HC-One Limited

Dingle Meadow

Inspection report

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22 March 2016
23 March 2016

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 22 and 23 September 2015. At which a breach of legal requirements was found. This was because the provider had failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff in the home deployed to meet the needs of the people living there.

After this comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. We undertook this focussed inspection on the 22 and 23 March 2016 to check that the provider had made and sustained the improvements they had told us they would make.

This report covers our findings in relation to those requirements. It also covers some additional information that we looked at on the day. You can read the report from our last comprehensive inspection, by selection the 'all reports' link for Dingle Meadow on our website at www.cqc.org.uk.

Dingle Meadow provides accommodation and personal care for up to 46 older people. Some people lived with dementia. At the time of our inspection 40 people were living at the home.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service us run.

At this focussed inspection of 22 and 23 March, we found that some improvements had taken place to ensure staffing levels in the home reflected the dependency levels of the people who lived there.

We found that people living at the home had not received their medication the evening prior to the inspection taking place. This had impacted directly on the health and wellbeing of some people living at the home.

We found that appropriate arrangements had not been made to ensure that agency staff were given an induction and handover prior to them commencing on shift at the home.

Systems in place to ensure that sensor mats were regularly checked to ensure they were working effectively were not consistently applied, leaving people at risk of harm.

You can see what action we told the provider to take at the back of the full version of this report.

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 is not safe.

Staffing levels were being assessed according to people's individual needs, which were regularly reviewed. However, not all staff were equipped with the skills and knowledge required to keep people safe from harm.

An additional member of staff had been recruited on to shift and people told us this had made a difference.

People did not receive their medication as prescribed which had an impact on some people's health and wellbeing.

Systems were not in place to check equipment to ensure it was working appropriately in order to keep people safe.

Dingle Meadow

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.

We undertook this focussed inspection on 22 and 23 March 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our inspection on 22 and 23 September 2015 were in place. We inspected the service against one of the five questions we ask about services; is the service safe. This is because the service was not meeting some of the legal requirements in relation to that question.

The inspection was undertaken by two inspectors and an expert by experience. An expert by experience is a person who has experience of this type of service. As the registered manager was on leave, we spoke with the deputy manager, the operations director, a manager of another home who was supporting the deputy, six members of staff, 14 residents, seven family members and three members of the local authority contracts and commissioning services. We reviewed the arrangements the service had in place for the deployment of suitably qualified staff to meet the needs of people living at the service. We had received information about an incident regarding equipment and keeping people safe. We used this information to assist us in our planning of the inspection and looked at what actions the provider had taken in response to this.

Requires Improvement

Is the service safe?

Our findings

At our comprehensive inspection on 23 and 24 September 2015 we found that the provider had failed to provide sufficient numbers of suitably qualified, competent, skilled and experienced staff who were deployed in order to meet the needs of the people living at the home. People told us that they did not have their needs met in a timely manner. Relatives and staff spoken with all raised concerns regarding staffing levels. We observed there were periods where no staff were present in the lounge as staff were busy supporting other people. We were told that staffing levels were determined by the number of people living in the home and not their dependency levels. This meant there was no allowance in place for when people's dependency levels changed and this had a direct impact on the people living in the home and the staff who supported them.

At our focussed inspection on 22 and 23 March 2016, we found that the provider had taken a number of actions to improve staffing levels. We saw that each person living at the home had their dependency levels assessed. This information was used to assess the number of staff required to support people living in the home. We noted that an additional member of staff had been employed on shift during the day. Senior staff had recently completed training on how to lead and run a shift and daily shift allocation sheets had been introduced, which identified roles and responsibilities for each shift.

People told us they thought there were enough staff to support them and meet their needs. One person said, "Yes [they have enough staff], I've got no complaints" and another said, "Yes I'm alright". Another person told us, "At times yes. Yesterday they were a bit pushed and at the weekend". People told us that they didn't have to wait long to be supported. One person told us, "Not long at all" and another said, "They're pretty quick actually". One person who required additional support told us, "The staff are lovely. I like to go to bed at 10.30 pm but some nights I'm kept waiting until 11.00 pm before I go to bed" a member of staff spoken with confirmed this to be the case and told us, "[Person] is kept waiting sometimes if there are only two of us around and the senior is giving out medication".

Relatives spoken with gave us a mixed response in terms of staffing levels, comments received were, "I've always found plenty [staff] here. It's very rare we've come here and haven't seen anybody", "There are definitely enough staff, I've come here every week since November, usually in the morning. I've never seen anything untoward", "There is [enough staff] today, but sometimes there isn't" and, "At times, no, definitely not. They're rushed off their feet. What ties them up is going to answer the door". We discussed this with a member of staff. They told us care staff were given pagers that would alert them to people's call bells in their bedrooms, but they also alerted them to the door bell and were expected to respond to that as well. A member of staff told us, "The pagers have helped, but it has an impact as it's used for the doorbell so only carers are aware of the doorbell going". This meant that care staff were not always able to respond to people's requests for support in a timely manner, as they were constantly answering the door to the frequent number of visitors to the home.

