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Dean Wood Manor

Inspection report

Dean Wood Manor
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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We carried out an unannounced inspection of this service on 3 November 2015, with a further two announced inspection visits on 5 and 12 November 2015.

Dean Wood Manor is owned and operated by a partnership trading as Dovehaven Care Group. The premises are based around an original Grade II listed building that has been extended. There are extensive gardens surrounding the home and on-site car parking is available.

We last inspected this location on 12 August 2014 and found the service to be compliant with all regulations we assessed at that time.

The vast majority of people who used the service at Dean Wood Manor were living with a diagnosis of dementia; therefore people were accommodated in the service depending on their assessed needs. The Woodlands Unit, located on the lower ground floor, provided residential type care, whereas the ground floor at Dean Wood Manor

Summary of findings

accommodated people living with more complex needs. For the purposes of this report, care provided on the ground floor of Dean Wood Manor, will be referred to as the 'nursing unit.'

Dean Wood Manor is registered with the Care Quality Commission (CQC) to provide nursing and personal care to a maximum of 50 people. At the time of this inspection, 33 beds were occupied on the nursing unit, and each of the seven beds were occupied on the Woodlands Unit.

At the time of this inspection there was no registered manager in post at Dean Wood Manor. The acting manager told us they were applying to the CQC to register as the registered manager for the service. A registered manager is a person who has registered with the CQC. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection, we found multiple breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 in regard to person-centred care, dignity and respect, safe care and treatment, safeguarding service users from abuse and improper treatment, premises and equipment, receiving and acting on complaints, good governance and staffing. We are currently considering our enforcement options in relation to these regulatory breaches.

Following the takeover of Dean Wood Manor in March 2015 by Dovehaven Care Group, the new owners embarked on an extensive refurbishment programme. At the time of our inspection visit, the refurbishment work was still on-going and the building contractors were still on site. We looked at how the service had planned to manage and mitigate the risks associated with the refurbishment programme and found a risk assessment had been produced in July 2015. However, during our inspection visit, we found the service had failed to adhere to its own risk assessment which exposed people who used the service to the risk of avoidable harm.

During day one of our inspection, we found the service had failed to ensure that the building contractors were working in a way which would keep people who used the service safe. They were working in a way which exposed people who used the service to a risk of harm. We found a communal door leading to an area where building work was being carried out had been wedged open. This area was left unsupervised and contained power tools, trailing electric cables, and step ladders. We also observed a number of care staff going about their duties without recognising the potential danger for this situation.

We found the service had failed to deploy sufficient numbers of staff in order to meet the needs of people who used the service and failed to demonstrate a systematic approach in determining the number of staff required. Furthermore, the service failed to ensure staff were suitably qualified, competent, skilled and experienced; and failed to ensure staff received appropriate professional development and supervision.

The service failed to protect people who used the service against the risks associated with the safe management of medicines. We found medication was not administered as per instructions; errors were identified on Medication Administration Charts and the medicine's fridge temperature was too high on the nursing unit.

People were not protected against the risk associated with the control of infection. We found that during refurbishment work, wall mounted personal protective equipment (PPE) such as disposable gloves and aprons and hand cleansing units had all been removed. This meant appropriate PPE was not available at the point of care.

Care plans and associated documentation were not of a consistently good standard with gaps and omissions in recording. Information was disorganised and not easy to understand. Care plans were not sufficiently person-centred and did not consistently demonstrate people's likes, dislikes, personal preferences and their life history.

We found the service had failed to ensure that people who used the service, and/or their representatives, had been involved in decisions relating to the refurbishment work and that insufficient information had been provided.

We found the service had failed to follow nationally recognised evidence based guidance in the care and support of people living with a diagnosis dementia.

We looked at staff recruitment to make sure safe recruitment practices were being followed. We found the identity of people applying to work at the service had

Summary of findings

been checked, references had been sought and checks had been completed with the Disclosure and Barring Service (DBS). A DBS check helps to ensure that potential employees are suitable to work with vulnerable people.

The service had an appropriate whistleblowing policy in place and staff told us they were aware of the policy and were confident about how to use it.

Records confirmed that regular checks of the fire alarm had been carried out to ensure that it was in safe working order. Documentation and certificates demonstrated that relevant checks had been carried out on the gas boiler, electrical systems and fire extinguishers.

Personal emergency evacuation plans (PEEP) were not always completed and the evacuation status of each person who used the service was not readily available as the service did not maintain a 'PEEP grab file' for use in emergencies.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The service had a policy in place concerning DoLS and information was included about best interests. We looked at a sample of DoLS documentation and found that due processes had been followed by the service and that decisions were made in those peoples best interests. However, we found the conditions of two peoples' DoLS had not been adhered to and the service had failed to keep these people safe.

