Finchworth Limited

Dinsdale Lodge Care Home

Inspection report

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27 November 2017

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 23 and 27 November 2017 and was unannounced. This meant the staff and provider did not know we would be visiting.

Dinsdale Lodge 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.

Dinsdale Lodge Care Home accommodates 26 people in one adapted building across two separate floors. Both floors accommodate people with residential care needs, some of whom have a dementia type illness. On the day of our inspection there were 23 people using the service.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like 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.

Dinsdale Lodge Care Home was last inspected by CQC on 29 September 2016 and was rated Requires improvement. No breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified at the previous inspection but some improvements were required in the Responsive and Well-led key questions.

At this inspection we checked to see whether improvements had been made and we found improvements had been made in all the areas identified at the previous inspection.

Accidents and incidents were appropriately recorded and investigated.

Risk assessments were in place for people who used the service and described potential risks and the safeguards in place to mitigate these risks. The registered manager understood their responsibilities with regard to safeguarding and staff had been trained in safeguarding vulnerable adults.

Medicines were stored safely and securely, and procedures were in place to ensure people received medicines as prescribed.

The home was clean, spacious and suitable for the people who used the service and appropriate health and safety checks had been carried out. A refurbishment programme was ongoing at the home, which included incorporating design that was dementia friendly.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The provider had an effective recruitment and selection procedure in place and carried out relevant vetting

checks when they employed staff. Staff were suitably trained and training was arranged for any due refresher training. Staff received regular supervisions and appraisals.

People's needs were assessed before they started using the service and continually evaluated to develop support plans.

People were supported to have maximum choice and control of their lives, and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were protected from the risk of poor nutrition and staff were aware of people's nutritional needs. Care records contained evidence of people being supported during visits to and from external health care specialists.

People who used the service and family members were complimentary about the standard of care at Dinsdale Lodge Care Home. Staff treated people with dignity and respect and helped to maintain their independence by encouraging them to care for themselves where possible.

Care plans were in place that recorded people's plans and wishes for their end of life care.

Care plans were written in a person-centred way. Person-centred is about ensuring the person is at the centre of any care or support plans and their individual wishes, needs and choices are taken into account.

Activities were arranged for people who used the service based on their likes and interests and to help meet their social needs. The service had good links with the local community.

People who used the service and family members were aware of how to make a complaint and the provider had an effective complaints process in place.

The provider had an effective quality assurance process in place. Staff said they felt supported by the registered manager and were comfortable raising any concerns. People who used the service, family members and staff were regularly consulted about the quality of the service via meetings and surveys. People told us the management were approachable and accommodating.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staffing levels were appropriate to meet the needs of people who used the service and the provider had an effective recruitment and selection procedure in place.

Accidents and incidents were appropriately recorded and investigated and risk assessments were in place for people and staff.

The registered manager was aware of their responsibilities with regards to safeguarding and staff had been trained in how to protect vulnerable adults.

People were protected against the risks associated with the unsafe use and management of medicines.

Is the service effective?

Good

The service was effective.

Staff were suitably trained and received regular supervisions and appraisals.

People's needs were assessed before they began using the service.

People were supported by staff with their dietary needs.

The provider was working within the principles of the Mental Capacity Act 2005 (MCA).

People had access to healthcare services and received ongoing healthcare support.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect and independence was promoted.

People were well presented and staff talked with people in a polite and respectful manner.

People had been involved in writing their care plans and their wishes were taken into consideration.

Is the service responsive?

Good

The service was responsive.

Care plans were written in a person-centred way.

People had been involved in planning their end of life care.

The home had a full programme of activities in place for people who used the service.

The provider had an effective complaints policy and procedure in place and people knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

The service had a positive culture that was person-centred, open and inclusive.

The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

Staff told us the registered manager was approachable and they felt supported in their role.

The service had links with the community and other organisations.

Dinsdale Lodge Care Home

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 was planned to check 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 inspection took place on 23 and 27 November 2017 and was unannounced. This meant the staff and provider did not know we would be visiting. One adult social care inspector and an expert by experience formed the inspection team. An expert by experience is a person who has personal experience of using, or caring for someone who uses this type of care service.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, statutory notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff. We also contacted Healthwatch. Healthwatch is the local consumer champion for health and social care services. They give consumers a voice by collecting their views, concerns and compliments through their engagement work. Information provided by these professionals was used to inform the inspection.

