Kahanah Care

Dene Court Residential Care Home

Inspection report

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Ratings

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

Overall summary

This inspection was unannounced and took place on 10, 13 and 26 November 2015. The inspection was carried out by two inspectors on the first day, one inspector on the second day and two inspectors on the third day. The previous inspection of the home was carried out on 27 January and 6 and 10 February 2015 where we found breaches of regulations. These related to the care and welfare of people who use services, assessing and monitoring the quality of service provision, consent to care and treatment, and records. During this inspection we found some improvements had been made, but these were not fully effective and required further action. We also found some new breaches of regulations.

Dene Court is registered to provide accommodation with personal care for up to 28 older people. There is a

Summary of findings

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. The manager is also registered to manage another home owned by the provider, and their working week was shared between the two services.

There were insufficient staff to meet each person's needs safely. On the first day of our inspection neither the manager or deputy manager were on duty. There were four care staff on duty to meet the needs of 25 people living there. The demands on the care staff were high and this meant staff were unable to meet some people's needs fully. Staff had insufficient time to provide adequate care and support to people with high levels of care needs in particular in relation to protecting them from falls, managing depression and anxiety.

Staff had no time to provide activities or meaningful engagement and we saw some people remained in their chair all day with very little interaction from the staff. We saw evidence that people living in the home and staff had raised concerns about staffing levels being too low but their concerns had not been investigated or actioned. On the second day of the inspection staffing levels had increased. The deputy manager was on duty plus five care staff and this meant staff were more relaxed and had more time to interact with people. However, people currently had high levels of need, for example the daily handover sheet indicated that at least 17 people needed regular checks for mobility, whereabouts and mood. There were no instructions for staff as to how this was managed other than to do "regular checks." Staff told us they "Kept an eye out" and could not say what "regular checks" entailed. People's records showed a high level of falls. After the inspection the provider told us they were in the process of recruiting more staff.

There was insufficient evidence of regular social activities or how social stimulation, engagement and social isolation was managed within the home or the community. Individual social needs had not been assessed and there was no plan to show how these would be addressed. Daily records showed no evidence of these needs being met although highlighted people being low in mood, asking to go out, wandering/ exploring the home or identified as requiring to be kept busy. These were not addressed and most people spent their time without social stimulation for long periods other than during personal care tasks and meals. There were some visits each month from visiting entertainers and activity providers, but these were infrequent. People were rarely supported by staff to go out of the home, and instead relied on relatives or friends to take people out.

Systems to assess and regularly monitor risks to people's health were not fully effective. Where risks had been identified these were reviewed on a monthly basis, for example tissue viability and weight loss (the frequency of reviews had improved since the last inspection). However, where the reviews identified changes in the level of risk this information had not always been transferred to the main part of the care plan. This meant the care plans did not always provide up-to-date information. For example, one person's care plan said they were independently mobile but the review said they required two staff and were non-weight bearing at times and at high risk of falls. There were no instructions to staff on the actions they should take to minimise any identified risks such as falls and weight loss. Daily records did not always show that staff had provided adequate care to reduce risks such as falls, dehydration, anxiety and low mood. Therefore people remained at risk. Staff identified risk and informed health professionals but did not then devise an action plan of how to further minimise risk.

Some care plans had been improved since the last inspection while others continued to provide only basic information on the person's daily routines and lacked detail on how they wanted staff to support them. It was unclear how people had been involved in drawing up and agreeing their care plan. Some relatives had been asked to check and agree the care plans for example for people who were living with dementia. The records did not clearly show each person's capacity to make decisions about their daily needs, or explain how staff were expected to involve the person or seek their consent before providing care. Where restrictive equipment was in place, such as pressure mats to indicate to staff when someone was mobilising and may require assistance, there was no record of any best interests discussions or effectiveness.

Summary of findings

Some aspects of medicine storage and administration were potentially unsafe. The pharmacy that supplied medicines to the home had recently changed the way they supplied medicines. Medicines were no longer supplied in four –weekly monitored dosage packs, and instead were supplied in bottles and packets and therefore it was important that effective recording systems were followed. However, we saw unexplained gaps in the medicine administration charts with little or no evidence to show these had been investigated or actions taken to check the medicines had actually been administered. Administration records of prescribed creams and lotions were poor, with many unexplained gaps. The management team had carried out spot checks on the medication administration processes and had identified some problems, but they had failed to investigate these fully or take actions to address the problems.

Staff did not receive supervision regularly in line with the provider's supervision policy. The policy stated that all staff should receive supervision six times a year but the supervision records showed that on average staff had received supervision twice in the previous ten months and some had only received formal supervision once. Staff meetings were held regularly and these were minuted.

Overall the home was maintained to a good standard and was equipped to meet the needs of each person living there. However, there were some areas where redecoration and updating needed some further attention. For example some paintwork was scuffed and scratched, a ground floor shower room was being used as a storage area and needed repairs, and a cupboard door with a sign saying 'fire door keep locked' needed adjustment as it could not close. Some furniture and equipment appeared scuffed and worn. The deputy manager told us replacement items were on order. After the inspection they showed us systems they had put in place immediately after our inspection to monitor decoration and maintenance issues and make sure these are completed promptly. The home provided a range of equipment included nursing beds, handrails and bath hoists to help people move safely and as independently as possible.

