Dalemain House Residential Home Ltd

Dalemain House

Inspection report

19 Westcliffe Road
Southport
Merseyside
PR8 2BL

Tel: 01704568651
Website: www.dalemainhouse.co.uk

Date of inspection visit:
29 November 2017
04 December 2017

Date of publication:
08 January 2018

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

An unannounced comprehensive inspection took place of Dalemain House on 29 November and 4 December 2017.

Dalemain House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Dalemain House provides personal care and support for up to 24 older people. The home is located in a residential area, close to the town of Southport, which can be reached by the local transport services. The home is a large converted house and all areas are accessible by a passenger lift and there is ramped access to the front garden. Accommodation includes 11 single rooms and five double rooms which are situated over three floors. There has been a change of legal entity for this service and the registered provider (owner) is now Dalemain House Residential Home Ltd. Although an inspection took place in 2016 and the overall rating was found to be 'Good', the service was inspected in accordance with our methodology for new services. This is for services to be inspected between six to 12 months from the date of registration.

There was a registered manager in post at the time of our inspection. 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.

During the inspection we received information of concern around the fire doors being padlocked; a lack of fire training; lack of equipment for the first aid boxes and topical creams applied to people being out of date. We looked at these areas on inspection. The fire doors had been inspected by the home's external fire contractor and no concerns had been raised by them or the fire service with regards to the fire doors and the locks. A further visit took place by the home's external fire contractor following our inspection to confirm the use of these doors and padlocks. We saw staff had received fire prevention training and further fire prevention training was planned for 2018. We checked a number of topical creams prescribed for people; these were in date and applied as prescribed. We found some equipment needed to be replaced in the first aid boxes and this was rectified during the inspection. The safety check of these boxes was confusing. This was brought to registered manager's attention and a more accurate record was put in place.

Staff were aware of what constituted abuse and how to an actual or alleged incident. Policies and procedures were in place to protect people from abuse and people we spoke with said they felt safe living in the home.

We found the home was operating in accordance with the principles of the Mental Capacity Act 2005 (MCA). Staff sought consent from people before providing support.

The registered manager had made appropriate referrals to the local authority applying for authorisations to support people who may be deprived of their liberty under the Deprivation of Liberty Safeguards (DoLS). DoLS is part of the MCA 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.

Risks to people's safety were assessed and monitored by the staff. This helped to maintain their safety and welfare.

People had a plan of care and received support from the staff and external health and social care professionals to help deliver effectives outcomes. Monitoring records and charts for fluids and diet, for example, were updated so they provided an effective evaluation of care.

People and/or their relatives had been included in the care planning, so they were involved in decisions around their care, support and treatment. There was clear evidence that care plans were subject to on-going review.

Ways in which people communicated were recorded to help make their needs known. With regards to the people we discussed, staff had a good knowledge of how people communicated their needs and how they wished to be supported.

Medicines were safely stored and administered in accordance with best practice. Staff were trained in administration and people were able to administer their own medicines to help maintain their independence.

We observed there were sufficient numbers of skilled and experienced staff to carry out care in a timely manner. People we spoke with told us the staff's approach was kind, respectful and caring when being supported. This was also confirmed by relatives we spoke with.

We observed good interaction by the staff when supporting people. Care and support was given in a polite and empathetic way. No one was rushed.

Service contracts and safety checks of services, such as the gas and electric supply, and various equipment were in place to ensure the environment was safe and well maintained. We noted that some maintenance work was needed for two bathrooms and the provider was undertaking the necessary work.

Staff files showed appropriate recruitment checks had been made so that staff employed were 'fit' to work with vulnerable people.

People had access to a complaints' procedure. There had been no recent complaints however people knew who to speak with if they had a concern. They were confident the staff would listen to them and respond appropriately.

People were provided with some social activities and these were arranged in accordance with people's preferred interests. The home was decorated for Christmas and people were looking forward to the festive arrangements.

We found that the home was clean and staff was adhering to good standards around the control of infection.

People were served nutritious and well balanced meals. Staff advised people of the menu of the day and alternative foods were provided if people wished for an alternative.

Staff received training and support to enable them to care for people effectively and safely. The staff training plan evidenced courses in key areas and staff were encouraged to take formal qualifications in care. New staff received a comprehensive induction.

The registered manager was aware of their responsibility to notify us, the Care Quality Commission (CQC), of any notifiable incidents in the home.

Quality assurances processes and systems were in place to monitor standards and drive forward improvements. This included a number of audits and checks on how the home was operating.

Feedback from people was sought so that the service could be developed with respect to their needs and wishes. People living in the home and relatives were complimentary regarding the service provision.