We used information the provider sent to us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with three people who used the service and six family members. We also spoke with the registered manager, deputy manager, activities coordinator and three care staff.

We looked at the care records of three people who used the service and observed how people were being cared for. We also looked at the personnel files for three members of staff and records relating to the management of the service, such as quality audits, policies and procedures.

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.

Good

Is the service safe?

Our findings

All the people we spoke with told us they felt safe at Dinsdale Lodge Care Home. A family member told us, "There is enough staff here." Another told us, "Staff are here straight away if my mum wants anything."

Staff recruitment records showed that appropriate checks had been undertaken before staff began working for the service. Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults. Proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates. Copies of application forms were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained.
We discussed staffing levels with the registered manager and looked at staff rotas. Staff, people who used the service and visitors did not raise any concerns about staffing levels.

A call bell audit had been carried out following staff reporting they were answering more call bells in the evening. The audit identified it was predominantly independent people who were activating sensor mats whilst going to the bathroom rather than calls for assistance. The registered manager told us they had worked with the local falls team to reassess people to see who needed sensor mats and who didn't. As a result, sensor mats were safely removed from those people who did not need them. We observed call bells were answered in a timely manner and staffing levels were sufficient to support people and keep them safe.

At the time of our inspection, the home was undergoing maintenance work. This included hall, stairs and landing walls being repainted and the carpets replaced throughout the building.

The home was clean, spacious and suitable for the people who used the service. Communal bathrooms and toilets were generally clean however we saw an accumulation of dust on two extractor fans. We brought this to the attention of the registered manager. This was actioned before our second visit to the home and we saw cleaning schedules had been amended to include this. Appropriate personal protective equipment (PPE), hand hygiene signs and liquid soap were in place and available. An annual infection control audit was carried out, the home's infection control champions attended regular study days and a monthly 'Preventing the spread of infection review tool' was completed. This meant people were protected from the risk of acquired infections.

Accidents and incidents were recorded and analysed to identify any trends, lessons learned or what action could be taken to prevent a re-occurrence. For example, referrals to the falls team and a review of staffing levels. Risk assessments were in place for people who used the service and described potential risks and the safeguards in place. This meant the provider had taken seriously any risks to people and put in place actions to prevent accidents from occurring.

Hot water temperature checks had been carried out for all rooms and bathrooms and were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) guidance Health and Safety in Care Homes (2014).

Equipment was in place to meet people's needs including hoists, pressure mattresses and wheelchairs. Where required we saw evidence that equipment had been serviced in line with the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). Portable Appliance Testing (PAT), gas servicing and electrical installation servicing records were all up to date.

Risks to people's safety in the event of a fire had been identified and managed, for example, a fire risk assessment was in place, fire drills took place regularly, and checks of the alarm system and firefighting equipment had been carried out. The service had an emergency and a contingency plan and Personal Emergency Evacuation Plans (PEEPs) were in place for people who used the service. This meant that checks were carried out to ensure that people who used the service were in a safe environment.

The provider had a safeguarding policy, which included a definition of abuse, information on preventing abuse and what action to take if abuse was suspected. Safeguarding incidents were appropriately recorded and CQC had been notified of any relevant incidents. Analysis of safeguarding incidents was carried out each month to identify if any lessons could be learned and whether any further action should be taken. The registered manager understood their responsibility with regard to safeguarding and staff received training in the protection of vulnerable adults. We found the provider understood safeguarding procedures and had followed them.

People had medicines support plans in place. These described the person's assessed need, such as whether they required staff to administer their medicines for them.

Medicines were securely stored in a locked treatment room. Temperatures were recorded for the room and those medicines that required cold storage in a refrigerator. We identified that some recent refrigerator temperature recordings were above the recommended level. We discussed this with the registered manager and deputy manager. The deputy manager told us they had identified this was due to the high levels of stock in the refrigerator and the temperature was increasing when the door was opened more regularly. A new, larger refrigerator had been ordered to resolve this.