The provider had monitoring systems in place to ensure the home ran smoothly but these had failed to identify the issues we found during this inspection such as high risk of poor nutrition and falls. Therefore, people were at risk of weight loss and continued falls. For example, care plans had not been fully checked to make sure they contained sufficient information about each person's needs. There were no audits to oversee falls, for example to establish any patterns and again no actions put in place to minimise risk effectively. One person had been identified as being at risk of falls and they were moved to a ground floor room, however no further actions were put in place and this person continued to fall. Systems to consult and involve people in planning their care needs or seeking their views on the services they received were not fully effective.

Some daily records for individuals indicated there had been incidents where there had been behaviour that could be challenging for staff. For example, one person had hurt their finger, one person had gone into other people's rooms at night and another person had shaken another resident. We had not been informed of these and actions had not been put in place to minimise these risks.

We discussed our concerns about our findings with the local safeguarding and quality team throughout our inspection who were now working with the home to help them make improvements.

Since the last inspection the registered manager had sought legal authorisation for those people who lacked capacity to make important decisions for themselves, and who may be deprived of their liberty. This meant they had addressed the breach of regulations we had found at the last inspection.

Most people we spoke with, and their relatives and visitors, were positive about the home. Comments included "I love it here!" and "It's alright." A relative told us "She looks better in here that she did when she was at home. I think that's because she is eating properly now." A community nurse who visited on the first day of our inspection told us they had no concerns about the support given to people to meet their health needs. However, we spoke with a social worker after our inspection who raised concerns about the care provided to one person. This matter was referred to the local authority safeguarding team.

Summary of findings

People received care and support from a staff team who had received relevant training and qualifications. This meant staff had the knowledge and skills needed to enable them to meet each person's mental and physical health needs.

During the inspection we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk from harm because the provider's actions did not sufficiently address the on-going failings. There has been on-going evidence of the provider to sustain full compliance since 2011. We have made these failings clear to the provider and they have had sufficient time to address them. Our findings do not provide us with confidence in the provider's ability to bring about lasting compliance with the requirements of the regulations. We are taking further action in relation to this provider and will report on this when it is completed.

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.
- Services placed in special measures will be inspected again within six months.
- The service will be kept under review and if needed could be escalated to urgent enforcement action.

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.

There were insufficient staff to meet people's needs safely.

Risks to people's health and safety were not managed effectively.

Some aspects of medicine administration and recording were potentially unsafe.

Is the service effective?

Requires improvement

The service was not effective.

Staff were not supervised in line with the provider's supervision policy.

Applications had been submitted for those people whose liberty may be restricted. Records showed people's capacity to make important decisions had been considered, although their capacity to make minor decisions about day to day issues had not been fully assessed.

Staff received training and updates on essential health and safety related topics.

Is the service caring?

Requires improvement

The service was not always caring.

People at the end of their lives could not be certain they would receive care that ensured their death was peaceful and dignified and met their expressed wishes.

Staff supported people in a caring and respectful manner but did not always have time to spend with people.

Is the service responsive?

Requires improvement

The service was not responsive.

Care plans did not always give sufficient or up to date information about each person's needs.

People's social needs were not met. There was no programme of regular activities in the home.

Is the service well-led?

Inadequate

The service was not well-led.

The provider did not have effective systems in place to monitor the service and ensure all aspects of the service were safe and running smoothly.

Summary of findings

Some improvements had been made in seeking people's views on the service, but these were not fully effective and had not been incorporated into the quality monitoring systems in the home.

Dene Court Residential Care Home

Detailed findings

Background to this inspection

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

This inspection was unannounced and took place on 10, 13 and 26 November 2015. The inspection was carried out by two inspectors on the first and third day and one inspector on the second day. The previous inspection of the home was carried out on 27 January and 6 and 10 February 2015. At that inspection we found breaches of regulations. These related to the care and welfare of people who use services, assessing and monitoring the quality of service provision, consent to care and treatment, and records.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports, statutory notifications (issues providers are legally required to notify us about) other enquiries from and about the provider and other key information we hold about the service. The previous inspection of the home was carried out on 27 January and 6 and 10 February 2015. At that inspection we found breaches of regulations. These related to the care and welfare of people who use services, assessing and monitoring the quality of service provision, consent to care and treatment, and records.

Before the inspection, the provider 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 improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the service before the inspection visit.

During our inspection we spoke with the provider, deputy manager, six staff, three relatives, and a health professional. We also spoke with 12 people living there, and observed staff interacting with others whose level of verbal communication was poor. We looked at the care records of ten people who lived at Dene Court including daily records and food and fluid charts.

We also looked at records relevant to the running of the home. This included staff recruitment files, training records, medication records, maintenance records, complaint and incident reports, including falls and performance monitoring reports.

Inadequate

Is the service safe?

Our findings

There were insufficient staff to meet people's needs safely. On the first day of our inspection there were 25 people living there. Neither the manager or deputy manager were on duty that day. There were four care staff, a cook, a morning assistant and a domestic on duty in the morning. Between 2pm and 5 pm there were three care staff on duty, and from 5pm to 9pm there were four care staff. Overnight there were two care staff on duty. During our visit the demands on the care staff were high, with frequent requests for assistance from people living there, and also telephone calls and visitors including health professionals seeking information or support from the staff.

