Dunsfold Limited

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Inspection report

Dunsfold Ltd
West End, Herstmonceux
Hailsham
East Sussex
BN27 4NX

Tel: 01323832021

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We inspected Dunsfold on the 12 January 2017 and the inspection was unannounced. Dunsfold provides accommodation for up to 18 older people living with dementia. On the day of the inspection, there were 13 people living at the service. Dunsfold is a residential care home that support older people living with dementia and disabilities associated with old age such as limited mobility, physical frailty or health problems such as diabetes. Accommodation was arranged over two floors with stairs and a stair lift connecting each level.

There was a registered manager in post. 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.

Although people and staff spoke positively of the service, we found the service was not well led. The provider's internal quality assurance system was not robust and failed to identify shortfalls we observed during the inspection. Accurate and complete records had not been maintained and policies and procedures had not been reviewed or updated to reflect best practice guidelines.

Staffing levels were not based on people's assessed needs. The deployment of staff was insufficient and healthcare professionals raised concerns over the visibility of staff within the service. The principles of the Mental Capacity Act 2005 (MCA) were not embedded into practice and conditions attached to Deprivation of Liberty Safeguards (DoLS) had not been acted on. The provider had failed to display their performance rating on their website and had not consistently notified the Care Quality Commission of significant events.

The provider and registered manager were unable to demonstrate how they followed and embedded best practice guidelines on the delivery of dementia care. Consideration had been given to making the environment dementia friendly, but further work was required. We have identified this as an area of practice that needs improvement and made a recommendation for improvement.

People did not have regular access to call bells. Risks associated with the environment and premises had not been mitigated or risk assessed. Radiator guards were loose and people's bedrooms were not consistently personalised. One person's bed had been made with a soiled quilt cover. We have identified these as areas of practice that need improvement and made recommendations for improvement.

Care plans were in place and person centred. However, guidance on the management of catheter care and supporting people who may not be oriented to time and place was not sufficient and lacked detail. We have identified this as an area of practice that needs improvement and made a recommendation for improvement.

The risk of social isolation had not been mitigated and people did not have regular access to activities that

were meaningful. Healthcare professionals also raised concerns over the lack of stimulation and interaction for people.

The management of medicines was safe. People received their medicines on time and staff told us how they minimised the use of medicines to manage behaviours. A programme of essential training was in place and staff told us that they felt supported and valued as employees. One staff member told us, "I really enjoy working here."

People spoke highly of the food provided. One person told us, "The food is very nice." Dietary requirements were catered for and people were maintaining a stable and healthy weight. People had regular access to healthcare professionals and the GP either visited the service weekly or conducted weekly telephone consultations.

Staff spoke highly of the people they supported and it was clear that staff had spent time building rapports with people. People's privacy was respected and staff demonstrated a caring approach to the people they supported.

Recruitment practice was safe and staff demonstrated a clear understanding of adult abuse and said they would talk to the management or external bodies immediately if they had any concerns, and they had a clear understanding of making referrals to the local authority and CQC. People said they were comfortable and felt safe living at the service.

The companionship that pets bring to older people was recognised by the registered manager and provider. The service had a cat that lived on site and people enjoyed spending time with the cat.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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

Dunsfold was not consistently safe.

Staffing levels were not based on people's individual assessed needs. The deployment and visibility of staff was poor.

Risks associated with the environment and premises had not been adequately addressed or mitigated. People did not have regular access to call bells.

The management of medicines was safe and risks associated with behaviours which challenge were managed and risk assessments were in place. Staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety.

Is the service effective?

Requires Improvement

Dunsfold was not consistently effective.

The principles of the Mental Capacity Act 2005 (MCA) were not embedded into practice. Conditions attached to Deprivation of Liberty Safeguards (DoLS) had not been actioned.

Staff received appropriate training and support to enable them to meet people's needs. People had access to external healthcare professionals such as the GP and district nurse when they needed it.

People spoke highly of the food provided. Dietary requirements were catered for and one to one support with eating and drinking was provided.

Is the service caring?

Good

Dunsfold was caring.

The companionship pets bring to older people was recognised by the management team and the home had a cat on site for people to pet and stroke.

People's privacy was respected by staff and staff had built positive relationships with people. People were supported to be independent. Systems were in place for people to be involved in decisions about their care.

Is the service responsive?

Requires Improvement 

Dunsfold was not consistently responsive.

The risk of social isolation was not consistently mitigated. People told us they did not have enough to do. People did not have regular access to meaningful activities.

People's care needs had been assessed and a care plan formulated. Systems were in place for people to provide feedback on the running of the service.

Is the service well-led?