On the nursing unit, we found the mealtime service was rushed and chaotic, and noise levels were unacceptably high; all of which contributed to a poor meal time experience for people who used the service. On the Woodlands Unit, people who used the service were encouraged to eat and drink in a positive manner and the dining experience was calm and well managed.

We looked to see how the service supported people with their on-going health and support needs and found appropriate referrals were made to external professionals and agencies in order to meet people's needs. For example, the service had regular contact with community older age mental health services and regular input from physical health teams such as community physiotherapy.

Throughout our inspection visit, we found a lack of co-ordinated operational leadership which impacted on the quality of care being provided. Additionally, since taking ownership of Dean Wood Manor, we found the provider had failed to demonstrate sufficient oversight to recognise and respond to existing and newly emerging issues. The Provider failed to deliver on reassurances made to CQC during the takeover of Dean Wood Manor. In particular, reassurances around training and development of staff and involvement of people who used the service and/or their representatives.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve;
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made;
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of 'Inadequate' for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

Summary of findings

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The service failed to protect people against the risk of harm during building and refurbishment work.

Individual risks to people who used the service were not consistently assessed and findings acted upon.

The service failed to protect people against the risks associated with the safe management of medicines.

The service failed to deploy sufficient numbers of staff to keep people safe.

Is the service effective?

Inadequate

The service was not effective.

Training and development, and supervision and appraisal of staff were inadequate.

Three people who used the service that were the subject of Deprivation of Liberty Safeguards had been allowed to abscond from the home.

Environment not dementia friendly, ie toilet doors not distinctive for people living with dementia to recognise, lack of signage to help with orientation around the home.

The mealtime experience on the nursing unit was chaotic, rushed and disorganised. The mealtime experience on the Woodlands unit was pleasant and people who used the service were supported appropriately.

Is the service caring?

Inadequate

The service was not consistently caring.

Some staff did not always interact with people who used the service in a manner which promoted their human rights and protected their privacy and dignity.

On the Woodlands unit, we observed some positive interactions between staff and people who used the service.

Is the service responsive?

Inadequate

The service was not responsive.

The service did not follow relevant nationally recognised evidence based guidance in the care and support of people living with dementia.

The delivery of day to day care and support was too task based and did not sufficiently take into account people's likes, dislikes and personal preferences.

Management of complaints was inadequate.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led.

At the time of our inspection there was no registered manager at the service.

The provider had failed to demonstrate sufficient oversight of existing and newly emerging issues.

Systems for audit and quality assurance were not effective and failed to identify wider systemic problems.

The service did not effectively demonstrate how the views of people who used the service and/or their representatives were sought.

The service failed to notify CQC of a number of serious incidents.

Dean Wood Manor

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection was carried out on Tuesday 3 November 2015, with a further two announced inspection visits on 5 and 12 November 2015. The inspection team consisted of three adult social care inspectors, an inspection manager, and a specialist nurse adviser.

Before the inspection we reviewed all the information we held about the service including statutory notifications and safeguarding referrals. We also liaised with external professionals including Wigan Council, NHS community services and Greater Manchester Police. Information shared by both Wigan Council and Greater Manchester Police was of concern to CQC and related to quality of care issues and the failure of Dean Wood Manor to keep people safe.

During our inspection we spoke with the following people:

- Four people who used the service
- Five visiting relatives
- Eight members of staff directly involved in providing care
- Three managers
- Two visiting NHS health care professionals

We looked in detail at:

- 10 care plans and associated documentation
- Six staff records including recruitment and selection records
- Training matrices
- Audits and quality assurance
- Variety of polices of procedures
- Safety and maintenance certificates

We observed how care and support was being delivered in communal areas of the service and inspected the kitchen area, laundry, communal bathrooms and people's bedrooms. We also completed a Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

Due to the nature of the service at Dean Wood Manor, we were unable to speak with people who used the service on the nursing unit to ask if they felt safe. This was because these people who used the service were unwell and it was inappropriate to ask them questions.

However, during our inspection visit, we were able to speak with a number of visiting relatives. One relative told us, "I'm concerned about [My relative's] safety because there have been a number of occasions when I've visited and found [My relative] had been left alone in the lounge. [My relative] is known to fall and this worries me." Another relative told us, "I don't consider [My relative] is safe here all of the time. Some people being cared for here can be aggressive and lash out but there isn't always enough staff around to intervene. On one occasion, I witnessed someone lash out and hit another person who lives here but I couldn't find a member of staff to help." A third relative told us, "On the whole I think [My relative] is safe. I've never had a cause to complain."