Staff were unable to provide any group or individual activities or social engagement other than during personal care tasks and meals. Some people remained in their chair all day with very little interaction from the staff. Two of these people were known to have depression and a tendency to low mood. A recent resident's meeting raised the issue of low staffing levels. People commented "they weren't happy that they had to wait for staff to attend them" and the minutes stated, "Everyone voiced their concerns that the staff looked busy and they don't like to ask for things or put more jobs on the staff." Management reassured people that "there were enough staff on duty to deal with anything they need or want" but most people living at the home would be unable to initiate this conversation with staff.

Many people living at the home required regular monitoring of their whereabouts to keep them safe. People currently had high levels of need, for example the daily handover sheet on 30 and 31 October 2015 indicated that at least 17 people needed regular checks for mobility, whereabouts or mood. There were no instructions for staff as to how this was managed other than to do "regular checks." Staff told us they "Kept an eye out" and could not say what "regular checks" entailed. People's records showed a high level of falls. Staff said they had no plan as to how they ensured these people were safe but said to each other, "Do you know where [X] is?" We saw one person mobilising independently throughout our inspection without staff support who was listed as needing monitoring and was at high risk of falls and lashing out at people, both of which had happened recently. After the inspection the provider told us they were in the process of recruiting more staff.

We asked staff to tell us how their day was organised. One care worker said, "We have a lot of tasks to do. There is no time for one to one with residents." They said the daily routine for staff only allowed two half hours to specifically interact with residents. A half hour in the morning and a half hour before bed. We saw and were told the rest of the day was spent delivering meals, assisting four people to eat and drink, helping the majority of people to the toilet at set times, doing the laundry and delivering personal care. One person needed constant reassurance and the provider had given them notice to leave as they could not meet these needs.

On the second day of the inspection the deputy manager was on duty plus five care staff. The higher level of staffing that day meant staff were more relaxed and had more time to interact with people. We asked the deputy manager how they measured the dependency of the people living there, and how they identified safe staffing levels, but they were unable to show us any formal methods of determining staffing levels. They told us they were aware the staffing levels were low and they were in the process of recruiting more staff. Again staff were unable to tell us how they monitored people's safety or mood. One person known to be anxious and suffer from depression was walking around the home crying, which was distressing the other person walking with them. Care staff walked past them without acknowledging them until we asked a care worker to spend time with them, which they did and the person became calmer.

This is a breach of regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Staffing.

At the last inspection we found risk assessments had not been reviewed regularly and care plans did not provide up to date information on areas of risk to people's health or welfare. At this inspection we found some improvements had been made. Risk assessment covered most areas of risks, for example behaviour, pressure sores, weight loss and moving and handling and these had been reviewed more frequently. However, care plans and action plans had not then been drawn up to give staff clear instructions as to

actions to take to minimise these risks. For example, although people continued to have falls, there were no care plans to address what actions to minimise falls were used and whether these were effective.

Some important risks had not been assessed or reviewed regularly. For example, the risk of falls had not been assessed for a person who had fallen a few months previously resulting in a broken femur. The person's age and health needs indicated they may be at significant risk of further falls but this had not been assessed and no actions taken to further reduce the risk of further falls. We looked at some people's history and incidence of falls. This showed people were not safe and that actions had not been taken to effectively minimise their falls. People continued to fall despite the risk being known to staff. One risk assessment said the person was able to independently mobilise. However, we saw this was not the case and a note in the review section of the plan in October stated the person now was at high risk of falls and required two care workers to assist as they were non-weight bearing at times. The moving and handling assessment had not been updated or added to the care plan. The person had had some falls, including two on 7 November and one on 8 November but no actions were added to the care plan. Therefore the risk would not be clear to staff.

One person had fallen at least six times in five months. The GP had been called to discuss a medication review but there were no further instructions other than "to get their sleep pattern in order." Another person had fallen repeatedly between July and November 2015 and action taken had been to move them to a ground floor room in September 2015 when one became available. They had become increasingly unable to mobilise unaided from October 2015 but went on to have another fall. We were particularly concerned about one person who had been identified as at high risk of falls. They had fallen at least ten times since March 2015 and the daily records showed another four falls including one resulting in a black eye and another requiring paramedic input. They were now in hospital after being found on the floor. There were no overall fall audits to identify if there were any patterns in people's falls relating to time, staffing levels or place for example. One care worker said they did have a pressure mat in place for one person. They said it wasn't particularly effective as the mat was by the door and by the time the person got there it could too late. There was no monitoring of whether any preventative actions to minimise risk were effective or reviewed. There was no overall assessment of falls within the home so we were unable to see how many falls there had been over time.

Where risks had been identified the information was not always transferred from the risk assessment or review to the main care plan document. For example, a care plan had been updated on 21 August 2015 saying "[The person] has been physically and verbally abusive to staff and residents. Behaviour charts have been filled in." However, a review sheet dated 28 October 2015 showed "[The person] has seemed to be more calm this month and seems more settled." This information had not been transferred to the main care plan with details about why the person was more settled. There was no further information to staff to explain how to recognise signs of distress that may lead to anger, or how to support the person, for example by offering an activity that may help to calm the person.

