood what was expected of them and were motivated to provide and maintain a good standard of care. Comments included; “Really like working here, everybody gets on and we work as a team.” “I was made welcome when I first came here to work, team work is the best.”

The provider told us people were at the heart of what they were striving to achieve. They had developed a culture within the service of a desire for all staff at all levels to continually improve. For example offering staff opportunities for development such as management courses. People told us they "were happy," the staff wonderful" and "Home from home."

There was an effective quality assurance system in place to drive continuous improvement within the service. Audits were carried out in line with policies and procedures. Areas of concern had been identified and changes made so that quality of care was not compromised. Where recommendations to improve practice had been suggested, they had been actioned. For example, gaps in staff training had been identified, staff had now received the required training and further specialised training in managing behaviour that challenges had been booked.