On the Woodlands Unit, which provided residential type care, we were able to speak with three people who used the service. The first person who used the service told us, "The staff do what they can and I feel safe." A second person commented, "I feel safe. I would tell someone if I didn't feel safe." The third person told us "I'd tell my family if I didn't feel safe. They would help me."

We looked at how the service aimed to protect people against abuse. We found the service had a variety of policies and associated procedures which included a vulnerable resident's policy, safeguarding of residents from abuse policy, the use of physical intervention policy, infection control policy, medication policy, and handling of resident's money policy. Safeguarding training was also provided. However, we found no information was displayed around the service which gave guidance about how to raise a safeguarding concern.

Following the takeover of Dean Wood Manor in March 2015 by Dovehaven Care Group, the new owners embarked on an extensive refurbishment programme. At the time of our inspection visit, the refurbishment work was still on-going and the building contractors were still on site. We looked at how the service had planned to manage and mitigate the risks associated with the refurbishment programme and found a risk assessment had been produced in July 2015. However, during our inspection visit, we found the service had failed to adhere to its own risk assessment which exposed people who used the service to the risk of avoidable harm.

During day one of our inspection, we found the service had failed to ensure that the building contractors were working in a way which would keep people who used the service safe. They were working in a way which exposed people who used the service to a risk of harm. We found a communal door leading to an area where building work was being carried out had been wedged open. This area was left unsupervised and contained power tools, trailing electric cables, and step ladders. We also observed a number of care staff going about their duties without recognising the potential danger for this situation. We spoke with the manager about this who addressed the issue with the contractors and care staff.

We then looked more widely at the how the service assessed and managed individual risk. We looked at a sample of 10 care plans and found a variety of risk assessments had been completed on admission to the service and these included assessments for falls, moving and handling, behaviour, and continence. However, after looking at records of accidents and incidents, and comparing these to risk assessments contained with individual care plans, we found that in over half of cases, where accidents or incidents had occurred, individual risk assessments were not always updated. For example, we found that one person who used the service presented with behaviours that challenge the service and during one particular sequence of incidents, this person had exhibited violence and aggression towards another person who used the service; this resulted in injuries being sustained by both parties. However, we found no evidence to demonstrate how the service had reassessed the risks posed by this person or what preventative strategies had been put in place to reduce the likelihood of such incidents occurring again.

During our inspection visit, we spoke with a visiting healthcare professional (HCP) who shared information of concern with us regarding one person who used the service. We then case tracked this person by looking at their care and treatment records. We found that four days prior to our inspection, staff at Dean Wood Manor had identified that this person was experiencing swallowing

difficulties and therefore initiated a soft diet. However, we found this person's care plan and associated risk assessments had not been updated, staff working in the kitchen had not been informed and the service had not made a referral to speech and language therapy. This meant that this person's previous diet could have been maintained by staff who had not been updated of the changes. This had the potential to expose this person who used the service to a risk of choking.

We spoke with the manager and compliance manager about this and referred our concerns to the local authority adult safeguarding team.

We looked at how well people were protected by procedures for the prevention and control of infection. We found that during the refurbishment work, wall mounted personal protective equipment (PPE) such as disposable gloves and aprons and hand cleansing units had all been removed. We asked a senior carer about this and were told that PPE equipment was now stored in a room off the main corridor and was collected as-and-when required. This meant that PPE was not readily available at the point of care which in turn increased the risk of infections being spread.

We found that personal emergency evacuation plans (PEEPS), which outline the level of assistance people would need in the event of an emergency, were not always completed in peoples care plans and the service did not maintain a central 'PEEPS grab file' in case of emergencies. This meant the evacuation status of each person who used the service was not readily available.

We found the service had failed to ensure the premises were safe to use for the intended purpose; failed to assess the risks to the health and safety of people who used the service; failed to do all that was reasonably practicable to mitigate any such risks; and failed to assess the risks associated with spread of infections.

This is a breach of Regulation 12(1)(2)(a)(b)(d)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to Safe care and treatment.

During our inspection, we checked to see how the service managed medication safely. We found the service had an appropriate medication policy and associated procedures. However, we found staff had failed to follow the medication policy by not protecting people against the risks associated with the safe management of medicines. This was because medication was not stored, administered and recorded correctly.

