The Dales (Northwest) Limited

The Dales Care Home

Inspection report

6 Marine Park
Wirral
Merseyside
CH48 5HW

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
The Dales Care Home is a residential care home providing accommodation and personal care for up to 31 people. The home is over three floors over two joined up Victorian properties in a residential area of Wirral. Each floor was accessible via a lift. At the time of our inspection 27 people were living at the home.

The Dales is also registered to provide personal care for people in their own homes. However, at the time of our inspection nobody was being provided with this service.

People's experience of using this service and what we found
When we arrived three staff members were not following COVID-19 personal protective equipment (PPE) guidance when supporting people. They were not wearing face masks and did not have them on their person. Face masks had been provided however; the box of masks had been left on the top floor of the home. This indicated that night staff were not consistently using face masks when supporting people

Infection control audits had taken place and the provider also completed audits of cleaning and domestic duties within the home. However, the provider had not ensured that there was a culture of safety amongst the staff team during the COVID-19 pandemic.

The provider had taken steps to ensure that the homes environment was safe; there were a series of risk assessments and regular checks of the safety of the environment and fire safety procedures.

We recommended that the provider assess the safety of the carpet.

There had been improvements made in the safe administration of people's medication. However, we recommended that the provider review the safe storage of medication.

At our last inspection we recommended that the provider review how they determined the number of staff they deployed at the home. We saw that there had been recent staffing pressures due to COVID-19; however, the deployment of staff had been reviewed and the number of night-time staff had been increased from two to three staff members during the late evening and overnight.

The atmosphere at the home was pleasant and homely. People appeared to be comfortable with staff members. We spoke with people who told us that they were happy with the time they got up. We saw that some people who preferred to get up later were still in their rooms. Staff were aware of people's preferences.

There had been an improvement in the frequency and quality of the checks and reviews of people's care plans. We also saw that care plans had been regularly updated when people's needs changed.

People were supported to have maximum choice and control of their lives and staff supported them in the

least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff members told us that the home manager was very approachable. The provider had held video calls with the day and night staff teams during some evenings; to help maintain communication.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update:
The last rating for this service was requires improvement (published 4 February 2020) and there were breaches of regulation.

At this inspection we saw that the provider had made improvements in relation to the breaches of regulation. However, during this inspection, the provider was in breach of regulation in a different area. Therefore, this is the second inspection when the service has been rated requires improvement.

Why we inspected
The inspection was prompted in part due to concerns received about people receiving appropriate personal care and receiving care that safely met their needs and preferences. A decision was made for us to conduct a focused inspection to review the key questions of "Is the service safe?" and "Is the service well-led?" to inspect and examine those risks.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the "Is the service safe?" and "Is the service well-led?" sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Dales Care Home on our website at www.cqc.org.uk.

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

We have identified breaches in relation to infection control practices and monitoring the safety of the service.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

The Dales Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was completed by two inspectors.

Service and service type
The Dales Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service is also registered as a domiciliary care agency. These provide personal care to people living in their own homes. At the time of our inspection nobody was receiving this service.

Notice of inspection
This inspection was unannounced. We arrived at 7:20am as we wanted to observe what care and support people received early in the morning and to observe the practice of night staff.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and healthcare professionals who work with the service. We used all of this information to plan our inspection.

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

During the inspection-
We spoke with six people who used the service and two relatives about their experience of the care provided. We spoke with eight members of staff and the provider (who is also the registered manager). Staff members included the home manager, two senior care workers, four care workers and the cook. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two staff files in relation to safe recruitment. A variety of records relating to the management of the service, including accident and incident records and quality assurance audits.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at documents relating to the safety and management of the home.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

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

At our last inspection the provider had failed to ensure that systems were in place and were sufficiently thorough to show that the safety of the service was effectively managed. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, improvements had been made and this breach of Regulation 17 had been met.

- The provider had taken steps to ensure that the homes environment was safe; there were a series of risk assessments and regular checks of the safety of the environment and fire safety procedures.
- The provider had assessed the safety of the communal areas and had taken action to reduce people's access to a small set of stairs that was often out of the sight of staff.
- The use of portable firefighting equipment had been reviewed by a relevant professional and action taken following their recommendations.
- Some of the joints in the carpet were worn. We observed one person stepping over a join in the carpet.

We recommended that the provider assess the safety of the carpet.

- We observed the morning handover from night staff to day staff. During this handover incoming staff were updated on any risks and staff planned and recorded their response.

Using medicines safely
At our last inspection the provider had failed to ensure that systems for assessing the safe use of medication were of sufficient quality. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, improvements had been made and this breach of Regulation 17 had been met.

