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Dean Wood Manor

Inspection report

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced inspection of Dean Wood Manor on 08 and 09 June 2016. We carried out a further announced inspection visit on 15 June 2016.

At our last inspection on 03, 05 and 12 November 2015, we found multiple breaches of regulations. The home received a rating of 'Inadequate' and was placed into special measures.

During this inspection visit, we found sufficient progress had not been made and there were continued systemic failures across the home. We found continued multiple breaches of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to: Person-centred care; Dignity & respect; Need for consent; Good governance; and, Staffing. We are currently considering our enforcement options in relation to these regulatory breaches.
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, there were 32 people living at the home . The premises are based around an original Grade II listed building that has been extended and recently modernised. There are extensive gardens surrounding the home and on-site car parking is available. The home is owned and operated by a partnership trading as Dovehaven Care Group. Throughout this report, the Dovehaven partnership is referred to as the 'Provider'.

We looked at how people's medicines were managed and found the service had continued to fail in ensuring that medicines were manged safely and administered appropriately; and had failed to ensure that staff responsible for the management of medicines were competent, skilled and experienced to do so safely.

We looked at people's care records to ascertain that care, treatment and support which people needed was being delivered safely and that risks to people's health and wellbeing were being appropriately managed. We found people's care records contained a variety of risk assessments and associated documentation. For example, skin integrity, allergy status, nutritional risks, continence, falls and waterlow. However, we found that risk assessments had not been consistently updated in response to people's changing needs and, in some cases, risk assessments were incorrectly scored which meant that effective measures were not taken to minimise risk.

We looked at staffing levels to ensure there was sufficient numbers of staff to meet people's needs. At the time of our inspection visit 32 people were living at the home. The home was not at full occupancy because the Provider had agreed to a voluntary embargo on admissions following our last inspection. At this inspection, we saw that a dependency tool had been implemented and was used to determine the number of staff required to meet people's needs. However, despite the use of a dependency tool, we found that throughout our inspection visits, their continued to be insufficient numbers of staff deployed to keep people safe and to meet their needs.

We looked at the recruitment policy and associated procedures and found safe recruitment practices were

in place. Disclosure and Barring Service (DBS) checks had also been completed to ensure the applicant's suitability to work with vulnerable people. Records were maintained which demonstrated nursing registrations were valid and up-to-date.

We looked to see how the service sought to protect people from abuse and found there were appropriate safeguarding and whistleblowing policies and procedures in place. Staff were able to describe the homes alert process and the local authority procedures. All the staff spoken with demonstrated they had a working knowledge of the types of abuse and the procedure to follow if they suspected that a person was at risk of, or was being abused.

We asked staff about whistleblowing. All of the staff we spoke with told us they would not hesitate to use the policy and identified internal reporting protocols.

Since our last inspection of Dean Wood Manor, the Provider had given reassurance that all staff would be enrolled in a new training & development programme that was being managed through a new 'Dovehaven Training Academy'. However, during this inspection, we found insufficient progress had been made to ensure that staff were fully supported and qualified to undertake their roles.

Training records we looked at demonstrated that progress had been made in relation to mandatory training and that the vast majority of staff had completed, or were scheduled to complete, all of the required training. However, in respect of key additional training, we found low numbers of staff had completed recent training in respect of the mental capacity act, deprivation of liberty, dignity & respect, dementia, record keeping, equality & diversity and nutrition & hydration. This was of particular concern given the specialist nature of the service provided at Dean Wood Manor.

We looked at supervision records and found progress had been made in the frequency staff received supervision. However, we saw the vast majority of supervision sessions were being used as a punitive measure to address issues when staff had made an error.

During this inspection, we found serious systemic problems in respect of the Providers failure to adhere to the principles of the Mental Capacity Act 2005 and the application of legislation which governs the use of Deprivation of Liberty Safeguards within a care setting. We also saw restrictive practice was commonly used which constituted a deprivation of people's Human Rights. For example, towards the end of our first day of inspection, just before the day shift handed over to the night shift, we found 18 people who used the service had been moved into the West Lounge and we observed people were prevented from leaving the lounge whilst the staff changeover took place. We noted the impact that this had on people as there were several people displaying high levels of agitation during this time. All the staff we spoke with confirmed that moving people into the West lounge was custom and practice at the home and that people were moved to the lounge whether they were agreeable or not. We ascertained from the staff that this was done at this time due to handover because there was insufficient staff at that time to supervise people in other areas of the home.