On the nursing unit, we found the temperature of the medicines fridge was too high. This compromised the integrity of stored medicines such as insulin. We spoke with the deputy manager about this who told us the fridge temperature had only been running high that morning. We therefore asked to see evidence of recent temperature records, but these could not be produced. The deputy manager told us the maintenance operative would be called to repair the fridge and that the integrity of the stored medication would be checked.

We observed a medication round and looked at the Medicine Administration Records (MAR) of 11 people who used the service. Of the 11 MAR charts we examined, we found a combination of errors in the way medicines were given, and how information was recorded.

In one example, we found a prescribed medicine was not being administered as per the special instructions which stated it must be given before food and drink and that the person must remain upright after the medication had been given. However, during the morning medication round, we observed this medicine being given to the person who used the service with their breakfast. We spoke with the member of staff who was completing the medication round about this and were told that on occasions, this particular medication was also given to the person who used the service whilst they were still in bed and with a cup of tea.

When we asked why the medication was not being given as per the special instructions, we were told that the vast majority of medicines were given out before or during meal times. By not administering this particular medication as prescribed, the service compromised the effectiveness of the medication and exposed the person who used service to adverse side-effects by failing to ensure they remained upright after its administration.

In another example, we found that one person who used the service had been prescribed a regular maintenance dose of pain relief. The instruction for its use stated it should be given twice a day. However, by looking at this person's MAR chart, we found it was being given as-and-when required. We spoke with the deputy manager about this who told us this person who used the service

Is the service safe?

regularly refused this medication therefore it was not given as frequently as prescribed. However, we found that the code which should be used on the MAR charts to indicate a refusal had not been detailed on this individual's MAR chart. This meant it was not clear whether or not this person who used the service was receiving or refusing their maintenance dose of pain relief.

In a third example, we found errors in recording. Another person who used the service had been prescribed an alternating dose of medication which meant they should receive a 6mg dose one day, and a 7mg dose the next. However, this person's MAR chart indicated they had received a 7mg dose of medication every day. We spoke with the member of staff responsible for the medication round about this and were told the person who used the service was receiving the correct dosage but that it was accepted practice within the home to sign the MAR chart each time the quantities were routinely checked. This meant that when examining the MAR chart, it looked as though the medication had been administered.

The consequence of the service adopting this unusual practice meant that if a health care professional had been required to look at this person's MAR chart to ascertain the dosage being given, false information would be provided. Due to the type of medication involved, we back-counted the quantities to ensure the person who used the service had not received an overdose. Our checks confirmed the correct quantities were present.

We shared our concerns with the manager and compliance manager and asked for a full review of medicines management be completed. We also referred our concerns to the local authority adult safeguarding team.

We found that Dean Wood Manor had failed to ensure medicines were manged safely and administered appropriately and had failed to ensure compliance with its own medication policy.

This is a breach of Regulation 12(2)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to Safe care and treatment.

We looked at staffing levels at Dean Wood Manor and found that during the day on the nursing unit, one registered nurse was supported by a senior carer and six care assistants. At night, one registered nurse was supported by one senior carer and four care assistants. On the Woodlands Unit, during the day, one senior carer was supported by a care assistant. At night, this reduced to one senior carer.

We asked the manager about staffing and whether a dependency tool was used to determine staffing levels. Initially, we were told a dependency tool was not used and that staffing levels were historical. However, later during our inspection visit, we were told by the compliance manager that a dependency tool was used, but this was completed off-site by a senior nurse manager. During our inspection, we asked the service on several occasions to provide us with evidence of the dependency tool, but this was not produced.

On the Woodlands Unit, we spoke with a senior carer to ascertain the dependency levels of each of the seven people being cared for on the unit. We were told that two people who used the service were dependant on the full support of two carers; this included support with moving and handing and personal care. We asked the senior carer how the needs of these individuals were met during the night as only one carer was on duty. We were told that the member of staff would be required to 'phone upstairs' in order to get help. However, we were told that as the nursing unit was always very busy, staff on the Woodlands Unit frequently had to wait for long periods before help was provided which meant here were delays in people receiving the care and support they required in a timely manner.

We also observed two instances when people who used the service were left supervised in the lounge. This was because one member of staff was busy providing care in a person's room, and the other member of staff had been called away elsewhere in the building. However, during this time, one person who used the service was shouting for help and appeared agitated and distressed whilst left alone in the lounge.

This demonstrated the service had failed to deploy sufficient numbers of staff in order to meet the needs of people who used the service, and failed to demonstrate a systematic approach in determining the number of staff required.

This is a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to Staffing.

Inadequate

Is the service safe?