For another person there was also no risk assessment related to aggressive behaviour despite regular comments of this happening in the person's daily records especially relating to personal care. For example, detailing ways to reduce this risk or any triggers or how to manage it. Therefore there was no guidance for staff about how to manage this person safely other than to use the "right approach" although the plan did say not to keep persuading them to have a bath. On 22 October for example the person was "agitated and violent" all day but no record of how this was managed. Staff we spoke to knew that people had been identified as being at risk but were not able to tell us how they were managed. They were aware that they needed to monitor people's whereabouts for example, but could not tell us how this was managed effectively to minimise risk.

Monthly Waterlow risk assessments had been completed. Waterlow risk assessments are a nationally recognised tool to particularly to assess the risk of skin pressure area damage. However, when a high risk was identified there was no related care plan to show what actions staff should take to minimise this risk. Also daily records did not mention pressure area status to show the risk was being monitored.

Some people had been identified as being at risk of malnutrition and/or dehydration. Their food and fluid intakes were monitored using a food and fluid chart but these did not explain the ideal food or fluid intake levels, or

the actions staff should take if the person's intake level fell below this amount. Staff had not added or recorded the total amount of fluids consumed each day. This would ensure staff were analysing people's overall intake and taking appropriate action. One person's fluid chart recorded the person had taken only 145mls of fluid on one day and 450mls the following day.

All fluid charts were completed at set times such as breakfast, mid-morning, lunch, and mid-afternoon, and suggested people were only able to drink during these times. We did not see staff offering food or drink in between these times unless someone asked, which most people were not able to do. One night record stated a person had a 'rumbling tummy' and when the care worker gave them some food "They couldn't get it down fast enough." There was no evidence in the records to show any actions had been taken as a result. For example, ensuring the person had access to regular snack food, finger food, high calorie diets/milkshakes or food and drink outside set times. Those people requiring supplement drinks did receive them on a regular basis. Although staff had asked one family to supply the person's likes and dislikes records did not show how this had been implemented. Aside from the lack of effective monitoring of people's nutritional needs we saw that staff did not have time to spend with people to encourage them to eat and drink, distract people with chat or address people's low mood which may have enabled people to eat and drink. After our inspection a social care professional told us about a person who had lost a significant amount of weight over a short period of time. On the third day of the inspection we read this person's care plan and found their care plan did not explain what action staff should take to monitor the person's weight or to encourage them to eat sufficient food to maintain their health.

Staff had identified where people were at risk of losing weight and weights were monitored. However, actions taken were related to accessing advice from health professionals, which is good practice. However, although their advice had been taken, such as review medication or continue offering diet and fluids, this was not well managed to consistently monitor effectiveness. This put people at risk of malnutrition.

People were not fully safe from harm. One incident we saw recorded in a person's daily notes was not recorded in the accident and incident book. It is important to record all accidents and incidents to enable clear auditing of these, show that actions have been taken and any lessons learnt. The information indicated an injury was caused to one person living at the home by another person living at the home. Although the person saw a GP there was no further action noted of progress or any actions taken by staff to minimise this risk. Another incident in one person's daily records stated they had "grabbed another resident by the wrist and shook them." There was no further information recorded. Another daily record indicated a person had been going into other people's rooms at night but there was no information about how this was managed. We had not been informed of any incidents that could be identified as safeguarding. The daily handover sheet also identified people who could show behaviour that could be challenging for staff and put other people at risk. For example, one person could become aggressive with other people and another person was recorded as needing observation when near females but there were no care plans on how staff should monitor this effectively.

Staff told us, and records we saw confirmed that all staff received training on how to recognise and report abuse. Staff we spoke with had a clear understanding of what might constitute abuse and how to report it. All were confident that any concerns reported would be fully investigated and action would be taken to make sure people were safe. However, we were not confident from looking at records and staffing levels that this was consistently the case.

This is a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014

Some aspects of the home's premises and level of maintenance did not ensure people were safe, especially those people living with dementia who were independently mobile. When we looked around the home we saw some areas had been redecorated since the last inspection and appeared bright and attractive. However, there were some areas that required further maintenance. For example, some paintwork was scuffed and scratched. Some doors had been replaced but they had not been painted and still had only the primer coat. A cupboard door marked 'fire door keep locked' could not close properly and was left open. A 'Doorguard' automatic door closer let out a steady beeping noise indicating the battery was not working. There were no supplies of batteries in the home – staff told

us new batteries had been ordered. In the meantime the door was held open despite the potential fire risk, and despite the annoying beeping sound that could be heard all over the house.

Other areas needing attention included curtain hooks off, broken cupboard doors, a broken light pull and excess electric wires. The staff toilet was unfinished and accessible to people living at the home. There were exposed electric wires and a broken call bell. This room on the ground floor and some bedrooms and a bathroom had unrestricted windows meaning they opened wide which was unsafe. This was particularly unsafe as one person had been identified as regularly trying to leave the home. The action recorded was that all windows were restricted.

A maintenance person was employed who had a plan of maintenance and further updating to the environment. Many areas had been re-carpeted and most of the bedrooms had been re-decorated. There were new washing machines with detergent dispensers. However, there was no clear plan in place to identify regular maintenance tasks (such as adjusting fire doors).