Inadequate 

Dunsfold was not well-led.

The provider had failed to establish quality assurance systems which were used to drive improvement. Shortfalls in documentation had not been identified and the provider's internal quality assurance framework was not robust.

Policies and procedures had not been updated and reviewed in line with changes in policy and legislation.

Significant events had not been reported to the Care Quality Commission (CQC).

Dunsfold Ltd

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.

The inspection took place on the 12 January 2017 and was unannounced. The inspection was carried out by two inspectors.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

Before the inspection we checked the information that we held about the home and the provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We spoke with six people, registered manager, provider (owner), a chef and two care staff. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. After the inspection, we gained feedback from six healthcare professionals. Their comments can be found in the body of the report.

We looked at eight care plans and associated risk assessments, three staff files, medication administration record (MAR) sheets, incidents and accidents, policies and procedures and other records relating to the management of the service. We also 'pathway tracked' people living at the home. This is when we followed the care and support a person has received and obtained their views. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

We lasted inspected Dunsfold in December 2014 where we rated the service as 'Good.'

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Dunsfold. Observations of care demonstrated that people were comfortable in the presence of staff. People's behaviour also showed us they felt safe. People responded to staff with smiles and one person told us, "Yes there are no risks here. I feel safe." Another person told us, "I have no worries here." However, despite the positive feedback, we identified areas of practice which were not safe.

A systematic approach to determining and reviewing staffing levels was not in place. Staffing levels consisted of three care staff throughout the day and two staff at night. We asked the registered manager how they ensured that staffing levels were based on the individual needs of people. The registered manager told us, "Staffing levels have been this way since I've been in post and I started in 2014." We queried whether staffing levels had increased based on people's change in needs or the service being at full capacity. The registered manager told us, "Last year, we had a couple of weeks where we were at full capacity; however, staffing levels remained the same." On the day of the inspection, a person living with dementia had been recently admitted for respite care. Staff told us how it had taken all three of them to support the person with personal care that morning. We queried why staffing levels had not been increased based on the new admission and the impact of a new environment on the person. The registered manager told us, "Staffing levels have always been three care staff in the morning and three in the afternoon." The registered manager was not able to demonstrate that staffing numbers in the service reflected individual's needs. Staff members had mixed opinions around staffing levels. One staff member told us, "We could do with more staff. Take today for example, we were behind as it took three of us to assist one person with personal care. Weekends can be busy but we manage." Another staff member told us, "If people go off sick, it can be struggle but we always manage. I would say that activities are lighter at weekends as one of us has to cook as well."

Staff members were required to provide personal care, along with provision of activities, cooking, giving out medicines and cleaning at weekends. A cook was employed five days a week, however, at weekends; this responsibility fell to care staff. The provider was unable to demonstrate how these tasks were factored into the assessment of staffing levels. The absence of a formal systematic approach to determining staffing levels, also meant the provider was unable to demonstrate how two staff at night was sufficient in the event of the home needing to be evacuated in an emergency. Personal evacuation plans identified that everyone required support to safely evacuate in the event of a fire. Two people's personal evacuation plans stated that they were unable to weight bear and required the assistance of two staff members to help them evacuate the area of a fire. This meant that whilst the two staff were helping the two people evacuate the premises there would be no staff available to remain at the assembly point to ensure the safety of the other people in the service. Additionally there would be no staff available to meet with the fire and rescue crew as detailed in the fire evacuation plan for the service. This placed people at risk of moving back toward a fire in the premises. People's bedroom doors were also not fire doors (fire doors provide an additional safeguard in the event of a fire and enable people to remain behind a fire door for additional 30 minutes), which meant the provider would be unable to operate a 'stay put policy.'

Healthcare professionals also raised concerns around the visibility and deployment of staff. One healthcare

professional told us, "I can often be let in by the cleaner or cook and have to hunt for [care] staff." Another healthcare professional told us, "The visibility of staff is poor; people are left unattended in the lounge area." A third healthcare professional told us, "Often one member of staff is acting as the carer, cook and cleaner. It can be very difficult to find staff." Observations throughout the inspection, found that staffing levels were stretched at times. Staff responsibilities meant that at times staff left people unattended in the communal lounge. For example, when providing personal care to people during the morning and when preparing supper in the evening.

Failure to have sufficient numbers of staff deployed to meet people's needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Risks associated with the safety of the environment and premises had not safely been mitigated or addressed and the décor of the service required refurbishment. Banisters and doorframes were significantly worn and chipped. Sink fittings in some bedrooms were worn with exposed chipboard. This posed the risk of further deterioration and being unable to be adequately cleaned. Radiator guards throughout the service were loose and coming away from the wall and one handrail on the stairs was loose and at risk of coming away from the wall. Information produced by the Health and Safety Executive advises that all free standing wardrobes should be assessed and fixed to the wall to mitigate the risk of being overturned or pulled down by 'residents'. We found that all wardrobes within the service were free standing and adequate risk assessments were not in place.