We looked at the recruitment files of six members of staff and found appropriate checks had been completed. This included checks with the Disclosure and Barring Service (DBS) which helps to ensure that potential employees are suitable to work with vulnerable people. We found that references had been sought and identification checks had been completed.

We looked at how staff were supported to raise concerns and found the service had an appropriate whistleblowing policy. Staff told us they were aware of the policy and were confident about how to use it.

We saw records to confirm that regular checks of the fire alarm were carried out to ensure that it was in safe working order. We saw documentation and certificates to show that relevant checks had been carried out on the gas boiler, electrical systems and fire extinguishers.

Inadequate

Is the service effective?

Our findings

During our inspection, we looked at training staff received to ensure they were fully supported and qualified to undertake their roles. We spoke with staff about induction, training and development and supervision. We also looked at a training matrix maintained by the service.

We also spoke with visiting relatives about staff training. One relative told us, "The majority of staff seem to know what they're doing, but others don't really seem very knowledgeable." Another relative told us, "When I enquire about [My relative] the staff always seem well informed and able to provide me with information. I've never seen anything to think they're not trained. A third visiting relative told us, "I really do not think the staff are well trained. I've had cause to complain about poor standards of basic care and surely this a reflection on the quality of training staff receive."

We spoke with six members of staff, five of whom confirmed they had received an induction which included orientation to the service, opportunities for shadowing, and familiarisation with policies and procedures. Staff told us on-going training was a mixture of online e-learning, practical workbooks and some face-to-face training. Topics covered included safeguarding, mental capacity act, deprivation of liberty, dementia, and health and safety. Each of the six members of staff were able to explain their roles and responsibilities and expectations in respect of keeping people who used the service safe and how to raise safeguarding concerns. However, we found staff had limited awareness around dementia with gaps in knowledge evident.

One member of staff told us, "I think we need more practical face-to-face training." Another member of staff commented, "We definitely need more training, the basics are covered but not in any detail."

We asked to look at supervision and appraisal records but none could be produced during our inspection visit. We asked each of the six members of staff about supervision and appraisal and only one member of staff was able to confirm they had received supervision. However, no documentary evidence of this could be produced.

We looked at a training matrix maintained by the service and found wider systemic issues around training and development. Records indicated that Dean Wood Manor employed 37 staff who were directly involved in providing care and support. However, we found that 49% of staff had not completed dementia training; none had completed challenging behaviours training; 73% had not completed person-centred care training; and no staff had completed record keeping training.

We found the service had failed to ensure staff were suitably qualified, competent, skilled and experienced; and failed to ensure staff received appropriate professional development and supervision.

This is a breach of Regulation 18(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to Staffing.

We spoke with the manager about the refurbishment programme at Dean Wood Manor. We were told that when the new owners took over Dean Wood Manor in March 2015, a number of structural problems were identified with the building and a number of urgent repairs were needed. We were told many of the repair issues had been complicated by the fact the main building at Dean Wood Manor is Grade II listed. One member of staff told us "The last few months have been hell." Another member of staff commented "The whole building work has been a nightmare for all concerned."

At the time of our inspection, we found communal areas on the nursing unit had been painted the same colour scheme throughout, and that toilet doors were painted the same colour as people's bedroom doors. There was no appropriate signage to provide a pictorial prompt to enable people to navigate themselves around the building. This meant that people living with dementia were unable to recognise familiar locations, such as a toilet, bathroom or bedroom.

During our inspection, one person who used the service approached a member of the inspection team in a panicked state and was very anxious to locate the toilet, but was unable to do so. We immediately asked a member of staff to help this person to the toilet which they duly did. However, we learnt that this person who used the service had unfortunately been incontinent. We later spoke with a member of the care staff about this and were told that prior to the refurbishment work, this person who used the

service had been able to locate the toilet independently and tend to their own personal care. This was because the toilet doors were previously painted a distinctive colour and easily recognisable.

This is a breach of Regulation 15(1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to Premises and equipment.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found the service had a DoLS policy and associated procedures. DoLS records were a combination of electronic and paper based records which detailed those people who used the service that were the subject of a DoLS. We looked at DoLS documentation concerning 11 people who used the service and found that due processes had been followed by the service for each DoLS application and that decisions were made in people's best interests. However, by looking at incident records and comparing these with people's individual DoLS authorisations, we found three examples where the service had failed to ensure the conditions of the DoLS were met.

In the first example, we found that during the building refurbishment work, one person who used the service who was living with dementia had been able to abscond from the home after the building contractors left an external door open. This person was then found to have fallen into a pond of the neighbouring property and needed to be rescued by three members of staff. The incident report stated that this person who used the service suffered no lasting ill-effects. However, this was an avoidable incident which exposed the person who used the service to an unacceptable risk of harm.