This is a breach of regulation 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Medicines were not always recorded after they had been administered and this meant there was a risk people may not receive their medicines as prescribed. The pharmacist had recently changed the method of supplies to the home. Tablets were no longer supplied in four weekly monitored dosage packs and instead they were supplied in bottles or packets of foil strips of tablets. Where we found unexplained gaps in the medicines administration records (known as MAR) it was no longer possible to check the monitored dosage pack to see if the medication had been removed from the pack. A random check had been carried out on stock levels of a few medications, but the checks had not identified missing signatures on the MAR charts. The balances of each supply of medicines had not been checked regularly. This meant they did not have robust systems in place to identify any incidents of missed medications, or to investigate the causes and take actions to prevent recurrence.

There were suitable secure storage facilities for medicines. Medicines were stored in a secure medicines trolley. This was kept in a room that was locked when not in use. However, after our inspection a social worker told us during a recent visit to the home they had seen some poor practice relating to medication administration.

There were no photographs of people provided in the medicine administration records to help staff identify people when completing medicine rounds. The recording sheets were divided to help staff locate records for each person easily. However, the room numbers had not been amended when people had changed bedrooms. This meant there was a risk that new staff, or staff who had been absent for any period, may have difficulty identifying people and ensuring medicines were administered to the correct person.

Creams and lotions were kept in people's bedrooms along with administration records. However, these had not been completed each time the creams had been applied. This meant there was a risk the creams had not been applied as prescribed. The records had not been monitored regularly and no actions had been taken to identify the reasons why the forms had not been completed or actions taken to address this. The deputy manager told us they were confident the creams had been applied. They also said they had reminded staff of the importance of completing the forms. However, the reminders had not resulted in any improvement.

This is a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider had a policy in place of only allowing medicines to be administered by staff who had received training on the safe administration of medicines.

Some people were prescribed medicines on an 'as required' basis. There was guidance in each person's records to explain when these should be administered. We observed the midday medicines round people who were prescribed pain relief on an 'as required' basis if they were in pain, and if they wanted pain relief. Where they refused pain relief this was recorded correctly.

Care plans provided information to staff on people's medicines and how they should be administered. For example, one care plan said "[The person] likes to have all her tablets put into her left hand and she will use her right hand to put them in her mouth. Close monitoring is needed as she will sometimes no pay attention and will drop them

Inadequate

Is the service safe?

into her lap." During the medicines administration round we saw the member of staff following this instruction and watched carefully to make sure the person swallowed each tablet.

People who were able to verbalise their experiences at the home told us they felt safe at the home and with the staff who supported them. Comments included "You couldn't get any better people. They are looking after me well." A relative told us "I am confident my mother is safe. When I have had any queries or concerns the staff have answered me or found out the answer."

There were good personal emergency evacuation plans (PEEP) for each individual. These gave good information as to what people's risks were and how to manage and support them in an emergency such as a fire. For example, one said the person would most likely try to find a member of staff and shout out. Another said the person would need full assistance and would not understand.

Risks of abuse to people due to unsuitable staff were minimised because the provider made sure prospective new staff were checked to make sure they were suitable to work at the home. These checks included seeking references from previous employers and checking that job applicants were safe to work with vulnerable adults.

Requires improvement

Is the service effective?

Our findings

The service was not fully effective. People's nutritional needs were not fully assessed to make sure they received a diet in line with their needs and wishes.

Care plans did not contain sufficient information about each person's likes and dislikes and dietary needs. Older style care plans did not contain specific reference to eating, drinking, likes or dislikes. Care plans that had been updated since our last inspection using a new format contained a section on eating and drinking. However, this information was not always used to inform care delivery to ensure people ate what they wanted especially if they were at risk of losing weight.

Staff had some awareness of dietary needs despite the lack of reliable information in the care plans. The cook and kitchen staff told us they were aware of people's dietary needs such as diabetic and high calorie. People who were able to said they enjoyed the meals and said they were always offered foods they enjoyed. Comments included "The food is excellent" and a relative told us "She looks better now than she did when she was living at home. I think that's because she is eating properly now. Her face has filled out and she looks much healthier." A senior care worker said how a social worker had told them how much better one person was since being at the home as they had neglected themselves at home, especially with preparing food.

People who were at risk of weight loss were weighed regularly and the staff sought advice and treatment from health professionals where necessary. During our inspection the staff received a telephone call from a professional who wanted to know how a person was settling into the home. The staff were able to respond to the professional's questions knowledgeably and they were also able to turn to the care plan and records to give information about the person's weight and eating habits. However, those people at risk did not have clear action plans within the home to ensure they were offered food and fluids more regularly than at set mealtimes.

This is a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safe care and treatment

People were offered a choice of two main meals at lunchtime and could ask for an alternative if they did not like the meals offered. Menus were displayed on the notice boards in the dining rooms. On the second day of our inspection people were offered ham, egg and chips or burgers, egg and chips. The meal appeared appetising and people seemed to enjoy the meal. Where people had difficulty eating they were offered assistance from staff. Meat was cut up into small pieces for some people who had difficulty cutting or chewing meat. Where people were at risk of choking meals were pureed or minced in line with advice given by the speech and language therapy team (known as SALT).