- At our previous inspection we saw that staff instructions for the administration of "when required" (PRN) medication did not always contain the required information to help ensure that staff administered this medication appropriately. At this inspection the provider was in the process of redesigning the system used to ensure staff had the necessary information. Shortly after our visit the provider confirmed that this had been completed.
- Medication was not always stored safely. The medication cabinet is kept in the dining room which is a

communal area. We saw that staff had left two tubes of medicated creams on top of the cabinet for over half an hour. Also, some eye drop medication that required refrigeration had no date of opening recorded; this means that it would be difficult to ensure that they are used within the recommended timeframe.

We recommended that the provider review the safe storage of medication.

● Medication audits had taken place that had highlighted some areas that had then been improved.

Preventing and controlling infection
● When we arrived the three staff members present were not wearing face masks; they did not have them on their person. Face masks had been provided however; the box of masks had been left on the top floor of the home. This indicated that night staff were not consistently using face masks when supporting people; this is not following COVID-19 personal protective equipment (PPE) guidance.

This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Infection control audits had taken place and the provider also completed audits of cleaning and domestic duties within the home.
● The provider was making use of regular testing of staff members to help prevent any spread of COVID-19. Any staff member testing positive was self-isolating.
● Staff came into the home and then changed into their work clothes in a designated area.

Staffing and recruitment
● At our last inspection we recommended that the provider review how they determined the number of staff they deployed at the home. We saw that there had been recent staffing pressures due to COVID-19; however, the deployment of staff had been reviewed and the number of night-time staff had been increased from two to three staff members during the late evening and overnight.
● Care staff were supported by housekeeping and laundry staff, a cook, maintenance person and an activities coordinator.
● At our last inspection we recommended that the provider review the checks they had in place to ensure that new staff were recruited safely. There were no checks on new staff physical and mental health, to enable the registered manager to assess their suitability for the role. These checks were now in place

Systems and processes to safeguard people from the risk of abuse
● Staff had received safeguarding training, were knowledgeable about safeguarding people at risk of abuse and knew what actions they would take is they suspected any abuse was taking place. The provider had a safeguarding policy and kept records about any safeguarding concerns and the actions taken.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; continuous learning and improving care

At our last inspection the provider had failed to ensure that they had notified the CQC of events that they had a legal obligation to do so. Following the last inspection, the provider has been informing the CQC of notifiable events.

At our last inspection the provider had not ensured effective assessment of the quality and safety of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, improvements had been made and specific actions had been taken by the provider following our previous report. This breach of regulation had been met.

- When we arrived the night staff members were not using appropriate PPE. The provider had not ensured that there was a culture of safety amongst the staff team during the COVID-19 pandemic.
- The provider had failed to provide the CQC with an action plan following breaches identified in our previous inspection report published on 4 February 2020.
- There had been an improvement in the frequency and quality of the checks and reviews of people's care plans. We also saw that care plans had been regularly updated when people's needs changed.
- The provider had systems for auditing the quality and safety of the service. For example, accidents and incidents were reviewed by the home manager; documenting any actions taken. Also, we saw an audit of people's mealtime experience and checks that the provision of personal care met people's needs and preferences.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Staff members told us that the home manager was very approachable. The provider had held video calls with the day and night staff teams during some evenings; to help maintain regular communication.
- Some people's family members told us that they found it difficult to communicate with staff at the home and obtain information in a timely way during the COVID-19 pandemic.
- We saw that some people were using the telephone to speak with their family members. Staff told us that this can be difficult as there is one phone line. Internet access was available for people and staff told us that

the activity co-ordinator arranged for some people to make video calls to their family members.

We recommended that the provider reviews their communication with people's family members.

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

● We had received information of concern that people were forced to get out of bed early in the morning against their will. When we arrived at 07:20 about half of the people living at the home were up and dressed. However, everybody looked comfortable and had a hot drink and some toast or cereal.

● We spoke with people who told us that they were happy with the time they got up. We saw that some people who preferred to get up later were still in their rooms. Staff were aware of people's preferences.

● We briefly spoke with people and observed their interactions with staff. We saw that staff knew people well and used this knowledge to engage people in conversations. Staff respectfully adapted their approach to each person.

● The atmosphere at the home as pleasant and homely. People appeared to be comfortable with staff members. Staff asked people their preferences and consulted with them about their choices; making sure they had the information they needed.

● Staff told us that they enjoyed their roles and felt supported. They told us that they were happy to help out and had worked overtime during the difficult COVID-19 time period. This had meant that people had been supported by staff who were familiar to them.

● People were provided with individualised support and there were examples of people being supported in a person-centred way in smaller details.

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

● There had been an improvement in reporting events when something had gone wrong. The home manager had reported incidents to the CQC, local authority and people's family members and had taken action to help prevent any reoccurrence.

Working in partnership with others

● The provider was working in partnership with people's family members in the care planning process. The home manager and staff worked in partnership with people's GP's, district nurses and other health and social care professionals.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Staff were not following COVID-19 personal protective equipment guidance.