In the second example, another person who used the service who was living with dementia had been able to abscond from the home during the night. The service reported this person who used the service as 'missing' to Greater Manchester Police. When officers attended, they found an external door to be open and unattended and were able to gain access to the building where people who used the service were present. This meant that other people who used the service could have absconded at any time, despite one person already being missing. Records indicated that a number of hours later, the person who used the service was safely returned.

In the third example, we found this person who used the service had been able to abscond during the early evening via an unsecured external door. The service reported this person as 'missing' to Greater Manchester Police and was later safely returned back to the home.

By failing to keep people safe, and by failing to ensure the conditions of people's individual DoLS authorisation were met, we found the service had been neglectful.

This is a breach of Regulation 13(1)(2)(3)(4)(d)(6)(b)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to Safeguarding service users from abuse and improper treatment.

We looked at how the service adhered to the principles of the Mental Capacity Act 2005. Specifically, we looked at how the service sought consent and assessed the mental capacity of people who used the service. We found the service had a policy in place concerning the MCA and care planning documentation contained 'consent to care treatment assessments' which included an assessment for mental capacity; acting within the MCA; planning; risks; and, reviews.

Staff spoken with had undertaken MCA training and gave good explanations of what the MCA is and gave examples of where people who used the service lacked capacity and were assisted to make decisions. Examples were given about different ways of communicating to help ensure people understood decisions to be made.

Inadequate

Is the service effective?

During our inspection we looked at how people who used the service were supported to eat and drink and the meal time experience on both the Woodlands and nursing unit. We spoke with the Chef who told us the menu was on a four week rolling programme and two choices were offered at both lunch and tea time. We looked at a list displayed in the kitchen which detailed people's individual likes and dislikes and also those people who required thickeners or other special diets, such as a soft diet.

During lunch time service on the Woodlands Unit, the dining table was presented with a table cloth and cutlery but no condiments or napkins were present. Soup and a sandwich were served along with a choice of a hot or cold drink. Staff encouraged people who required help with eating and drinking. The atmosphere was pleasant and staff interacted well with people who used the service.

On the nursing unit, we observed the evening meal service. Dining tables were presented with a table cloth but no condiments were present. 11 people who used the service had been seated at their respective tables by 3:54pm. One person who used the service repeatedly stated they were thirsty and wanted a drink but this went unnoticed by staff. Three meals had been served at this time but by 4:18pm, eight people who used the service had still not been served. One person who used the service got up from their seat and left the dining area.

People who required help with eating and drinking were offered support but we observed staff rapidly moving from one person to another. Throughout the mealtime service, we observed a lack of leadership and direction of staff; the service was rushed and chaotic and noise levels were unacceptably high. All of which contributed to a poor meal time experience.

We looked to see how the service supported people with their on-going health and support needs and found the service worked closely with other professionals and agencies in order to meet people's needs. For example, the service had regular on-going contact with community older age mental health services and regular input from physical health teams such as community physiotherapy.

Inadequate

Is the service caring?

Our findings

Due to the nature of the service at Dean Wood Manor, we were unable to speak with people who used the service on the nursing unit to ask whether they thought the service was caring. This was because these people who used the service were unwell and it was inappropriate to ask them questions.

However, we were able to speak with a number of visiting relatives. One relative told us "I think the staff are caring [My relative] seems well looked after. Another relative told us "There are huge inconsistences in the caring attitude of staff. Some staff are great but others appear not to care." A third relative told us "[My relative] has settled well and is much calmer than they were in the previous home.

During our inspection visit, we spoke with the manager about how the service promoted equality and diversity, and protected people's human rights. We asked whether anyone who used the service was from a different cultural or ethnic group other than white; if anyone who used the service identified as lesbian, gay, bisexual or transgender (LGBT); and what faiths were practised.

We were told that no one identified as LGBT, and that each person who used the service was of white British heritage. We were told that a number of people did practice a faith, but no specific information was provided about how people's pastoral needs were routinely met. We asked the manager how the service sought to ensure that the care and support provided was fair, accessible and promoted people's human rights. We were shown a policy entitled 'respecting and involving people who use services' which included information about equality and diversity, listening, choice, and encouraging resident's autonomy. However, we found the service did not always apply the principles of this policy.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We completed a SOFI observation for 30 minutes in the East lounge of the nursing unit.