We looked at medication administration records (MAR). A MAR is a document showing the medicines a person has been prescribed and records whether they have been administered or not, and if not, the reasons for non-administration. Records we viewed were up to date

Full medicines audits were carried out monthly and additional audits of three records were carried out on a weekly basis. These looked at the MARs and storage to ensure appropriate arrangements were in place for the safe administration and storage of medicines and the provider's management of medicines policy was being followed.

Good

Is the service effective?

Our findings

People who used the service received effective care and support from well trained and well supported staff. One person told us, "The staff give me a shower and they know what they are doing." Another person told us, "The staff help with anything, I just have to ask." A family member told us, "The staff get my mum out of bed and put her in the chair, they know what they are doing and my mum is very safe in their hands." Another told us, "The staff are absolutely marvellous, my mum gets everything she requires. She presses her buzzer and staff come straight away."

The registered manager maintained a mandatory training matrix. Mandatory training is training that the provider deems necessary to support people safely. We looked at staff training records and saw mandatory training included safeguarding, health and safety, first aid, fire safety, moving and handling, infection control, dementia, mental capacity, food safety, and care planning. Records we saw were up to date. The registered manager was aware of any training that was due to expire and it had been booked.

New staff completed an induction to the service and were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care.

Staff received regular supervisions and appraisals. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace.

People's needs were assessed before they started using the service and continually evaluated in order to develop support plans.

People's nutrition support plans provided information on individual preferences, whether they had any specific dietary needs and guidance for staff to follow to support the person. For example, one person required one to one support at mealtimes and a fork mashable diet due to the risk of choking. We saw a speech and language therapist (SALT) had been consulted and their guidance was included in the support plan. The person was weighed monthly as advised and staff were to check the person's mouth was clear when they finished their meal. Malnutrition Universal Scoring Tools (MUST) were in place for people to record and identify those people at risk of malnutrition.

People had access to a choice of food and drink throughout the day and we observed staff asking people what they would like to eat that day. At lunch time we observed there were pictorial menus to assist people. People were asked if they wanted a dignity tabard to avoid food spoiling their clothes. Some people had plate guards so that their food was easy to access and not falling off the plate. Staff assisted people to their tables and we observed staff supporting people on a one to one basis if they required assistance with their meal.

Staff chatted with people throughout and the mealtime was not rushed. Residents appeared to enjoy their meal. Food was proportionally sized and looked very nourishing and appetising. People were supported to

eat in their own bedrooms if they preferred.

We observed a person who during their meal began to cough and was slightly distressed. The staff member supporting them handled the situation with ease and confidence, and reassured the person that everything was ok. People told us they enjoyed the food and did not have any complaints.

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.

People can only be deprived of their liberty to 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. DoLS applications had been submitted when appropriate and CQC had been notified of any authorisations. Mental capacity assessments had been carried out and decision specific best interest decisions were in place for people who lacked the capacity to make their own decisions. The registered manager and staff we spoke with had an understanding of the principles and their responsibilities in accordance with the MCA.

Some of the people who used the service had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms in place. This means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). Records we saw were up to date and showed the person who used the service and family members had been involved in the decision making process.

People who used the service had access to healthcare services and received ongoing healthcare support. Care records contained evidence of visits to and from external specialists including GPs, community nursing teams, opticians and podiatrists.

Some of the people who used the service were living with dementia. We saw carpets throughout the home were old and patterned. The registered manager told us new carpets had been ordered and once the rest of the home had been re-painted, the new carpets would be installed. Corridors throughout the home were wide and clear from clutter. There were lots of posters and photographs on the wall of famous movie and music stars, and dementia friendly signage was in place throughout the home. Following consultation with people who used the service and family members, two corridors of the home had been designated dementia friendly zones. People had chosen the names for these corridors and we saw they incorporated dementia friendly design such as brightly coloured doors, additional signage and wall displays. The provider told us of their plans to create a 'dementia garden' in the grounds. This meant the service incorporated some environmental aspects that were dementia friendly.

Good

Is the service caring?

Our findings

Family members were complimentary about the standard of care at Dinsdale Lodge Care Home. One told us, "We are very happy with the care my mum gets." Another told us, "Staff call my wife 'granny [name]', they are lovely and friendly."

People were well presented and looked comfortable in the presence of staff. We saw staff speaking with people in a polite and respectful manner and staff interacted with people at every opportunity. Staff knew how to support people and understood people's individual needs. For example, we observed a staff member knock on a person's door and ask if they wanted to sit in their chair for a while. The person said "yes" so the staff member assisted them to move to the chair.