We also met a relative who wanted advice and information about a person's diet and possible weight loss. The staff were able to show the relative the records of the person's weight which showed their weight was low but stable. They discussed dietary supplements and foods the person liked and disliked and possible ways to help the person increase their calorie intake. The staff had recently spoken with the person's doctor and sought advice on dietary supplements and they were able to reassure the relative of the doctor's advice and opinions.

At lunch time we saw that people were able to choose where they ate their meal. There were two dining rooms where people could have their meals. Alternatively some people chose to sit in their bedrooms and a few people chose to remain sitting in a lounge chair and ate their meal from an adjustable table.

At the last inspection we found consent had not always been gained before people received care or treatment. During this inspection we found consent forms had been drawn up for those people staff had assessed as not having capacity to make important decisions for themselves. They had asked the person's next of kin to sign the forms to consent to care on the person's behalf. However, there was no recorded evidence to show they had considered the person's ability to make certain decisions for themselves or be involved in their care using best interest processes. For example, there was no recorded evidence to show when people could make decisions about daily activities such as what clothes to wear, or what food to eat, but unable to make informed decisions about the medication they took or any medical treatments necessary.

For example, there were no best interest discussions about whether a particular restrictive practice was in the person's best interest such as using pressure mats. A pressure mat is used to alert staff when a person is mobile. Staff said they

Is the service effective?

used one if the person was at risk of falls. There was no record of discussion with them or their family or health professionals about whether it was in the person's best interest to use the pressure mat.

One person's care plan said they did not want night checks but they continued to be checked regularly at night. There was no recorded evidence of people's involvement in their care plans. However, there were records showing that people had been involved in making decisions about moving rooms to help minimise falls, for example.

During the inspection we saw staff asking people's consent before carrying out any care tasks. Staff asked people "Would you like…?" and "Can I help you with….?" before carrying out any tasks. This showed the staff understood the Mental Capacity Act 2005 (the MCA) and the need to seek consent, although the records did not always provide sufficient evidence to demonstrate each person's level of ability to make decisions. 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. We did not see records discussing people's best interests, for example in the use of restrictive measures intended to protect people. Therefore, there were no processes in place to ensure staff were working within the principles of the MCA so people's rights were protected.

This is a breach of regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Need for consent.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the last inspection we found some people were at risk of having their liberty deprived, but no application had been made to seek legal agreement for this. During this inspection we saw applications had been submitted to the local authority and they were waiting for assessments to be carried out before approval could be obtained.

The deputy manager told us they had previously visited a specialist centre for people living with dementia where they had gained ideas on 'dementia friendly' decorations and furnishings. We saw some ideas had been incorporated into the design of the premises, for example in one corridor there was a sign saying 'memory lane' and pictures of scenes that might evoke memories. We saw no other evidence of items that might stimulate reminiscence. There was very little evidence of signage or decorations that might help people find their way around the home, or find their bedroom easily. We saw some people walking around the home and seeking information from staff about where they wanted to go. One person was asking "where was the bathroom?" and this was recorded as a regular occurrence. The deputy manager had ideas about ways to help people find their way around the home more easily but there were no firm plans to put these into place in the near future.

People received health care and support from staff who had the skills and knowledge to meet their needs although there were concerns about staffing levels and the quality of information in people's care files to enable them to do this. Staff had received training and yearly updates on essential health and safety related topics. They had also received training on topics relevant to the needs of the people living at Dene Court, including dementia and continence. Training was delivered in a variety of ways, including distance learning and classroom based training delivered by professionals with knowledge and expertise in the topic. Most of the staff held a relevant qualification, for example National Vocational Qualification (NVQ) at either level two or three. People were supported by staff who had undergone an induction programme which gave them the basic skills to care for people safely.

Staff received supervision on an individual basis from the deputy manager. Records showed these were not always carried out on a regular basis in line with the provider's supervision policy. On average staff had received two supervision sessions in the previous ten months, although some had received three and some had only received one. Staff told us they received supervisions and they could

Requires improvement

Is the service effective?

always seek advice or supervision whenever they required. Staff meetings were held regularly and these were an opportunity for staff to speak up and raise any issues or concerns.

The home arranged for people to see health care professionals according to their individual needs. Healthcare professionals who provided feedback said the staff contacted them to discuss issues with individual's healthcare and acted on any advice given. Staff appeared knowledgeable when talking to health professionals. For example, one person had had an eye test and received new glasses. Where one person had increased periods of being unsettled and distressed their GP had visited and amended their medication. Another person had their dentures checked and a problem treated and one person with back pain had seen the GP promptly.

We recommend further improvements should be considered to the environment to help people living with dementia move around the home safely and promote independence.

Requires improvement

Is the service caring?

Our findings

People at the end of their lives could not be certain they would receive care that ensured their death was peaceful and dignified, or met their expressed wishes. After the inspection a care manager raised concerns about the care given to a person at the end of their life. They told us the records of care given at the end of the person's life were poor. During our inspection we looked at the person's care plan and found they did not explain how the staff should support the person when they became distressed, how to recognise signs of pain or serious illness requiring medical attention, or the emotional support the person needed. This meant it was not possible to check that staff had given the person the care or support they needed at the end of their life.