During this time, we observed three people who used the service seated in the lounge and two others who were pacing about the room. Staff were observed to walk through the lounge but no staff were in attendance for any length of time. A wall mounted television was on with the volume very loud. The channel selected by a member of staff was also inappropriate as the daytime television programme shown people arguing, shouting and screaming. This did not contribute to a relaxing or therapeutic environment.

We observed two members of staff bring a person who used the service into the lounge in a wheelchair. They proceeded to transfer this person from the wheelchair into an armchair which was located directly underneath the wall mounted television. There was no meaningful communication and both staff members failed to ask the person who used the service whether or not they wished to be seated under the television set. We then observed this person who used the service spend an amount of time holding their head in their hands and covering their ears.

We spoke with a member of staff about this to understand whether or not this person who used the service had a preference to sit under the television. We were told by the member of staff that they didn't think so, but weren't sure. The member of staff added that 'people are just sat anywhere in the lounge.'

We then observed another person who used the service ask twice be taken to the toilet. On each occasion, two members of staff told this person to 'wait a minute.' We then spoke with a member of staff and asked them to attend to this person's personal care needs. Unfortunately, this person who used the service then indicated to staff that they were 'too late.'

We also observed some of the interactions between staff and people who used the service were not always appropriate. For example, we observed one member of staff continually making attempts to reason with a person who was living with a diagnosis of dementia. This person who used the service clearly lacked comprehension of what was being asked of them, yet the member of staff persisted in a manner which almost became argumentative. This demonstrated a lack of care, compassion and understanding towards people who used the service.

This is a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to Dignity and respect.

However, on the Woodlands unit, we observed a number of positive interactions between staff and people who used the service. On one occasion we observed a person who

Inadequate

Is the service caring?

used the service appeared to be upset. A member of staff was then observed to sit alongside this person and hold their hand and offer reassurance, which clearly had a positive effect. One person who used the service told us "I'm well looked after, the girls are caring." Another person commented "I don't want for anything, I'm OK and looked after well."

Inadequate

Is the service responsive?

Our findings

Due to the nature of the service provided at Dean Wood Manor, the vast majority of people who used the service were living with a diagnosis of dementia. We therefore asked the manager whether or not the service worked to a specific dementia model and we were told they did not. This meant the service had not considered the relevant nationally recognised evidence based guidance in the care and support of people living with dementia.

We looked at a sample of 10 care plans to understand how people who used the service had their individual needs met. In particular, we looked to see how people's likes and dislikes, personal preferences and hobbies were identified by the service.

We found that since March 2015, the service had started a process of transferring old care plans from the previous provider onto new Dovehaven Group documentation. We found a variety of documents relating to both nursing and personal care. These included a pre-admission assessment; MCA assessment; a variety of risk assessments; monthly weight charts; information relating to continence, mobility, skin integrity and nutrition. Each care plan also contained a 'map of life' which provided details of people's background history, family details, previous employment and other significant events. Care records also included 'daily record' documentation where day-to-day events were recorded.

Across each of the eight care plans we examined, we found that information was not consistently recorded and there were a variety of gaps and omissions. For example, in one care record we found that reviews of care had not been consistently recorded despite 'daily record' documentation demonstrating changes to this person's support needs. In another care plan we found the 'map of life' had not been fully completed so no information was available about their personal preferences.

A number of people who used the service at Dean Wood Manor presented with behaviours that challenge. As part of these people's individual care plan, we found that appropriate risk assessments had been completed which indicated that one-to-one support and supervision was required.

We case tracked one person with behaviours that challenge to understand how the service was meeting their needs. We found this person who used the service had one-to-one close supervision from 7:00am until 11:00pm. Documentation contained within their care plan indicated the decision to initiate one-to-one supervision had been in their best interests. A guidance document detailed that one-to-one support should completed in sight of the person who used the service and general observations should be documented on an on observational chart. We completed a period of observation to see how the person who used the service and member of staff responsible for supervision interacted with each other. We found that for the vast majority of time, there was little or no interaction from the member of staff and they simply followed the person who used the service from a distance around the unit. We also observed that on two occasions this person who used the service was left unsupervised. This placed other people at risk.

We asked to see this person's observational charts and were shown documentation from 02 November 2015 to 05 November 2015. These indicated that this person who used the service had presented with physical and verbal aggression during this period but we found no evidence to indicate what follow-up action had been considered or implemented. We then asked to see historical behaviour charts but these could not be produced.

We found the service had failed to follow nationally recognised evidence based guidance in the care and support of people living with dementia; had failed to consistently demonstrate that people's care plans were sufficient to meet their needs; and failed to ensure that the support provided to people with behaviours that challenge was evidence based and met their needs.