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.

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

Risks to people's health and wellbeing and the environment were recorded and monitored.

We found good systems in place to ensure medicines were managed safely.

There were sufficient numbers of skilled and experience staff to support people safely and to ensure their care needs were met.

Staff received safeguarding training and were able to tell us about the types of abuse and what actions were needed to report actual or potential harm.

The home was clean and staff adhered to good standards of infection control.

Is the service effective?

Good

The service was effective.

People received care and support from the staff. Staff worked closely with external health and social care professionals to help deliver effective outcomes.

Staff followed the principles of the Mental Capacity Act 2005 and sought consent form people regarding their support.

Staff were supported through induction, appraisal and the home's training programme.

People were offered a good choice of nutritious and well balanced meals.

Is the service caring?

Good

The service was caring.

People's care and support was delivered in a caring and respectful manner.

We observed positive interactions between people living at the home and staff.

People told us they received a good standard of care from the staff and that staff knew them well.

People were informed about changes to their care and support and involved in decisions made.

Is the service responsive?

Good

The service was responsive.

People took part in a variety of social activities and told us they enjoyed them.

Care records contained information relevant to each person with reference to personal preferences and choice. This helped to provide an individual approach to care.

Staff received end of life training and people's future wishes were recorded.

People and/or their relatives had access to a complaints procedure. People told us they had confidence that their concerns would be listened and responded to.

Is the service well-led?

Good

The service was well led.

A registered manager was in post.

The registered manager had notified CQC of events and incidents that occurred in the home in accordance with our statutory notification requirements

Quality assurance systems and processes were in place to monitor the service to and to drive forward improvements.

People living in the home, relatives and staff were complimentary regarding the overall management of the home.

Feedback from people was sought so that the service could be developed with respect to their needs and wishes.

Dalemain House

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.

An unannounced comprehensive inspection took place on 29 November & 4 December 2017. A comprehensive inspection looks at all of the five key questions we ask, if the service safe, effective, caring, responsive and well led? We award a rating for reach question and also award an overall rating for the service.

The inspection team comprised of an adult social care inspector, an assistant inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had expertise with older people and people who were living with dementia.

Before our inspection we reviewed the information we held about the home. This included notifications we had received from the provider about important events which the service is required to send to us by law, such as incidents which had occurred in relation to the people who lived at the home.

During the inspection we spoke with the provider (owner), registered manager, five carers, a cook, the activities coordinator and two ancillary staff. We spoke with six people living at the home and three relatives.

We undertook observations of the home over the course of the two days. This included some aspects of care and support for people living at the home and a tour of the general environment, décor and furnishings, bedrooms and bathrooms, lounge, dining room, kitchen and external grounds. During the inspection we spent time reviewing records and documents. These included the care records of three people who used the service, four staff personnel files for recruitment purposes, staff training matrix, medication administration records, audits and other records relating to the management of the service.

Good

Is the service safe?

Our findings

People we spoke to told us what made them feel safe. Their comments included, "I feel safe here because of the staff", "The surroundings and the people (staff) make me feel safe", "The fact there are people (staff) around and everyone has to go through the staff and we have an alarm system" and "Things are done for me. All the staff are very good, it's a nice home to be in". A relative told us, "You can't just walk in, and we know (family member) feels secure." We saw that the home was kept safe and visitors and people living at the home were asked to sign in and out in the visitors' book so staff were aware of who was in the home.

At the time of the inspection 16 people were living at Dalemain House. We looked at the current staffing levels; the registered manager was on duty with three care staff, a cook, a domestic member of staff and a laundry assistant. The provider (owner) was also present at different times to support the registered manager. At night people were currently supported by two care staff. The registered manager said that at night three carers would provide support for people if their dependencies increased and there was a bank member of staff who could be called on for 'cover'. 'Bank staff' are carers with no fixed contracted hours that often help to cover shifts where there is need. The registered manager also stated that an extra staff member often worked between 4pm-9pm as they appreciated this could be a busy time if people wished to go to bed early and this provided extra support for the night staff early evening.

We asked people if there were sufficient numbers of staff to look after them. People said, "There's so many people (staff) around and the boss is good", "We get them and lose them, the turnover comes from people being promoted, but we do well here" and "Yes, I only have to ask and they help me." Relatives reported, "I think so, they work hard. If (family member) needs to go to the toilet, there's somebody there straight away" and "Yes, there's usually two (referring to staff) in here (referring to the lounge) all the time, I don't know how they manage."

Staff told us that the deputy or the registered manager would take turns to be 'on-call'. This meant they were available for staff to contact in case of emergencies and for 'out of hours' cover.