None of the care plans we sampled provided information about people's wishes and preferences relating to end of life care. Some plans stated that people "did not have a fear of dying" and "[The person] is a Christian" but no further practical information of how staff would meet these needs. Therefore staff would not know how to meet people's wishes in relation to end of life care. One care plan was not updated to include managing a person's recent bereavement. Staff had received some training relating to end of life care and the manager told us they plan to provide further training on this topic in the forthcoming year.

This is a breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Good governance.

Staff were friendly, cheerful, patient and encouraging, although they were often too busy to give people the reassurance and support people needed when they expressed anxiety. During our inspection, one person spoke many times of wanting to kill themselves or wanting to die. Sometimes staff walked past the person without giving any words of reassurance, while other times they stopped for a few moments to offer comforting words. However, they were unable to stay with the person long enough to give them the reassurance they needed. Their care plan said the person often spoke of wanting to die, but there was no information about how to manage this, for example, by offering reassurance or distraction.

This is a breach of regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Person centred care.

People said they were supported by kind and caring staff. Comments included "I think the staff here are quite good." One person said "Oh, yes they are very nice, look at it. I'm all cosy and warm." When staff were interacting with people as they carried out tasks or passed by they was a lovely rapport between them when staff were not busy completing a task. One person said "They look after me, I always get a smile." Healthcare professionals told us they found staff to be caring.

People's privacy was respected and all personal care was provided in private. For example, a member of staff noticed a stain on a person's blouse and offered to help them change into a clean blouse. One care worker assisted a person with their breakfast. They told them what was on the spoon and explained they had a clothes protector on and not to worry. People appeared physically well cared for. Few people were able to care for themselves and staff ensured people were clean and well dressed. For example, one person's care plan said they felt the cold and we saw they had a blanket and warm clothes in the lounge.

People made choices about where they wished to spend their time. Some people preferred not to socialise in the lounge areas and spent time in their rooms. One person was enjoying a morning lie down. Staff said the person went back to bed when they felt like it. Another person had gone back to their room for a nap and another person was going to the shops independently. Each person who lived at the home had a single room where they were able to see personal or professional visitors in private.

Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful and compassionate way.

Requires improvement

Is the service responsive?

Our findings

People did not receive care that was responsive to their needs and personalised to their wishes and preferences. Their needs were also not fully reflected in their care plans.

Many of the people at the home had mental health needs, dementia, depression and anxiety. Although these needs had been assessed and documented in care plans, there were no comments within daily records that these were being met. For example, one person's care plan showed they needed regular reassurance or time one to one with staff due to their depression or anxiety. The person was stated as being "too scared to be on their own" and crying and becoming distressed with negative thoughts. This person spent very little time with staff other than tasks and daily notes showed they were regularly distressed and shouting and at times becoming aggressive so they were moved to their room by staff. There was no evidence of how their distress was managed. At times they had interacted negatively affecting other residents but were told "this wasn't acceptable". This person was constantly recorded as being distressed and upset wanting to go home or out over a long period of time but there was no plan as to how to manage their behaviour or help the person, for example by offering company, distraction or an activity. On one occasion since October the daily records stated "Went out down to the shops with [their relative], very happy when they came back." This was not recorded again up to the time of our inspection. Staff said they did not take people out, "they would have to risk assess it but they haven't".

There were no records of how the home was meeting each person's individual social and leisure needs. Therefore we looked at the daily records and spoke to staff. Staff told us they had little time for one to one time with people. We saw little interaction between staff and people living at the home other than during tasks or when passing. One person was at risk of isolation and low mood . Their care plan stated they loved dancing and music but there was only one reference to them joining an external musical entertainment event in October. Before their mobility decreased they were recorded as regularly "exploring or wandering around the home" but we did not see any evidence of meaningful engagement or stimulation.

Information had been provided by a person's relative about their care. Although the new care plan format was detailed and contained comprehensive information about people's background, likes and preferences, we did not see how this was used in practice to meet people's individual needs. One person had detailed information given to the home by family. This was not included in the care plan. For example, details such as likes a shower (they were having baths) and a history of nail infections requiring a regular podiatrist (they were assessed as having perfect feet to be done in-house). This person living with dementia was a keen gardener and loved the park and walks. Their daily records stated repeatedly that they "walked around the home, explored the home, were 'wondery' and off wandering." When we asked staff what this person did all day, they said "They like to explore the home." This meant they walked around the home all day. We saw little interaction with staff during our inspection and the person spent the day walking around the home on their own, or particularly with a person with depression who cried often. They had been out twice with family but no other engagement was recorded or seen. The person was able to tell us there was nothing to do. One care worker said if they had time they gave this person a duster or magazines to sort but this was not recorded or seen. Their care plan said the person liked to be kept busy.

This is a breach of regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Person-centred Care.

Each person had their needs assessed before they moved into the home. This was to make sure the home was appropriate to meet the person's needs and expectations. There was family involvement but this information was not always used to inform the care plan or put into practice.

Care plans were not fully personalised to each individual although they contained some information to assist staff to provide care in a manner that respected their wishes. A senior care worker said "Now the care plans are on the computer nothing gets missed and we know what's changed." The staff responded to changes in people's health needs although these were not always clearly documented or updated in the care plans. For example, one care plan was not updated about the person's mobility decline and still included the person's interactions with their husband who had since died. They also now needed one person to assist them with eating and drinking but the care plan had not been amended despite them now having a food and fluid chart to monitor intake. One care plan said to monitor someone's bowel habits stating "Will need

Requires improvement

Is the service responsive?

assistance with bowels" but no further information about how to do this. The bowel chart showed one entry per month. Another care plan did not include a person's increased incontinence when out or what to do about it.