Throughout the service were various slopes and ramps which posed as a potential trip hazard. Hazard warnings were in place on the flooring, but were significantly faded. The provider told us, "These are regularly repainted but they fade easily." However, interim measures were not in place to identify the trip hazard. One ramp between the lounge and hallway was a free standing ramp and had not been fixed to the bannister. This posed the risk of the ramp coming away from the bannister and presented as a possible falls risk. The stairway in the service overhung the hallway and a restricted head height was not marked as a danger. A toilet seat in the staff toilet was broken and no adequate hand washing facilities were available. Although this toilet was designated as a staff toilet, it was opposite a 'residents' bedroom who could freely access it. In the main hallway, the levels in flooring changed and a step was present. The hazard warning sign on the floor was not readily visible and there was no hand grab rail to assist 'residents' with the step. At the end of the inspection, the provider had taken action and asked the maintenance worker to fit a hand rail. However, the provider was dependent upon inspectors to identify this shortfall.

Guidance produced by the Health and Safety Executive (HSE) advises that water temperatures within care homes should not exceeded 44c. Water temperatures above 44c place people at risk of scalding. The monthly water temperature checks from December 2016 recorded that the water in five people's bedrooms was 45c. Documentation failed to reflect what action had been taken, whether the water valve was readjusted or whether the temperature was tested again. We brought these concerns to the attention of the registered manager who confirmed the maintenance worker would retest the water immediately. After the inspection, the registered manager sent us evidence that the water temperatures were no longer exceeding 44c. Documentation confirmed that water temperatures had not previously exceeded 44c. However, the provider and registered manager were dependent upon inspectors to identify this shortfall

Incidents and accidents reflected that no harm had occurred to people as a result of the shortfalls with the environment and premises. However, the associated risks had not been mitigated and acted on. This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People did not have regular access to call bells. Each bedroom had a call bell point; however, only one

person had a lead attached to the call bell point on the wall. This enabled them to press their call bell from other areas of their room instead of having to press the button on the wall. The provider and registered manager told us, "Each person's ability to use a call bell is assessed and documented in their care plan." We found care plans recorded whether people could use their call bell, however, care plans failed to consider when people spent time away from the call bell point. For example when sitting in their chair or away from their bed, they would be unable to access the call bell as a lead or cord had not been provided. Also when lying in bed, they would be dependent upon sitting up and pressing the call bell button on the wall. For example, one person spent the day in their bedroom during the inspection. Their care plan identified they could use the call bell; however, when sitting in their chair, they were unable to access their call bell as a lead had not been attached to the call bell point on the wall. The person's bedroom had been left open and staff could visibly check on them when walking past. However, they had been assessed as able to use a call bell, yet one was not readily available for them to access.

We recommend that the provider reviews all call bell risk assessments and the availability of call bells within the service.

The management of medicines was safe. There were systems in place to ensure the safe storage and management of medicines with organisational medicine policies and procedures in place for staff to follow. All medicines were stored in locked cupboards and within drug trollies with the keys held securely. Medicines were only administered by care staff who had completed additional training and competency checks. When administering medicines, staff followed best practice guidelines. For example medicines were administered individually with the Medication Administration Record (MAR) chart only being signed once the medicine had been administered. Staff clearly explained the purpose of the medicine to people and gained their consent to provide the medicine.

People's medicines were regularly reviewed by the GP and staff told us how they promoted the minimal use of medication to manage behaviours. One staff member told us, "One person has recently been taken off anti-psychotic medication which is good." Protocols were in the place for the use of 'as required' medicines and the temperature of the medicines cabinet was recorded on a daily basis to ensure medicines were stored appropriately.

Staff recruitment practices were thorough; people were only supported by staff who had been checked to ensure they were safe and suitable to work with them. Staff records showed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). A DBS check helps employers make safer recruitment decisions and prevent unsuitable people from working with people who require care and support. All potential employees were interviewed by the registered manager to ensure they were suitable for the role.

Staff had a good understanding of what to do if they suspected people were at risk of abuse or harm, or if they had any concerns about the care or treatment that people received in the home. They had a clear understanding of who to contact to report any safety concerns and all staff had received up to date safeguarding training. They told us this helped them to understand the importance of reporting if people were at risk, and they understood their responsibility for reporting concerns if they needed to do so. One staff member told us, "Safeguarding could be physical, verbal or sexual abuse. Any concerns I would go straight to the manager." Another staff member told us, "Any concerns I would go the manager or the local authority."