We looked at how people who used the service were supported to eat and drink and the meal time experience. Since our last inspection, we saw improvements had been made to ensure people with additional needs were appropriately supported to eat and drink. However, the overall meal service remained chaotic and staff lacked supervision and direction to ensure other people who used the service received their food and drink in a timely manner.

We looked at Dean Wood Manor's approach to end of life care and found that since our last inspection

improvements had been made. The home was now taking part in a pilot scheme working with Wigan Hospice to support people nearing the end of life, their families and staff.

The vast majority of people who used the service at Dean Wood Manor were not able to actively participate in planning and agreeing their own care and support. This meant that care planning documentation was completed solely by staff from the home. However, we found that care plans did not always demonstrate that people's lawful representatives had been consulted. We also found that information contained in people's care plans was confusing, contradictory and did not adequately guide staff to the care and treatment needs of the people they were supporting.

Since our last inspection, we found that clinical and operational oversight provided by Dovehaven Care Group was inadequate. Overall governance was ineffective and there was a continued lack of co-ordinated leadership which directly impacted on the quality of care being provided. In particular, we found governance arrangements for clinical audit and questioning of practice was wholly inadequate.

The overall re-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.

During our last inspection of Dean Wood Manor, we placed the service into special measures. Services placed in special measures are inspected again within six months; therefore this inspection was a comprehensive re-ratings inspection. Where 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.

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.

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.

People were not protected against the risks associated with the management of medicines.

Individual risks to people were not consistently assessed and findings acted upon.

There was insufficient numbers of staff to keep people safe.

Is the service effective?

Inadequate

The service was not effective.

We found serious systemic failures in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards.

Training, professional development and supervision of staff was not effective.

Insufficient progress had been made with regards to adhering to national best practice guidance in developing a 'dementia friendly' environment.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not always actively engage with people before a task was completed with them.

Some staff referred to people who used the service by referring to stereotypical labels rather than by their name.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans did not always demonstrate that people's lawful representatives had been consulted.

We found limited evidence of meaningful person-centred activities taking place.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager at the service.

Operational and clinical leadership & governance was inadequate.

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

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 was a comprehensive re-ratings inspection and was planned to check whether the Provider was meeting the legal requirements and regulations associated with the Health & Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection team consisted of an inspection manager, five adult social care inspectors and medicines inspector (pharmacist) from the Care Quality Commission (CQC). The inspection team was also supported by a nurse advisor with specialist skills and experience in general nursing and the care of older people living with dementia.

Since our last inspection, CQC had been continuously liaising with the Wigan Council, Wigan NHS Clinical Commissioning Group and the Provider from Dovehaven Care Group. Before the inspection, we reviewed all of the information we held about the home in the form of statutory notifications sent to CQC including those related to safeguarding incidents, deaths and injuries.

Due to the nature of the service provided at Dean Wood Manor, we were unable to speak with people who used the service to ascertain their views about the care and support provided. However, we spoke with five visiting relatives and completed a number of 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 also spoke with the provider, the manager of the home, two regional managers, a quality assurance manager, three registered nurses, 10 care staff and various support staff including housekeeping, maintenance and catering.

We looked in detail at 10 care plans and associated documentation, eight staff files including recruitment & selection records, a variety of staff training & development records, audit & quality assurance, various policies & procedures, and safety & maintenance records .

Inadequate

Is the service safe?

Our findings

Due to the nature of the service provided at Dean Wood Manor, we were unable to speak with people who used the service to ask if they felt safe. However, we were able to speak with visiting relatives and received a mixed response. Comments we received included; "Not had any need to raise any serious concerns, just the odd hiccup now and again". "If I have any concerns I just mention it to the staff and they will sort it but I've no worries about safety". "I sometimes worry about [relatives] safety because some of the other people living here can lash out. The staff try and stop them but they can't be everywhere at once". "No concerns about safety".

At our last inspection in November 2015 we found that medicines were not handled safely and following our visit we raised a number of safeguarding alerts with the local authority. As a result of this, a pharmacist inspector supported the inspection team on this visit to look at how people's medicines were managed. We looked at 21 medication and administration records (MAR). We found that improvements had not been made and the way medicines were handled remained extremely unsafe.