There were good examples of initiatives implemented at the home to support people with dementia. A person at the home who did not have dementia had taken part in dementia training to help understand dementia and how it affected some of the people they lived with. The registered manager told us they were hoping to offer this course to other people at the home in the future.

The deputy manager told us that staff on night shift at the home wore pyjamas. Research had been carried out and found it helped to promote a healthy sleep pattern. It was discussed at residents' meetings before being implemented. The deputy manager told us it provided a prompt to people who got up frequently and couldn't settle at night and they gave an example of a person who used to sit up all night who now goes to bed.

We saw staff knocking before entering people's rooms and closing bedroom doors before delivering personal care. Care records described how staff were to respect the privacy and dignity of people. For example, "I would like staff to knock on my door before entering my room" and "[Name] wishes to maintain her current level of personal care to ensure her health, comfort and wellbeing are maintained."

People who used the service and family members all had positive comments on how staff promoted privacy and dignity. They told us that toilet doors were always closed and staff always knock on their doors before entering their bedrooms. Our observations confirmed staff treated people with dignity and respect and care records demonstrated the provider promoted dignified and respectful care practices to staff.

People were supported to be as independent as possible. Care records described what people could do for themselves and what they needed staff to assist them with. For example, "[Name] needs full assistance off two carers with all washing and dressing", "[Name] may require some assistance to dry herself after bathing" and "[Name] is independent when moving." People who used the service told us, "I like to dress myself", "I go to the luncheon club every week, I like to go on my own so the carers get me a taxi there and back. I love going out on my own" and "I can go to the local shops and the library by myself." Our observations confirmed staff supported people to be independent and people were encouraged to care for themselves where possible.

People's preferences were clearly documented in their care records. For example, what time they preferred to go to bed and rise in the morning, dietary preferences, choices about their laundry, and activities.

Communication support plans described people's individual communication needs and the support they required from staff. For example, "[Name] needs staff to be patient and give him time to respond to simple questions", "Staff to only offer two choices to one question" and "[Name] often loses track during conversations. A gentle reminder or suggest word may help." One of the people at the home was blind and had trouble identifying which door staff were knocking on. A door bell had been installed on the person's door so they knew it was their room that staff were visiting.

People's religious and spiritual needs were catered for. Some of the people who used the service had asked if they could say grace, or a short prayer, before meals. This was acknowledged and respected by staff to meet the spiritual needs of residents, and grace is now said before every meal by those people who want to be involved.

We saw that records were kept securely and could be located when needed. This meant only care and management staff had access to them, ensuring the confidentiality of people's personal information as it could only be viewed by those who were authorised to look at records.

Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. Advocacy information was made available to people who used the service but none of them were using independent advocates at the time of our inspection visit.

Good

Is the service responsive?

Our findings

At the previous inspection we found some information in relation to people's care was not recorded appropriately. At this inspection, we found care records were regularly reviewed and evaluated. Care records were person-centred, which means the person was at the centre of any care or support plans and their individual wishes, needs and choices were taken into account.

Each person's care record included important information about the person, such as next of kin, medical history, diagnosis and details of their personal background, family and friends, and interests. We saw these had been written in consultation with the person who used the service and their family members.

Support plans were in place and included moving and handling, continence, nutrition, communication, overnight support, hygiene needs, medication, and pressure care. These described people's specific assessed need, how the need was to be addressed and a risk assessment where relevant. For example, one person needed support to mobilise and was at risk of pressure damage. The support plan described how two staff were to assist with all moving and handling, the equipment the person had in place to support them and specific instructions for staff to follow. For example, "Staff to inform [name] of all steps to be taken when completing any transfer so [name] is aware of what is going to happen and when." The accompanying risk assessment described the steps taken to minimise the risk to the person. Guidance was also provided for staff in the person's pressure care support plan to check daily for any signs of damage to the skin, apply barrier cream and report any concerns to the community nurses.

Daily records were up to date and contained information on people's diet, health, personal care, sleep and activities they had taken part in.

End of life care plans were in place for people as appropriate and included information on the person's wishes for their end of life care, any religious requests and whether they had any funeral arrangements in place. This meant people had been involved in planning their end of life care.