Some care staff we spoke with told us there were no problems with staffing levels. A staff member said, "The staffing is fine, at present and people receive the care they need." Other care staff commented that staff turnover could be a problem at times, as it resulted in an uneven level of skills and commitment amongst the team. We found on inspection there were sufficient numbers of skilled staff present to support people safely and in accordance with individual need.

Staff records contained a minimum of two references, photographic identification and an application form. There were disclosure and barring service (DBS) checks on file. These checks helped to ensure employees were suitable to work with vulnerable people. One staff member had two character references. We spoke with the registered manager about this, who explained that usually at least one professional reference was required. The registered manager stated that they had had a conversation with the member of staff and based on this information decided that two character references were sufficient.

We looked at how medicines were managed and saw medicines were administered safely to people. People had a medicine administration record (MAR). The MARs we viewed contained photographs of people to assist with accurate identification, as well as information regarding any allergies that people had. The charts seen had been completed fully. A bio- dose system (monitored dosage system) was in place for staff to administer medicines. We checked the stock balance of a number of medicines and found these to be accurate.

Medicines were stored in a locked trolley which was kept in a locked clinical room. The temperature of the room and the medicine fridge were monitored and recorded daily; we saw that these were within safe ranges. If medicines are not stored at the correct temperature, it can affect how they work. There was a controlled drug cupboard and controlled drug register in the clinical room. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Act and associated legislation. At the time of the inspection no one was prescribed a controlled drug.

We saw one person whose dosage of their medicine could change dependent on their blood test. This was well managed by the staff and given in accordance with instructions from the hospital. The dosage of this medicine was an important part of the person's treatment which staff monitored closely.

We reviewed how a thickening agent was given by the staff. Thickening powder can be prescribed to thicken people's drinks when a person may have swallowing difficulties to accept fluids and reduce the risk of choking. The number of scoops of thickening powder required to ensure the correct consistency of fluid for each person was recorded on the person's chart. This instruction was in accordance with the instructions from the speech and language therapy team (SALT). At the time of the inspection we received information of concern around people's creams. We saw that topical preparations such as creams, were recorded when given and dated when in use.

People were encouraged to manager their own medicines and this practice was risk assessed to ensure they could undertake this safely. One person had not signed their risk assessment regarding self-medication and this was brought to the registered manager's attention to action. People had a plan of care which outlined their medicines and those to be given as needed, (PRN) medicines. Guidelines for the use of PRN medicines were available.

Staff who gave medicines told us that as part of their induction they had 'shadowed' a more experienced member of staff. They went on to say their competency around giving medicines had been assessed through observation by the registered manager. We saw sample evidence of a recent medication competency assessment for one member of staff; this assessment included checking the member of staff's knowledge as well as observation of skills.

Staff told us to promote good infection control they had personal protective equipment (PPE) and used it every day to support people with personal care and for serving food. This included, for example, hand gel, aprons and gloves. We found the home to be clean with good adherence around the control of infection.

People's records were kept secure and were accessible to the staff. People had a plan of care which included a personal emergency evacuation plan (PEEP) for use in the event of any major incidents/emergencies. These were sufficiently detailed to ensure staff knew what level of support each person needed. The registered manager explained the service was currently working on a 'grab bag'. This is a bag of essentials that is easily grabbed in the event of a fire evacuation. Staff told us they received fire prevention training and knew about the first evacuation procedure. This training was recorded.

We looked at how risks to people's health and safety were assessed and recorded. Care records recorded risks in areas such as, nutrition, falls and mobility with the involvement of the relevant person or their relative. The risk assessments were subject to review to reflect any change in dependency which could affect the level of risk. Any change in risk was recorded and staff told us this would be discussed at staff handovers. We saw people went out independently from the home and staff supported people with this and associated risks were recorded.

Essential safety checks, for example, gas, electrical and fire safety and legionella compliance were completed in accordance with the relevant schedule by suitably qualified external contractors. The service also completed its own checks such as, checks on the emergency lighting, fire alarms, hot water temperatures and various equipment. Health and safety audits were completed where obvious hazards were identified and maintenance work completed in a timely manner to ensure people lived in a safe well maintained home. Records seen for these checks were up to date.

On our tour of the home we pointed a few maintenance issues that needed to be addressed to keep people safe. These included the underside of a bath chair, which to be appeared rusty and flaking paint. This was possible a sharp surface and an injury risk for people touching it. Action was taken to rectify this. We also noticed in a bathroom on the second floor a low radiator that felt hot to touch and therefore posed a risk of scalds or burns if people were to hold it for support. The registered manager told us this was a rarely used bathroom, as people's bedrooms were 'en-suite'. However, this issue was brought to the provider's attention and the bathroom 'put out of use' to carry out some other maintenance work and to install a cover for the radiator. This work is due to be completed this month.