This is a breach of regulation 17 (2) (c) of the Health and Social Care Act (Regulated Activities) Regulations 2014 Good governance (Records).

There were ways for people to express their views about their care but these were not fully effective. Since the last inspection two residents meetings had been held and these had been minuted. At the last meeting held in September 2015 eight people attended and their views were recorded. However, there were no systems in place to seek the views or involve those people who did not attend the meeting. Future meetings were not planned or recorded in the home's diary therefore there was a risk these may not happen regularly.

People were not always involved in their care plans if they had been assessed as not having capacity for major decision making. Questionnaires had been drawn up and left in the entrance hallway with the expectation that relatives and other people visiting the home might pick one up and complete it, however, only one relative had completed a questionnaire. We discussed with the deputy manager the possibility of encouraging a better response, for example by giving people a questionnaire and asking them to complete it, or by offering assistance to complete it.

Each person received a copy of the complaints policy when they moved into the home. There was a complaints policy on the home's notice board. One complaint received by the home in 2015 had also been forwarded to the CQC. We had discussed the complaint with the provider and registered manager and had been given information to show they had listened to the concerns and had taken actions to prevent recurrence.

Inadequate

Is the service well-led?

Our findings

The home was not well-led. Failures in the management systems identified at the last inspection had not been adequately addressed. People remained at risk of unsafe care. The provider failed to put in place robust systems to identify where the home was failing to provide safe, effective or responsive care, or to take actions to address this. At the last inspection we issued a compliance action telling the provider they must take action to address failings in their quality assurance processes. During this inspection we found that, where improvements had been made, these were not fully effective and had failed to identify the problems we found during this inspection.

There was a registered manager in post who also managed another home owned by the provider. This meant they were only present in the home for part of the week. Many aspects of the day-to-day running of the home had been delegated to the deputy manager but this was not effective. For example, falls were not monitored and minimised effectively, people who could be at risk to others were not effectively monitored to ensure people were safe and care records had not been audited to ensure they contained up to date information or enough information to meet people's needs. Each day there was one team leader on duty in the morning and one team leader on duty in the afternoon and evening. This meant there was a staffing structure in place that ensured line management responsibilities were clearly set out but there were no systems in place for them to follow to ensure a good quality and safe, effective, responsive and well-led service.

There were no systems in place to determine safe staffing levels according to the number of people living in the home and their level of dependency and support needs. Where staff raised concerns in staff meetings relating to safe staffing levels these were not listened to, investigated or acted upon. Supervisions were not carried out in line with the provider's supervision policy

Care plans were not checked fully by the management team to make sure they contained sufficient detail about each person's needs. Where changes in care needs had been identified the audit systems had failed to identify instances where the information had not been transferred to the main care plan. This meant some care plans continued to provide inadequate and out of date information to staff on areas of risk, or the actions staff should take to keep people safe.

There were no systems in place to identify people's social needs. The level of regular planned activities had reduced since the last inspection but this had not been identified in any quality assurance or monitoring systems by the provider. People's social and leisure needs had not been met in a person-centred way in particular for people with anxiety, depression and dementia. Therefore people had little regular meaningful engagement with staff or purposeful occupation.

Audits and checks on medication storage and administration were not robust. Unexplained gaps in the medication records had not always been reported or followed up. When errors or omissions had been identified these had not been promptly or robustly investigated, and actions had not been identified to minimise the risk of errors happening again. The audits failed to identify poor recording of creams and lotions or actions to address this. The audits had also failed to identify areas of potential risk in relation to medication administration, for example, there were no photographs in place to make sure staff always correctly identified the person they were administering medicines to.

There were no systems in place to look at incidents and accidents in the home, any trends, or any actions that could be taken to prevent them happening again. Accidents and incidents which occurred in the home were recorded but not analysed and some not formally recorded other than within daily records. Where people had fallen frequently, or where they may be at risk of future falls, there were no systems in place to look at why, when and how falls were occurring or any further action they should take,

There had been some improvement since the last inspection in involving and consulting with people (resident's meetings had been introduced) but these were not fully effective. The residents meetings were not planned in advance and there were no systems in place to make sure they were held regularly. There were no actions recorded as to addressing any concerns raised during these such as staffing levels. Questionnaires were left in the entrance hallway had only resulted in one response.

Inadequate

Is the service well-led?

A maintenance person was employed who had a plan of maintenance and further updating to the environment. However, there was no clear plan in place to identify regular maintenance tasks such as adjusting fire doors and ensuring all areas of the home were safe for people to access freely. For example, ensuring window restrictors were in place.

This is a breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Good governance.

The deputy manager was aware of the need to report deaths and significant incidents to the Care Quality Commission. However, a relative told us there had been an outbreak of Norovirus earlier in the year but this had not been reported. This meant we had been unable to check that the staff had sought guidance and had taken sufficient measures to prevent further outbreaks from occurring. At least two possible incidents involving harm between people living at the home had not been notified to us but recorded in people's daily records only. This meant they were not fully meeting their legal responsibilities.

This is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notifications.