Staff were knowledgeable about the people they supported and specifically how to support people with behaviour which might challenge. One staff member told us, "We have one person who can be aggressive at

times and resistant to care at times. When resistant to care, if we offer them some space and say we'll come back in five minutes. They have calmed down. I always feel, how would I feel in that situation if someone was trying to assist me with personal care." Risk assessments were in place which considered how to manage behaviours which might challenge and provided clear advice and triggers for staff to be aware of.

Requires Improvement

Is the service effective?

Our findings

People spoke highly of the food provided. One person told us, "The food is very pleasant." Another person told us, "I do like the food, it is very nice." People felt staff were competent and knowledgeable. One person told us, "The staff are nice and know us." However, despite people's praise, we found areas of the service that were not effective.

People's rights were not always protected because the provider did not always act in accordance with the Mental Capacity Act 2005 (MCA). The 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. Mental health risk assessments were completed, which considered people's memory loss and social behaviour. However, mental capacity assessments had not been completed in relation to specific decisions the person was required to make. For example, mental capacity assessments had not been completed for decisions such as consent to care plans, restrictions imposed on people (such as the locked front door) or consent for care interventions. The registered manager told us, "We complete the mental health risk assessments, but not capacity assessments."

Training records confirmed staff had received training on the MCA 2005 and staff understood the principles of consent. One staff member told us, "We always ask people, is it ok to give you your medicines or what would they like to wear." Throughout the inspection, we observed staff gaining consent from people on where they would like to sit and what they would like to drink. However, the care planning process and documentation failed to evidence the principles of the Mental Capacity Act 2005 were followed.

People can only be deprived of their liberty so that they can 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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest and were unable to come and go as they pleased unaccompanied. Staff confirmed they had received training on DoLS and training records confirmed this. Some people had conditions applied to their DoLS authorisations. One condition noted that 'the managing authority should update their care plan to ensure they are reflective of the MCA. For example, care plans should clearly differentiate the type of decisions (person) has mental capacity to make.' Another condition included, 'the managing authority should explore opportunities to take (person) out from the home if they so wish.' We asked the registered manager to demonstrate how these conditions had been met. They confirmed that they had not acted on these conditions adequately. They commented, "We do offer to take the person out, but acknowledge this is not recorded."

Failure to work within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards Code of Practice is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Care and support was provided to a number of people living with a catheter in situ. A recent safeguarding had been raised around catheter care and learning from the safeguarding included the implementation of a urinary output monitoring chart. Each time a person's catheter bag was emptied, staff monitored the output. During the inspection, we observed a staff member identified that a person's output was very low and decided that they needed to encourage fluids. However, despite this good practice, we found that people's elimination care plans were not consistently detailed. For example, where people had a catheter in place their elimination care plans just stated, 'they had a catheter in place.' Guidance was not available on the signs of by-passing, what to do in the event of blood being in the catheter bag or the steps to take when staff felt the catheter was blocked or when to contact the district nurses.

We recommend that the provider seeks guidance from a reputable source about detailed catheter care plans.

Guidance produced by the Alzheimer's society advises that a safe, well designed and caring living space is a key part of providing dementia friendly care. A dementia friendly environment can help people be as independent as possible for as long as possible. Some consideration had gone into making the environment dementia friendly. People's bedrooms doors had their names on and a picture associated with their personality. For example, one person loved cats, so their bedroom door had a picture of cats on it to help them to recognise their bedroom as their own. Throughout the service, bathrooms were labelled with the universal sign of a 'WC'. However, signage to orient people to the lounge or dining room was not in place. Guidance produced by the University of Stirling dementia centre advises of the importance of lighting in dementia care homes. The dementia centre advised that, 'poor lighting can increase anxiety and may lead to trip and fall accidents if people cannot make sense of what is ahead of them.' Throughout the inspection, we found there was a reliance on centre light fittings. For people living with dementia, they need twice as much light as normal lighting standards and centre light fittings may not consistently provide this much light. People's bedrooms had no bedside or over bed light. Where a person did have a bed side lamp it was not plugged in. One person's centre light fitting was broken, so they were dependent upon their bedside light. Consideration had not been given to nationally consulted guidance on how to improve and promote the environment based on the needs of people living with dementia. The service had a large garden. Access to the garden was via the car park or through internal doors at the back of the building. Access from the back of the building was in the progress of being developed as there was no level access. This meant for people who required a walking aid, they would be unable to access the garden from that point within the service. The provider told us their plans to implement a safe and secure decking area.