At the time of the inspection we received information of concern relating to the fire doors being locked. The fire doors had a 'redlam bolt' that needed to be broken with a small hammer kept next to it. Breaking the bolt released the lock and opens the fire exit. We saw that these doors had been passed by the fire service and also by the home's service contactor for fire safety. Following the inspection these were however subject to a further service check by the same contractor and no issues were raised regarding their use. A member of staff on inspection was unsure of how these locks operated. The registered manager assured us all staff had been trained however the registered manager said they would revisit this learning to everyone's safety in the event of their use in an emergency.

At the time of the inspection we received information of concern that the first aid boxes did not contain the correct equipment. We therefore looked at the safety checks for the first aid boxes. The deputy manager had picked up that an item needed replacing. This was actioned during the inspection and it was agreed to simplify the records to evidence these checks as they were confusing.

Safeguarding systems and processes were in place to protect people from abuse. This included a safeguarding policy/procedure for staff to refer to. Contact details for the local authority's safeguarding team were available for everyone to refer to. The registered manager was aware of how to report safeguarding issues to the relevant authority, including us, the CQC.

Safeguarding training was provided for the staff and staff told us about the different forms of abuse. Keeping people safe was also discussed at staff induction along with whistle blowing. Staff comments included, "Safeguarding to me is keeping vulnerable adults safe; check that they do not get abused. Everyone here is safe" and "Yes I have had safeguarding training and would not hesitate to speak up if at all concerned." For one member of staff who had yet to receive this and training was planned for them they informed us, "I have not had it here yet but for me, it is taking care of people's well-being and preventing abuse. It is for staff and residents. If I had any concerns, I would speak to (the registered manager), another manager or the owner. I

would feel confident to whistle blow."

Staff told us they received equality and diversity training and advised us and how this helped protect people from discrimination or other abuse. Their comments included, "We respect what the residents want to do and how they want us to care for them" and "This is their home, we never forget this." Staff explained that this knowledge was important to avoid distressing people and thereby causing incidents or making people feel excluded or vulnerable.

Staff told us about the process for reporting incidents or accidents. A staff member said, "We fill in the charts and report it to the manager. We write it down and there is an investigation. We pay attention to what has changed and put it on the risk assessment." The registered manager had completed a referral to an occupational therapist regarding the increased risk for a person who suffered a fall; their risk assessment had been updated to reflect this. We saw accidents and incidents were recorded and the registered manager looked for trends and patterns to help reduce the risk of re-occurrence. Any trends identified and lessons learnt were shared with staff.

Good

Is the service effective?

Our findings

We asked people if staff were knowledgeable regarding their care and people were in agreement with this. People said, "I think the care is first class" and "I feel the help is really good, the staff seem well trained." When referring to accessing medical appointments a person said, "If I don't feel well, the girls get the doctor for me, never have to ask twice."

We found people's care needs were being met effectively. Staff told us the service worked together with external health and social care professionals such as, occupational therapists, falls team, speech and language therapists, district nurses, doctors and dieticians to support people to lead healthy lives. We saw evidence of relevant appointments and these were arranged at the appropriate time.

The registered manager informed us the district nurse team provided support with wound dressings, pressure sores on people's feet and blood tests. While we visited, a person attended a hospital appointment around skin concerns. The registered manager showed us how the service had worked with health professionals to address this. The person explained to us that their skin condition had improved with support from the home's staff and GP. Staff said, "Our working together with other professionals is good" and "We support people with their health needs as soon as an issue arises."

Staff recorded people diet and fluids and completed turning charts (when people need to be moved in bed to prevent their skin from becoming red or broken) according to assessed need. These charts help to monitor and provide an evaluation of care. Staff told us how they cared for people who had vulnerable skin; this included a change of position and good nutrition to prevent skin from breaking down. We noticed a 'React to Red' information on one of the pin-boards. 'React to Red' is a 'campaign that is committed to educating as many people as possible about the dangers of pressure ulcers and the simple steps that can be taken to avoid them'.

Staff members we spoke with had a variety of formal qualifications. These included National Vocational Qualifications (NVQ) in Health and Social Care. These had been completed by staff at level 2, with some staff about to start their level 3. We saw induction checklist records (induction packs); these covered a large amount of information for staff regarding the service. Two out of the four staff whose recruitment files we looked at had completed their first day of induction on their first day of employment. Another member of staff had completed it a few days after their noted start date. A post induction quiz assessed the new employee's learning within two weeks after completing the checklist. We saw that this included not just general learning, but checked staff's knowledge with regards to people's specific needs. A staff member told us their induction had been very positive.