The home did not have sufficient stock of medicines to ensure people could receive their medicines as prescribed. We saw that over a two month period 15 out of the 21 people whose medicines we looked at ran out of between one and six of their medicines for periods of up to a week. We also saw that some of those people ran out of the same medication on more than one occasion placing their health at greater risk of harm.

We found people were not given their medication safely. In March 2016, the CCG pharmacist team had reviewed people's medicines and letters were sent to the home detailing the changes the doctor would make to people's medicines. The CCG also sent new prescription ordering forms to the home for each of the people so that the nurses could order the correct medication. On the day of the inspection we found these letters remained unopened and the nurses on duty were unaware of the changes that had been made. As a consequence of this, people had continued to be given medication that was no longer prescribed. This had placed people's health at risk for three months.

We saw medicine rounds were poorly organised and people were not always given their medication at the time they needed it and the nursing staff could not demonstrate that they maintained the required time intervals between doses. We also saw that people were not given the correct dose of their medication. People did not have their creams applied properly. Nurses failed to administer antibiotics properly to one person who had just come out of hospital placing their health at risk of serious harm.

Most people were prescribed medicines to be given 'when required', such as pain relief or medicines to relieve constipation. We saw that there was insufficient information recorded to ensure that people were given medicines prescribed in this way safely and consistently. When people were prescribed creams there was little or no information available to guide care staff as to where or how often to apply them.

There was insufficient information recorded with regard to people's blood sugar levels to enable nurses to

administer insulin safely. We also saw that directions from a doctor had not been actioned to take a person's blood for testing so the person had not been able to have their anticoagulant reviewed by the doctor which had placed their health at risk of significant harm.

People were prescribed thickeners to be added to their drinks to reduce the risks associated with chocking or aspiration of fluids. However, we found information about the consistency of the thickened fluid was not available with the medication administration records meaning people were at risk of not having the drink they had to take their medicines with thickened properly. We also found that nurses and care staff were unsure if one person should have their dinks thickened or not.

We found that when people went on outings away from the home no arrangements were made to ensure people could have their medicines and as a result of this they missed doses of their medicines.

The records about medication were not accurate. There were missing signatures on the medicines charts so it was not possible to tell if people had been given their medicines as prescribed. We saw that nurses signed for medication before it had been administered and during the inspection we saw the medicines had not been given. We also saw a nurse giving medication but failed to sign the records to show the medicines had been given which placed the person at risk of being given a second dose of the same medication.

The storage of medicines was disorganised, the treatment room was untidy and cluttered and the medicines trolleys were chaotic. This meant that nurses spent a long time locating medication which added to the length of time the medicine round took.

We saw audits about medicines on the first day of our visit, including 35 medication administration error forms; however we saw that no supervision of nurses had taken place to lower the number of errors and the number of errors remained high placing people's health at risk of harm. On the second day of our visit a full medication audit had been done to identify the risks to people of unsafe medicines handling. We found that not all the medication concerns had been identified and that when concerns had been identified nothing had been done to address those errors. This meant that people were not being given medicine safely and people's health was at risk.

We found the Provider had continued to fail in ensuring that medicines were managed safely and administered appropriately and had failed to ensure that staff responsible for the management of medicines were competent, skilled and experienced to do so safely.

This was a continued breach of Regulation 12(1)(2)(c)(f)(g) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to safe care & treatment.

We looked at people's care records to ascertain that care, treatment and support which people needed was being delivered safely and that risks to people's health and wellbeing were being appropriately managed. We found people's care records contained a variety of risk assessments and associated documentation. For example, skin integrity, allergy status, nutritional risks, continence, falls and waterlow. However, we found that not all risk assessments had been updated in response to people's changing needs and, in some cases, risk assessments were incorrectly scored which meant that effective measures were not taken in order to minimise risk. For example, we looked at the waterlow scores for one person and found the score drastically varied from month to month and was not re-calculated to reflect their weight loss. This meant that the score was not accurate or reflective of the risk of skin breakdown. We found they were at high risk of developing pressure sores but we found there was no pressure relieving equipment in use for this person.

This was a continued breach of Regulation 12(1)(2)(a)(b) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to safe care & treatment.