During the inspection, we found that medication had not been dispensed to people the previous evening. We were not told of this incident when we arrived; it was bought to our attention by another visiting

professional, at midday. We spoke to the deputy manager who informed us that she had been made aware of the incident when she arrived in the morning and she had immediately reported her concerns to safeguarding and her operations director. However efforts had not been made to contact people's GP to discuss the potential impact of missed medication and any action required to keep these people safe.

We looked at the medication records for the people who had missed their night time medication. We saw in three specific instances, there was an impact on people not receiving their medication. One person had not received their pain relieving medication and medication to assist with their breathing. We saw another person who was agitated and frequently distressed during the day had not received their medication to reduce their anxiety and agitation. Another person who had not received their eye drops complained of pain in their eye the following day. We discussed the concerns with the deputy manager. We were told that an agency member of staff was responsible for running the shift that night and administering medication. We saw that no induction had been put in place for agency staff and there was no clear guidance for them to follow. This meant that people did not receive the support they required as staff were not suitably skilled and aware of their responsibilities. Following this, arrangements were made for an induction to taken place for the agency worker who was arriving the next day. We visited the following day and spoke to the agency worker who confirmed that they had been given an induction and that everyone who required medication that evening, had received it.

Our findings at this inspection demonstrated that staff did not always have the skills and competencies to meet people's care needs and keep them safe at all times. This meant that despite some improvements, there was still a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Prior to our visit we had been told about an incident involving the use of a sensor mat (sensor mats are used to alert staff as to when people get out of bed). We were told that in response to the incident, lessons had been learnt and a checklist would be completed to ensure each person's room was 'fit for purpose' and that the sensor mats were operating correctly before they retired to bed.

We looked at the care files of the people who had sensor mats to ensure these checks were taking place. We saw that risk assessments were in place for the mats, but there was no indication on the assessments as to how often the mats should be checked. We saw that the forms used for recording these checks were inconsistently completed. For example, a number of entries on the forms did not record that the sensor had been checked, but instead held comments such as, 'assisted to bed' or 'asleep'. We spoke with staff to clarify their understanding of the forms and the checking of the mats. One senior member of staff told us, "The maintenance man checks them, [sensor mats]. There are so many things to do, things can get missed". They told us they thought the mats should be checked twice daily but they were not confident that this was happening. They said, "It's not been explained to us properly how to fill it in [the form]. Everything is getting changed, I can't keep up". Another member of staff told us they knew at the start of a shift that they had to check if the service user was ok and carry out visual checks of their room but they weren't aware of a system being in place for checking the sensor mat was working.

This meant that lessons had not been learnt following the incident as staff were not clear of their roles and responsibilities regarding the completing of the checks and had not received guidance and training on how to keep people safe in respect of this concern.

We spoke with the deputy manager and asked what audits had been put in place to ensure these checks were being carried out. She told us she had instructed staff to audit five random supplementary files every night and to list the details on handover sheets, but there was no evidence that this was being done. The deputy told us that she had instructed staff verbally, but there was nothing in writing to confirm this. This

meant that despite assurances that systems were being put in place to ensure the safety of people living in the home, the registered manager could not be confident that people who were at risk of falling were being protected appropriately by staff on shift.

This was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

On the second day of the inspection, we were made aware of another incident that had occurred the week before. We are currently working with the relevant authorities in respect of this incident.

Staff spoken with told us that improvements had been made in staffing levels and the allocation of work on each shift had made a difference to care delivery in the home. One member of staff told us, "Staffing is not too bad; I haven't seen people kept waiting". They told us that there were fewer people living at the home who required more than one person to support them. They told us, "It was more manic previously, it feels a lot better now". Another member of staff told us, "The staffing has improved, we have an extra person working on shift and it has made a difference. It was the morning that was the problem because we had so many dependencies. Since this has reduced it has made quite a difference". Another member of staff said, "It [staffing] has improved. It's better when we have three on in the morning. When it's been two carers it's been rushed". Senior members of staff had attended training to assist them in how to manage and lead and shift. Staff spoken with talked positively about this training and how they felt they had benefitted from it. One member of staff told us, "It has made a difference, some staff do need leadership" and went on to describe the impact it had made on distributing workload evenly across the two floors of the home. Another member of staff said, "I have seen a difference, things have improved". We observed that the atmosphere in the home was calm, and staff responded to people's needs in a timely manner.

Everyone we spoke with told us that they felt safe living at the home. One person told us, "Yes [I feel safe] everyone's nice to me. I've got no complaints at all" another person told us, "Yes, [I feel safe] because of how many people are here. You're never on your own. Even in the night they check to make sure you're still alive!" and another person said, "Yes, we're safe. No doubt about it". Relatives told us they were confident their loved one was safe in the home. One relative told us, "Yes. There's somebody in the room at all times" and another said, "Yes, There's always someone around and they seem very vigilant anyway. She's got a buzzer to hand. She is as safe as she possibly can be".

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 did not take formal enforcement action at this stage. 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 Care and treatment must be provided in a safe way for people. Risks must be managed to ensure the health, safety and welfare of people using services.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always have the skills and competencies to meet people's care needs and keep them safe at all times.