We recommend that the provider seeks guidance from a national source on the design of dementia friendly environments.

Care and support was provided to people living with a swallowing difficulty. For people assessed with swallowing difficulty, the use of thickened fluids when drinking may be required to minimise the risk of choking. Thickened fluids are easier to swallow; however, the quantity and texture must be appropriate for the individual. Care staff were clearly aware of who required thickened fluids and the quantity of thickener to fluid. Input had been sourced from the Speech and Language Therapist (SALT) and dietician and the advice followed. A fortified diet was provided to all people to help maintain a stable and healthy weight. Documentation noted that people were maintaining a stable weight or putting weight on. Where people required a soft or mash-able diet, this was provided and one to one support with eating and drinking was provided when required. One person told us how they appreciated support from staff as they struggled to eat independently. The menu was on display in picture format for people in the dining room and on the day

of the inspection, people enjoyed chicken casserole. One person told us, "It's very nice today." Condiments were readily available and people were offered a choice of refreshments. A group of men sat together during lunchtime, engaging and conversing together, putting the world to rights.

Staff were aware of their roles and responsibilities to provide effective care. For new staff an induction programme was in place to ensure new starters received the appropriate training to enable them to provide safe and effective care to meet people's needs. New staff were able to shadow a current staff member until they were deemed competent and confident to provide care. There was a programme of training which included essential training for staff. Training included, moving and handling, infection control and safeguarding. The registered manager showed us a list of additional training that staff were due to attend. Training courses included; challenging behaviour, dementia awareness and dementia and responding to changes in behaviour. Staff spoke highly of the training provided and how they provided effective dementia care. One staff member told us, "I feel that we provide good dementia care as we understand our residents and listen to them."

Mechanisms were in place to support staff to develop their skills and improve the way they cared for people. Staff were encouraged to pursue National Vocational Qualifications (NVQs). The registered manager told us, "Four staff members have an NVQ level two and one staff member is in the process of finishing it. Staff are also working towards NQV level three and five." Staff also received regular supervision. Supervision is a formal meeting where training needs, objectives and progress for the year are discussed. Staff told us they felt supported within their roles and felt able to approach the registered manager with any queries, concerns or questions.

People were supported to have access to healthcare services and maintain good health. Referrals had been made to other health professionals when required. This included GPs, district nurses, dentists and chiropodists. A staff member told us, "We have a good relationship with the GP who will visit every Friday if necessary."

Good

Is the service caring?

Our findings

People told us that staff were kind and they enjoyed living at the service. One person told us, "The general atmosphere is nice." Another person told us, "It's rather good here." A healthcare professional told us, "Staff have good intentions."

During the inspection, we identified that one person's bed has been made with soiled quilt cover. This demonstrated lack of dignity for their possessions and personal belongings. We recommend that the provider seeks guidance from a reputable source on the importance of respecting people's belongings.

Despite the above concerns, staff told us how they treated people with dignity and respect. One staff member told us, "When supporting people to go to the toilet, I always ask, would you like me to leave the room." Throughout the inspection, we observed staff knocking on people's bedroom doors and gaining consent to go in. When supporting people with moving and handling, staff clearly explained the procedure to the person, providing care and dignity in the process.

Guidance produced by Age UK advises on the importance pets bring to older people and the registered manager had recognised this and enabled people to have pets. The registered manager told us, "A 'resident', who previously lived here, had a cat. Sadly they passed on, but the cat remained living with us. The 'residents' love the cat; he's very much a lap cat." Throughout the inspection, we observed the cat being waited on by people. One lady happily enjoyed spending their morning sitting next to the cat and stroking it. A staff member told us, "People love the cat. Although it has a name, it's amazing, how we all end up calling the cat by a different name."

People were supported to be independent and make day to day decisions. We observed that people were offered choices. For example, where to sit, what to eat and what they would like to do. Staff worked in partnership with people to promote their independence. One staff member told us, "When supporting people with personal care, I always encourage people to wash their own face." Another staff member told us, "When supporting people and drink, I always offer and say, do you want to try yourself before automatically assisting."

People were cared for by kind, caring and compassionate staff who knew them well. Staff spoke with compassion for the people they supported. One staff member told us, "I love my job; I really enjoy looking after the people." Another staff member told us, "The 'residents' are all lovely in their own way. I love listening to their life stories."

Soft toys can be a comfort to many people living with dementia. Staff told us how some people living at Dunsfold took great comfort in the companionship soft toys brought them. The registered manager told us, "We brought one person a soft toy for Christmas and they are never without it now." During the inspection, this was person spent their morning sitting with their soft toy which provided them with companionship and comfort. Another staff member told us, "One person has a group of soft toys which are a comfort to them and they call them 'her boys.' Staff understood and recognised the importance these soft toys held for

people.