The provider protected people from social isolation. Each person had an individual social activities plan and the activities coordinator had a full programme of activities and events in place. They told us how they had raised money via a Summer fete to take several of the people to the Emmerdale studios. Research had been carried out into specific activities for people with dementia and we saw some of these activities had been introduced at the home. For example, a 'Magic table' that stimulates physical and social activity, music therapy, doll therapy, sensory activities and animal therapy. Links had been established with the local dementia advisory service and the activities coordinator had written a blog that had been published and had won £20.

Singers and entertainers visited the home regularly and we saw photographs of previous activities that had taken place, such as a Halloween party, visits by local school children and a Remembrance Day event. The activities coordinator told us that one person loved to sing on the karaoke, explaining that, "her mood changes when she is singing, she is so relaxed and happy". They told us one person had recently had a

telephone line installed in their bedroom so they could talk to their family to prevent social isolation. A person who used the service told us, "We can't do without her [activities co-ordinator], she is so nice to us all."

The provider had a complaints policy and procedure in place. This described how to make a complaint and the timescales involved. There had been two recorded complaints at the service in the previous 12 months. We saw these had been appropriately dealt with and resolved. People and family members we spoke with were aware of how to make a complaint but they had not needed to make any.

Good

Is the service well-led?

Our findings

The service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. They had been registered with CQC since May 2017. We spoke with the registered manager about what was good about their service and any improvements they intended to make in the next 12 months. The main focus was on the redecoration of the premises, including painting the communal areas, the addition of more dementia themed displays and new carpets throughout the home. The provider also told us of their plans for the external grounds, including a dementia garden. The service had an action plan in place and we saw these improvements were recorded on the plan.

The provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.

The service had good links with the local community. The registered manager told us they had identified there were no 'safe havens' for people with dementia in Hartlepool. Safe havens are used when police officers come across a person living with dementia who has been reported missing from home, lost, confused, disorientated or they are unable to identify them. They are taken to a safe haven until enquiries can be carried out. The registered manager had contacted the local police and arranged for the home to be accepted as a safe haven.

The service had a positive culture that was person centred, open and inclusive. People we spoke with all had positive comments regarding the management of the home. They told us the management were all very approachable and visible, and they would have no concerns in approaching them if they had any worries or concerns.

Staff we spoke with felt supported by the registered manager and told us they were comfortable raising any concerns. Staff were regularly consulted and kept up to date with information about the home and the provider. Staff meetings took place regularly and additional meetings were held for senior staff and kitchen staff.

At the previous inspection we found development plans and quality monitoring had been introduced but it was too early to assess the effectiveness in driving continuous improvement. At this inspection, we looked at what the provider did to check the quality of the service, and to seek people's views about it. The provider regularly visited the home and carried out a monthly audit of the environment, kitchen and food, staffing, audits, medication, care plans and finance. Actions were put in place for any identified issues.

A quality framework was in place based on the CQC five key questions, which included an audit by the registered manager every six months to check whether the service was compliant with the five key questions. Where issues were identified, an action plan was in place. For example, the most recent audit in November 2017 identified that safeguarding training was due to expire for some members of staff, which was subsequently booked.

Senior staff completed a weekly checklist. This included a review of five care records, charts, fire, security and maintenance checks, cleanliness and a check that the weekly medication audit had been completed. In addition to this, senior staff also completed a daily checklist that included maintenance, cleanliness, infection control, charts and discussions with people who used the service.

The registered manager carried out night visits to the home, which included a review of staffing, choices, documentation and the environment. Any issues identified as a result of audits, checks or comments from visitors were recorded in the observations file and details of action taken was documented. For example, the issue we identified with dust on the extractor fans had been recorded. A discussion with domestic staff had taken place, and the cleaning of extractor fans had been added to the domestic cleaning schedule and the senior staff weekly checklist.

An annual quality assurance survey took place that was completed by people who used the service and family members. This asked questions on safety at the home, whether staff treated people with respect, the premises, the mealtime experience and activities. People were also given the opportunity to feed back at residents' meetings and contribute to new menus and suggest new activities.

This demonstrated that the provider gathered information about the quality of their service from a variety of sources and acted to address shortfalls where they were identified.