Staff told us they had completed different courses and that the training was very good. These included fire warden's training, risk assessment training, dementia training and training on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards.

The registered manager explained that this was a course on "creative activity provision". The registered

manager explained that they were working with the company providing staff's vocational training and assessment to offer more courses, including advanced level mental health awareness, infection control, dementia awareness, dementia and sensory loss, as well as a short course on safe handling of medicines. The registered manager told us that courses such as moving and handling, fire and medication competency were delivered as in-house, 'face to face' sessions. We were shown evidence of staff training, this included, moving and handling, medication, infection control, health and safety, dementia, food hygiene, fire and first aid. At the time of the inspection we received information of concern that staff had not received fire training. Records seen showed fire training was last given to staff in April 2017 and more sessions were planned. Following the inspection the registered manager sent us a training plan with future course dates.

We saw that there were three staff were being enrolled in the Care Certificate. The Care Certificate is the government's recommended blue print for induction standards. The registered manager explained that one of the three care staff waiting to be enrolled already had an NVQ level 2 in Health and Social Care. We spoke with the staff member who also confirmed the qualification and previous experience.

Staff told us they attended supervision meetings however when we looked at the supervision schedule there were some gaps. The registered manager informed us there were some to catch up on especially for weekend staff. We suggested that such regular meetings were important, for example to ensure even staff development across the team, align carers to the service's vision and to provide workers with the opportunity to voice concerns. Following the inspection the registered manager sent us dates when these meetings would be held. We saw evidence that for a new member of staff they had attended staff supervision within the first two months of their employment. We noted that staff annual appraisals were completed. The registered manager confirmed that staff received a copy of appraisal minutes.

We asked people what they thought about the food. Their comments included, "It's very good, I get a choice and I get lots of drinks", "It's good she's a good cook", and "if I don't like what's on offer, I have my own cheese and biscuits." A relative said, "They have a wonderful cook and they give residents and guests plenty of tea and coffee."

The menu was based over four weeks with the main meal served at lunch time. There was a mixed response from people around whether they were involved in planning the menus. The majority of people told us they were offered an alternative if they did not like the meal being served and we observed staff asking people what they would like to eat. There were no menus on the dining room tables for people to look at however on the inspection the registered manager produced laminated copies of the menus for the dining room. A menu was also displayed outside the dining room for people to see.

The dining room tables were attractively laid for lunch with flower arrangements and condiments. A member of the inspection team had lunch with people (with their permission). The meal consisted of boiled ham, new potatoes, green beans and carrots, with a small portion of bread sauce. The vegetables were served cold and this was brought to the registered manager's attention. On the second day of the inspection there was no issue with temperature of the food and people did not raise any concerns with us about the temperature food was served. Staff were available to support people with their meals and lunch was served at leisurely placed. Plenty of hot and cold drinks and snacks were served at other times during the day.

We saw that pureed foods were served together; they were not served individually to retain the colour and texture. We brought this to the registered manager's attention and we were informed the components of the meals would be served individually from now. This helped to ensure meals also looked more appetising.

The registered manager told us that a high number of people living at the home had a diagnosis of dementia

or suffered with some memory loss. When we toured the home we noticed patterned carpets. Some people with dementia can find patterned carpets difficult, as they may see things such as swirls move. We suggested to the registered manager the use of an environmental assessment tool to look at the home from a dementia-friendly point of view. This could also, for example, include the use of handrails painted in a contrasting colour to walls, so they were easy for people to see. There was little if any signage in the communal areas or on any corridor that would help people living at the home to find the way, or to be stimulated mentally by such engagement with their surroundings. The registered manager agreed that as more people with memory loss were now taking up residency, it would be useful to use such aids/tools to help support people. During the inspection no one living at the home raised any concerns regarding the environment and they said they knew their way around.

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We asked staff we spoke to what the Mental Capacity Act 2005 (MCA) meant to them. Staff told us, "The Mental Capacity Act is a regulation that protects people. It can be about very small or very big decisions" and "Everybody is deemed to have capacity to start with. The GP might do a mental capacity assessment or we get in touch with the Community Mental Health Team." Staff told us an example of people coming together to make a best interest decision for a person and how this was recorded. This decision was about whether the person should have an eye operation on their cataracts or not, weighing up the benefits and burdens. We saw 'do not attempt cardio pulmonary resuscitation' (DNACPRs) in people's care files and people had been involved with this decision.