Systems were in for people to be involved in decisions about their care and treatment. Each month, the registered manager completed a monthly review in partnership with the person and/or their representative. This review considered what was going well and any areas of care where their needs had changed. Feedback was obtained from the person. For example, the latest reviews considered how people found Christmas at Dunsfold.

Requires Improvement

Is the service responsive?

Our findings

People told us they felt comfortable living at Dunsfold. One person told us, "It's very comfortable." However, people had mixed opinions over the availability of meaningful activities. One person told us, "I don't do enough."

Guidance produced by Social Care Institute for Excellence advises that it is important that older people in nursing homes have the opportunity to take part in activities, including activities of daily living that helps to maintain or improve their health and mental wellbeing. People should be encouraged to take an active role in choosing and defining activities that are meaningful to them. An activity programme was on display which included activities such as social afternoon, old music, arts and crafts, old films and bingo. During the inspection, we observed a member of staff ask people individually if they would like to play bowling. This interaction was positive and encouraged involvement from people and in return people were keen to participate. The staff member commented, 'we'll play a couple of games then have a cup of coffee, how about that?' The staff member maintained engagement skills throughout the activity, tailored it to individuals and made it fun. People appeared to enjoy the sounds and feel of the game. However, the remainder of the day, the only interaction and stimulation for people was the television. A staff member in the afternoon had a chat with some people about their music preference and memories, however, this interaction was not used to plan other meaningful activities for people.

Healthcare professionals told us of the concerns they had around the lack of meaningful social activities. We received unanimous feedback from healthcare professionals that whenever they visited the service at various times of the day, they never saw activities taking place. One healthcare professional told us, "My main concern is that people are just sitting in front of that television all day. I have never seen an activity take place." Another healthcare professional told us, "Staff never seem to be interacting with people; they are just sitting in the lounge." We asked staff how the provision of activities was based on people's likes and how activities promoted emotional, social and psychological well-being. Staff were unable to describe how activities were tailored to people's likes. For example, one person was a keen gardener and bird watcher, yet there was no activities based on their likes and hobbies. We asked the provider and registered manager if any one coordinated the provision of activities. They confirmed that no one was specifically responsible for activities. This meant the provider was unable to demonstrate how they reviewed the activities available and how they assured themselves that activities were meaningful for people and promoted their quality of life.

During the inspection, we were informed that one person was on bed rest due to poor skin integrity. Documentation reflected that their skin was red, but had not broken down and there were no open wounds. Staff told us how they repositioned the person every two hours to reduce the risk of skin breakdown. Throughout the inspection, this person remained in their bedroom. We asked staff how the risk of social isolation was reduced. Staff told us how they would put the radio on for them in the background. However, we were unable to see any other steps to reduce the risk of social isolation. Healthcare professionals raised concerns to us that there was no clinical need for this person to be in bed all day. One healthcare professional told us, "Whenever we visit, they are always in bed and staff never seem clear when they were

last supported to sit in their chair or sit in their lounge." Another healthcare professional told us, "It would be nice for them to sit out for a couple of hours each day to aid stimulation." We looked at the daily records for this person dating back to the beginning of January 2017. We found that out of 18 days, this person was supported to access the lounge on two occasions. The 16 remaining days, they remained on 'bed rest'. The registered manager told us, "We've recently had a sickness bug within the service, so we decided not to bring the individual into the lounge and they are on bed rest due to poor skin integrity." Documentation did not consistently reflect the clinical rationale for the person to be on bed rest and reflected that their skin was intact, just discoloured. The impact of bed rest meant the individual's risk of social isolation was heightened. Apart from the radio and staff interaction when providing care, they remained in their bedroom all day with the door closed. We also reviewed a range of activity notes for other people. One person's activity notes for the week 1 November 2016 recorded that for most activities they were asleep or watching television. This was a consistent theme across the activity notes we reviewed.

Guidance produced by the Social Care institute for Excellence states that personalising people's bedrooms can provide them with reassurance and the remind the person with dementia what room they are in. We found some people's bedrooms were bland and lack personalisation. In one person's bedroom, the only thing to make the room personalised, was a CD player. We spent some time with one person who remained in their room all day. We sat down next to them and observed their immediate environment. From their chair, they were faced with magnolia walls, light beige curtains, a white sink unit, plain wooden furniture and an on over the knee table which was worn and degraded. There were no pictures for them to easily see and no bright or bold colour within the room. They spent their whole day looking at this immediate environment. Some consideration had been given to the décor of some people's bedrooms. One person's room was painted a bright blue colour which reflected their personality. However, this was not consistent across the service.