This is a breach of Regulation 9(1)(a)(b)(c)(2)(3)(a)(b)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to Person-centred care.

On the nursing unit, we found limited evidence of meaningful person-centred activities taking place. During our inspection, we observed well intentioned attempts being made by some staff to occupy people who used the service through the use of traditional activities such arts, crafts and board games. We spoke with the manager about this and were told the service had plans to employ an activity co-ordinator but this had not yet materialised. We were told that in the meantime, care staff were expected to participate in providing recreational activities.

Inadequate

Is the service responsive?

We found this 'one size fits all' approach to activities demonstrated a lack of training and understanding, and more widely, a lack of available resources to enable the service to tailor activities to meet people's individual needs, especially those living with a diagnosis of dementia.

However, on the Woodlands Unit, staff told us they were able to request the company minibus and each week a number of people who used the service were taken out on daytrips. We spoke with one person who used the service about this and they told us they enjoyed these activities.

During our inspection, two visiting relatives each separately approached the inspection team to make a complaint. The first relative told us about a variety of issues concerning the general care and support of their family member. This ranged from complaints about their relatives glasses and hearing aids going missing, to a lack of action around an offensive odour in their relative's bedroom. A member of the inspection team was invited by this family member to inspect their relative's bedroom and we were able to see for ourselves that the carpet was stained and there was a definite odour.

The second visiting relative raised a number of serious issues which constituted safeguarding; therefore during our inspection, we raised a safeguarding alert with the local authority.

Both relatives told us they had each made repeated complaints to staff at Dean Wood Manor but had received a poor response and issues remained unresolved. One relative was able to show us documentary evidence of a timeline of events which demonstrated multiple occasions when complaints had been raised with staff and management at Dean Wood Manor.

We asked to look at the complaints policy and complaints log. The services own complaints policy was clear and unambiguous and provided a framework for staff to respond appropriately to complaints. For example, the policy detailed how staff should deal with verbal complaints and those which are made in writing. However, we found only one complaint had been recorded by the service since February 2015. We spoke with the manager and compliance manager about why the complaints raised by the relatives we spoke with were not recorded, but no explanation could be offered.

We therefore found the service had failed to establish and operate effective systems for identifying, receiving, recording, handling, investigating and responding to complaints.

This is a breach of Regulation 16(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to Receiving and acting on complaints.

Inadequate

Is the service well-led?

Our findings

There was no registered manager in place at the time of our inspection. We were told by the acting manager that they were applying to register with the CQC. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

When asked whether they thought the service was well-led, a visiting relative told us "The manager is good. We could talk to anyone if we had concerns and we feel they would sort it out.' Another relative commented "I don't know who the new owners are, I've never seem them."

One member of staff told us, "I feel listened to by management, the manager is nice but needs more help." Another member of staff commented, "The nurse managers do what they can but there isn't enough nurses."

Throughout our inspection visit, we found a lack of co-ordinated leadership which impacted on the quality of care being provided. Since taking ownership of Dean Wood Manor, the provider had failed to demonstrate sufficient oversight to recognise and respond to existing and newly emerging issues. The providers failed to deliver on reassurances made to CQC during their takeover of Dean Wood Manor. In particular, reassurances around training and development of staff, and involvement of people who used the service and/or their representatives.

We looked at how the service monitored the quality of care and support being delivered at Dean Wood Manor and found the service maintained a quality assurance file which contained a variety of monthly audits. Topics for audit included admissions and discharges, staffing, complaints, training, medication, and infection control. However, given the systemic failings that we found at Dean Wood Manor, completion of these audits was ineffective and failed to demonstrate a commitment to self-improving systems. We looked at how accidents and incidents were audited and found inconsistences in the overarching analysis of these events in order to identify trends or contributory factors.

We looked to see how the service sought the views and opinions of people who used the service and/or their representatives. For example, through the use of resident and relatives surveys or meetings. However, the service was unable to produce any evidence that the views of people had been sought.

During our inspection, we were told that staff training records had been misplaced as a result of the refurbishment work. We were also told that since Dovehaven Care Group had taken over Dean Wood Manor, historical care plan documentation had been removed and placed in a locked storage room located on the top floor of the building. However, we were told that access to this room was restricted to the maintenance person. This meant that records relating to the care, treatment and support of people who used the service pre-March 2015, were not readily available.

We therefore found the service had failed to establish effective systems or processes to effectively assess, monitor and mitigate risks; failed to securely maintain records; and failed to seek and act on feedback.

This is a breach of Regulation 17(1)(2)(a)(b)(c)(d)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to Good Governance.