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). The registered manager had submitted applications and this was subject to on-going monitoring. We saw on approved application and this was linked to the person's plan of care.

Good

Is the service caring?

Our findings

We asked people if they were treated with dignity, respect, care, kindness and compassion. People said, "Yes, they're pretty good and kind", "I'm treated very well, they're kind and respectful and I get treated with dignity" and "They treat me as an equal, I can't complain about the staff at all." People said the staff listened to them. Relatives also reported that the staff were kind and caring and had time for them and their family member.

We spent time observing and listening to staff to see how they interacted with people they supported. We saw were attentive to people's needs and calls for assistance were answered promptly. A staff member said they did not leave people waiting as this would cause distress. The staff's approach was kind, warm, caring and respectful; it was evident the staff knew and understood people's individual needs and wishes. We observed good interaction between staff and the people they supported. There was a warm friendly atmosphere and people appeared at ease and comfortable in the presence of the staff. Staff took time to support people at their own pace, no one was rushed. When supporting people they explained what they were going to do and did not leave the person until they were satisfied that they were comfortable and had everything they needed.

Staff were available to offer encouragement over lunch and staff checked to make sure people had enough to eat and had enjoyed their meal. In the morning there was less staff interaction in the lounge as staff were busy helping people with their personal care. People told us the staff did not always have time to sit and chat but they appreciated this was because they were busy elsewhere.

People told us the staff knocked on their door before entering and waited until they had been given permission to enter. People told us their door was closed when receiving personal care and when they had visitors. This we observed on inspection. At the time of our inspection there were no male staff working at the home. We saw however that the preference around male and female staff to support people was recorded in people's plan of care following a discussion with them, as a mark of respect.

We asked staff how they promoted people's dignity and respect. Their comments included, "Residents are letting us know when we are doing the right thing, 'thanking' us in their way, for example, means we are doing it right" and "We respect residents' decisions, for example, whether they want to join in with the social activities or what time residents like to go to bed and get up." Staff told us they ensured each person's quality of life was maintained, as was their confidentiality. A staff member said, "Just do not tell anything about anyone (to people who do not need to know). Treat people as you want to be treated."

When we toured the home, we saw red X's on some people's bedroom doors. The registered manager explained these meant that the person had an order in place to "Do Not Attempt Cardiopulmonary Resuscitation". The registered manager told us people had agreed to these. We discussed with the registered manager whether this was the most dignified and confidential way to share this information. The registered manager said this would be discussed further with the provider and staff.

We saw that advocates such as, family members, were involved (where appropriate) with their family member's care. We saw that one person had an independent mental capacity advocate (IMCA). 'IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options'. Details of a professional company who offered an advocacy service were displayed. The local authority's advocacy service details were not available and the registered manager said they would access these.

Good

Is the service responsive?

Our findings

We talked to people about the social activities arranged in the home. People said, "I'm very limited getting around. I can read for a while and I like to get out for a bit with a carer", "The television is on and I enjoy the activities", "I go out a lot, watch TV and knit. I don't like the activities" and "I've got my telly and my music and talking books. That keeps me going and visitors pop in." We spoke with a person who spoke highly about the service and said, "Everything is good here." One person told us how much they had enjoyed the service where a harpist played for everyone; they said it had been wonderful and that hopefully the harpist would visit again for Christmas. Relatives told us they could visit their family member any time and that the staff arranged nice activities.

There was an activity board in the main hall way. This held a lot of information about the activities and was written in an amusing way. This included board games, movie and popcorn, sing-a-long, bingo, chair exercise, chiropodist and nails. It was however in small print and people told us they did not look at it. We discussed with the registered manager making the information more accessible and in accordance with the Accessible Information Standard - 'to make sure that people with a disability or sensory loss are given information in a way they can understand'.

We spoke with the staff about how they engaged people with social activities which were of their choice. This included speaking with an activities coordinator. They told us, "We do chair exercise every morning at 10am, for 10 to 15 minutes. Then we have a cup of tea, we read or chat about the newspapers. We tell people what we will be doing in the afternoon. Today for example, we are preparing for Christmas. Most people like Christmas. Residents made all the Christmas cards; they like to do painting, colouring and things for the season." During the inspection the Christmas tree was being decorated and on the second day of the inspection staff played a card game with people in the lounge. This appeared to be enjoyed by everyone who took part. A Christmas party was taking place before Christmas and relatives were invited for a festive lunch with carols. On our tour of the home we saw that people had made Christmas cards which were on sale to visitors. The home was also attractively decorated for Christmas.