Failure to provide meaningful activities and provision of care that suited people's needs or reflected their preferences and reduced the risk of social isolation is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People's needs had been assessed when they first moved into the home and care plans had been devised. Care plans were person centred and divided into six sections. 'My life so far, my assessment of risks in my life, medical services which may help my life, my plan, how my care is reviewed and other information you might need to know.' Care plans covered a wide range of areas from; maintaining a safe environment, communication, behaviour, eating and drinking and personal care. They considered the person's strengths and needs along with the prescribed care required. For example, one person's eating and drinking care plan identified their strengths as, 'I have a very good appetite with all food, I enjoy all my meals and I am especially fond of my desserts. I need to be fed my food and drink at all times by staff. I will not open my mouth anymore when I have had enough, so staff know I am full; however, I generally eat all foods given to me.' Their prescribed care was recorded as, 'staff to continue to assist (person) in feeding them their meals and drinks. Maintain a well-balanced diet. If any concerns are reported about (person's) food or fluid intake, then advice should be sought from the GP.'

Guidance produced by the Alzheimer's society advises that people living with dementia can often experience difficulties with orientation around their home and in relation to time. During the inspection, we found that a number of people experienced confusion as part of their dementia. We asked staff how they managed this. One staff member told us, "Some people can ask for their Mother or Father. I don't want to upset them or make them relive that their parents have passed on, so I say, 'Mum's ok, why don't we have a cup of tea'." This is a good example of respecting individuals' experience of reality, however we found guidance to ensure staff responded consistently in this was not recorded within the care plan.

We recommend that the provider reviews their care plans to demonstrate how people's individual dementia needs are met.

There was a complaints procedure in place and people told us they would talk to the registered manager if they were unhappy. The service had not received any formal complaints in over a year. A range of compliments had been received. One compliment noted, 'Thank you to everyone at Dunsfold to the care you provided to Mum.'

Systems were in place to involve people in the running of the service and obtain their feedback. Resident meetings were held on a regular basis and these provided people with the opportunity to discuss any concerns and give feedback. Minutes from the last meeting in December 2016 reflected that people were asked for their opinions on the menu and the complaints procedure was explained to people.

Inadequate

Is the service well-led?

Our findings

People and staff spoke highly of the registered manager. One person told us, "She is very nice." A staff member told us, "The manager is very approachable and always has an open door." Another staff member told us, "I would describe the manager as approachable and has a good leadership style."

Whilst the feedback about the management was positive we found the leadership of the service was not always effective. Robust systems to monitor the safety and quality of the service were not in place. Governance systems to identify shortfalls were ineffective and complete, detailed and contemporaneous records were not consistently in place.

Systems to monitor and analyse the quality of the service provided were not consistently robust and failed to identify the shortfalls that were observed as part of our comprehensive inspection. The provider completed monthly visits to the service which explored areas such as the premises, documentation and talking to service users and staff. We reviewed these monthly visit reports between the periods January 2016 to December 2016. Apart from the feedback from 'service users and staff' the documentation from each monthly report was the same. For example, each monthly report from January 2016 to December 2016 documented that the gardener would be visiting on the '2/52'. The monthly reports failed to identify the shortfalls we found or to record any actions. The only action from one month to the next was noted as 'general maintenance.' However, no action points to address this were recorded. The provider told us, "Maintenance is always on-going and any actions are recorded in the maintenance log for the maintenance worker to address." The provider's internal monthly report failed to identify that the principles of the MCA 2005 were not being adhered to, risk of social isolation was not mitigated, systematic approach to determining staffing levels was not in place and risks associated with call bells were not adequately addressed.

A planned maintenance and renewal programme was in place which identified how often areas of the home were subject to redecoration. However, this programme failed to address the issues associated with the environment and premises that we have reported in this report under the question 'Is the service safe?'

Care plans were subject to a monthly audit, however, this audit failed to identify omissions and shortfalls with recording. Each person had a bowel movement chart in place. One person's bowel movement chart reflected they had not experienced a bowel movement in nine days. Another person's bowel movement chart reflected they had not experienced a bowel movement in over ten days. Documentation also reflected that some people had not had a bath or shower since the 11 December 2016. One person's care plan identified they liked to have a shower once a week and a hair wash once a week. Documentation reflected they had not had a hair wash or shower in over a month. One person's care plan reflected they had not received support to brush their teeth in five days. We found omissions in recording were a consistent theme across the service. One person's Waterlow score (tool for assessing the risk of skin breakdown) had been calculated incorrectly. Healthcare professionals told us that they felt confident people's basic care needs were met and people looked well presented. Care staff also confirmed that people received care in line with their assessed need, but acknowledged documentation was poor. Despite care plans being subject to a

formal monthly audit, these shortfalls had not been identified.