We asked staff how people were involved in the choice of social activities. Staff told us, "We ask, 'what would you like to do? We approach everybody and give choices, such as hairdressing. When we asked one of the residents if they would like to try something new, they said they would like to do knitting. So we started knitting with (person), a baby blanket to start with" and "We do all sorts of games try to do different activities", "Some residents might want to do something different after 10 minutes, so we offer other things such as boules or skittles", "Some people like to fill their pockets with leaves, because they enjoy the feel" and "A resident with reduced sight enjoys painting, working with beads and gluing buttons. All of the residents like to talk about their families."

Staff told us that people in the care home come from all different kinds of backgrounds. This included people having different beliefs. Staff told us to meet the religious needs of people Holy Communion was offered in the home. This was a multi-faith session which everyone could attend.

There was a calendar in the main hallway which displayed the date, time, season and weather conditions. A person told us this was a good idea as they liked to know what the weather was 'doing'.

We looked to see how people were involved with their assessment and plan of care and how relatives were included in this process. We saw evidence of people's/and or their relatives inclusion in the care planning. This was well documented and a family review sheet was completed by the staff and relative when the care was reviewed. A person told us, "I am always asked and consulted about my health and my care."

The care documents provided information around people health, their care needs and a 'journey of life' recorded information in respect of family back ground, preferred interests, likes and dislikes and routine. We also saw that people's communication was assessed and recorded in their plan for care along with reference to an impairment or sensory loss. This included non verbal signs, such as facial expressions and gestures. Discussions with staff confirmed their understanding and knowledge of people's needs and how they responded to the different ways people liked to communicate.For example, one person liked to walk around the home in suitable night attire, rather than getting dressed. The staff told us how they facilitated this. Another person liked to hold a doll as this provided comfort to them. A staff member told us of the importance of the doll to this person and how it provided an effective means of communication.

We saw that for people who may present with a behaviour that may challenge staff were completing a chart to help monitor when these behaviours occurred and any triggers or distress. The chart also helped staff to understand what the behaviour was communicating to the staff and how to respond appropriately.

Staff told us they were informed of any changes within the home, including changes in people's care needs through daily handovers viewing people's care files. A staff member said, "People's needs change. We need to ask what they prefer. In each person's room there is a file that contains the person's preferences. A person might always want coffee, but we always offer choices, because some days the person might want tea instead."

Staff also told us how they completed care records, for example, people's food and fluid intake. Staff went on to tell us how they responded to a change in people's needs; this included recording this change in the risk assessment and plan of care. Staff explained that this would include assessing what needs would have to be met through outside agencies to support the person concerned. When reviewing peoples' care files we saw how changes to people's plan of care and treatment was recorded. This was carried out with the involvement of the person and their relative.

People told us the staff were prompt in responding to calls for assistance. Their comments included, "Yes, they answer the buzzer quickly "and "They (staff) are here fast, but I don't press it unless I have to". A relative told us, "(family member) doesn't have to wait a long time. We were told they (staff) aim to answer it within 10 seconds." We saw staff answered calls for assistance in a timely manner.

At the time of our inspection no one living at the home was receiving end of life care. The registered manager informed us that the district nurse team and doctors would provide support to people and staff at the appropriate time. We saw people and relatives completed an advanced plan of care. This recorded information relating to future wishes, for example, whether the person would prefer to stay at the home or be admitted to hospital, their priorities of care and funeral arrangements. Staff told us they had received some training around end of life care. A person said, "The girls have such a wonderful nature and they always deal with things like this in a sensitive way, they have helped me so much."

The home had a complaints' procedure and this was displayed for people to see. We saw that the

complaints policy was dated 16 December 2015 and had been due for review by 2016. The people's complaints' procedure came in a booklet. The registered manager informed us this was due to be reviewed and this would be actioned shortly. We saw that the last entry in the complaints' log was made in 2016 and the registered manager told us they had not received any complaints since then. We discussed that people may sometimes not think of something they would like to change as a complaint. A clearer guide for people could strengthen a culture where making suggestions, voicing concerns or complaints was not just accepted but seen as helping the service to continuously improve. No one we spoke with raised any concerns during the inspection. A person told us they would have no hesitation in speaking up if at all worried. They went on to say they had confidence the staff would 'sort things' out quickly.

Good

Is the service well-led?

Our findings

The registered manager had worked at Dalemain House since 2014 and was promoted from deputy to registered manager in 2016. We spent time talking with the registered manager and asked them to tell how to define the culture of the home and the main aims and objectives. Through discussion it was evident that the needs of the people living at the home came first and staff were committed to providing a 'homely' environment where people felt safe and well cared for. The registered manager appreciated that the need to look at the environment in terms of supporting people with memory loss was an area of further development and this would be explored with the provider.