People had individual falls risk assessments in place. However, these were not robust and failed to identify themes and recurrent risks around people falling. Falls risks assessments considered areas such as medication, mobility and continence needs. Guidance was then recorded on the person's needs, aims and outcome. However, monthly reviews of people's falls risk assessment failed to assess how many falls they had experienced that month and whether the assessed outcome and need remained effective. We looked at one person's history of falls throughout the year of 2016. We found that they experienced regular falls. However, after each fall, their care plan and risk assessment had not been updated to reflect the fall and whether the control measures in place remained effective. Documentation reflected that this person fell regularly between the period 14.00pm to 20.00pm. However, the provider's monthly incident and accident audit had failed to pick up this theme. We brought this to the attention of the registered manager and provider who confirmed improvements could be made to the auditing of incidents and accidents.

A wide range of policies and procedures were in place. Policies covered areas from safeguarding to Mental Capacity Act (MCA) 2005. However, not all policies and procedures had not been updated to reflect best practice guidance, policy and legislation. Policies and procedures referenced old legislation such as the Health and Social Care Act (2008) Regulated Activities 2010 and not the new fundamental standards. The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) had not been updated or reviewed to reflect changes in legislation and the DoLS policy failed to reflect the Supreme Court Ruling of March 2014. Failure to update and review policies and procedures poses the risk that the service is governed by procedures that do not reflect current policy, legislation and guidance.

The examples above demonstrate that the provider has failed to operate an effective quality assurance system and failed to maintain accurate records and to assess, monitor and mitigate the risks relating to the health, safety and welfare of people. This is a breach of Regulation 17 the Health and Social Care Act (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. During the inspection, we identified a number of incidences that had not been notified to the Care Quality Commission. The provider had failed to notify us when the outcome of DoLS applications had been granted, when a serious injury occurred to a 'resident' and when allegations of abuse had been raised. The registered manager told us that they felt these notifications had been made. We asked for evidence of this. This had not been provided at the time of writing this report.

This failure to notify the CQC is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

Registered providers are required to display their CQC rating. Providers must ensure that their ratings are displayed conspicuously and legibly at each location delivering a regulated service and on their website if they have one. The home had been inspected in December 2014 and had displayed their rating in the service but not on their website. This was raised with the provider who told us they would take action. Two weeks after the inspection, we checked their website and found they had failed to display their rating. Not displaying a rating is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Dunsfold provides care and support to people living with dementia. The provider's website reflected, 'Here, at Dunsfold, we are specialists in Alzheimer's and dementia.' We queried with the registered manager how

they assured themselves that they provided good practice dementia care and what best practice guidelines they followed. For example, SCIE or Alzheimer's society guidelines. The registered manager told us, "All staff are dementia trained but I don't recall following any best practice guidelines." The provider told us, "We had input from the care home in-reach team a couple of years ago who provided us with information and guidance on dementia care." We queried what learning had been taken away from this programme of training. The provider and registered manager were unable to comment.

We recommend that the provider seeks guidance on how to implement good practice dementia care and demonstrate that they are following nationally approved guidance.

Staff spoke fondly of the service and described the key strength of the service its caring approach. The registered manager told us, "Our key strength is that we are caring. Staff are amazing and care for the residents like they are their loved ones." A staff member told us, "I would describe communication as a key strength." Another member of staff told us, "We all really know the 'residents' and I think that's a key strength."

Systems were in place to obtain feedback from staff, relatives and people. Satisfaction surveys were sent out every six months. Feedback from the July 2016 satisfaction survey included praise from people and their relatives. One person commented, 'you are all lovely.' Results were analysed by the registered manager and used to drive improvement. For example, one person reflected they would like apple crumble on the menu. The action point from the satisfaction survey noted, 'apple crumble' now added to the menu in line with 'residents' wishes.'

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC of important incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that service users received person centred care that reflected their individual needs, preferences and was appropriate. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to act in accordance with the requirements of the Mental Capacity Act 2005 and had provided care and treatment of service users without the consent of the relevant person. Regulation 11 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered provider had failed to ensure that the premises were secure, properly used and properly maintained. Regulation 15 (1) (a) (b) (c) (d) (e)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that there were effective systems to assess and quality assure the service. Regulation (17) (1) (2) (a) (b) The provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user. Regulation 17 (2) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The registered person had not displayed a rating of its performance following an assessment of its performance by the commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed. Regulation 18 (1)