People living at the home were on the whole complimentary regarding the overall management of the home. We asked people what everyone liked best about the home. They told us, "The way the day goes by", "The friendliness of the place, I class this as my home", "You get no bills, there's no worries, if the roof fell in it's someone else's problem." Relatives' comments included, "It's homeliness and there are no nasty smells. Everyone seems to be well looked after, the staff are friendly and we didn't find anywhere better" and "It's just that (family member) is happy, "(family member) is warm and fed." Some comments were raised regarding the home needing more staff at times to support with personal care and also there being more privacy afforded to people in the lounge. This was in relation to people receiving visitors in this communal area. These comments were brought to the registered manager's attention for further discussion.

We talked with people about the registered manager's leadership. People told us they knew who the registered manager was and that they saw them most days. Their comments included, "The boss is really good", "The manager is very good, very efficient", "The manager is good, (registered manager) is fair and (registered manager) listens to you" and "If you need to speak to (registered manager), they always have time for you." We saw the registered manager had a visible presence in the home.

The registered manager and staff were aware of their responsibilities and there were clear lines of accountability. The registered manager reported day-to-day issues to the provider so they had a good knowledge of how the home was operating. We saw the provider was supportive and staff told us they were present most days. People were a little unsure of the frequency of the provider's visits however one person reported, "The owner is here all the time".

Staff spoke with great respect about the registered manager and said they were fair and were willing to listen to their views. Their comments included, "The (registered manager) is amazing, (registered manager) delivers best quality. (Registered manager) does not even need to tell us to do things, we just do it."

We talked to the staff about the ethos of the home. Staff were positive about the culture being open and transparent. Staff said, "Everybody works with the same goal. New staff need to work together. Everybody has the same good standard. I am proud of myself" and "The aim is to progress, keep doing training. We want the best quality of life for residents – it is a rest home." Staff understood what whistle blowing meant and said they would always speak up.

Staff meetings were arranged and staff surveys also sent out. The registered manager told us about the changes they had made to the induction for new staff and to the staffing rota in response to the comments received.

With regards to monitoring staff training we saw that the home used a 'scoring and comparing' approach for supervisions and appraisals. This meant that staff would note how they thought they had done in different areas; this was then compared with their line manager's view on the same score. This approach provided a good opportunity to check staff awareness of their own development needs and whether people were working towards the same goals.

We reviewed some of the quality assurance systems in the home to monitor performance and to drive continuous improvement. The registered manager was able to evidence a series of quality assurance processes and audits which had been developed to provide a detailed over view of how the service was operating. This included areas such as, infection control, medicines, health and safety checks on services and equipment and care plans reviews. We saw a three monthly building audit which highlighted work to be undertaken in January 2018 to replace some windows. A three monthly in-depth monitoring check was also undertaken and this included areas such as, fire safety, staffing, the premises, record keeping and care planning. Actions were recorded and signed off on completion and any matters arising were dealt with promptly. We advised the registered manager to record the work needed for the bathroom which was currently out of use for maintenance work.

We looked at how people's views were canvassed about the home. The registered manager told us that individual meetings were held with people living at the home and their relatives rather than holding collective meetings. We saw feedback about the home was sought from people and their relatives at the care reviews. One relative reported, "Dalemain House, first class. Could not ask for better attention." People we spoke with were unsure of the frequency of these meetings however no one requested a residents'/group meeting when we mentioned this to them. A person said, "I am more than happy with the arrangements and would speak to (registered manager) if I wanted to."

In September 2017 people and their relatives were given satisfaction surveys to complete. The emphasis of the surveys being around ensuring the wellbeing of the people living at the home. The comments received were very positive. They included, "Very satisfied overall", (Family member) is very happy and content", "Staff are very friendly and appear to be very caring towards the residents", "Home from home" and "Overall opinion is that the staff really care for their residents, this is demonstrated with empathy, love, care and attention." With reference to the home' strengths, the following comment was made, "Big enough to manage, small enough to care." A comment raised regarding the pathway being steep to the front door had been followed up by the registered manager.

The registered manager had notified CQC of events and incidents that occurred in the home in accordance with our statutory notification requirements. The registered manager had recently attended a training session on the CQC's revised key lines of enquiry which we use when inspecting services to help us assess standards. We saw a poster in the registered manager's office showing the key questions we ask to support everyone in the provision of service where people and staff felt safe and supported.

From April 2015 it is a legal requirement for all services who have been awarded a rating to display this. As there has been a change of legal entity for this service the rating awarded for this inspection will be displayed following this inspection.