We looked at staffing levels to ensure there was sufficient numbers of staff to meet people's needs. At the time of our inspection, 32 people were living at the home. The home was not at full occupancy because the Provider had agreed to a voluntary embargo on admissions following our last inspection. We saw that a dependency tool was used by the home to determine the number of staff required to meet people's needs. During the day, two registered nurses were required to meet the clinical needs of people who used the service. Registered nurses were supported by one senior carer, six care assistants and various support staff such as maintenance, catering and housekeeping.

However, despite the use of a dependency tool, we found that throughout our inspection visit, their continued to be insufficient numbers of staff to consistently keep people safe and to meet their needs. This was because the deployment of staff continued to be ineffective and there was an overreliance on allocating staff to specific areas of the home. For example, one member of staff would be allocated to the East and West Lounges in order to supervise people. However, this person would frequently be responsible for providing one-to-one support to people with additional needs; this meant they were unable to respond effectively when other people needed help and support in the immediate vicinity as they could not leave the person requiring one-to-one support.

Staff we spoke with told us they thought there was insufficient staff. Comments included; "There isn't enough staff. If we had more than what we've got we could do more. We can't leave the lounge areas unattended which means people who need support sometimes have to wait". "Later in the day we need to shut off one of the lounges, this is because there isn't enough staff. We have no choice, it's just not safe". "We should be able to take people out, especially when the weather is nice but we just don't have enough staff to do this."

This was a continued breach of Regulation 18(1) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to staffing.

We looked at the recruitment policy and associated procedures and found safe recruitment practices were in place. This was evidenced through our examination of employment application forms, job descriptions, interview notes, employee's proof of identity, written references and training certificates. Disclosure and Barring Service (DBS) checks had also been completed to ensure the applicant's suitability to work with vulnerable people. Records were also maintained which demonstrated nursing registrations were valid and up-to-date.

We looked to see how the service sought to protect people from abuse and found there were appropriate safeguarding and whistleblowing policies and procedures in place. Staff were able to describe the homes alert process and the local authority procedures. All the staff spoken with demonstrated they had a working knowledge of the types of abuse and the procedure to follow if they suspected that a person was at risk of, or was being abused.

We asked staff about whistleblowing. All of the staff we spoke with told us they would not hesitate to use the policy and identified internal reporting protocols. For example informing head office if they did not feel their concerns were being taken seriously. Staff also referred to the local authority and CQC as external agencies they would contact.

Health & safety and building maintenance records were examined and found to be in order. Up to date

certificates and checks had been completed in respect of gas and electrical safety, fire safety, hot water temperate and portable electrical appliances. Windows were compliant with safety regulations and suitable window restrictors were in place. Equipment used for moving & handling people had been service end maintained in line with regulations.

Inadequate

Is the service effective?

Our findings

Since our last inspection of Dean Wood Manor, the Provider had given reassurance that all staff would be enrolled in a new training & development programme that was being managed through a new 'Dovehaven Training Academy'. However, during this inspection, we found insufficient progress had been made to ensure that staff were fully supported and qualified to undertake their roles.

Training records we looked at demonstrated that progress had been made in relation to mandatory training and that the vast majority of staff had completed, or were scheduled to complete, all of the required training. Mandatory training modules included moving & handling, first aid awareness, food safety, infection control and health & safety. However, in respect of key additional training, we found low numbers of staff had completed recent training in respect of the mental capacity act, deprivation of liberty, dignity & respect, dementia, record keeping, equality & diversity and nutrition & hydration. This was of particular concern given the specialist nature of the service provided at Dean Wood Manor. We saw the vast majority of training was being delivered through online e-learning or the completion of topic specific workbooks.

We spoke with six members of staff and it was clear that not all aspects of the training received demonstrated the required knowledge to deliver services effectively. For example, staff we spoke with demonstrated gaps in knowledge and understanding around dementia, mental capacity and deprivation of liberty safeguards.

We looked at supervision and found that progress had been made in the frequency in which staff were now receiving supervision but the vast majority of supervision sessions were being used punitively to address issues when staff had made an error. The effectiveness of such sessions was questionable given the systemic issues we found during this inspection. In particular, we found clinical supervision and professional development for registered nurses was ineffective.

We found the Provider had continued to fail in ensuring that staff were suitably qualified, competent, skilled and experienced; and failed to ensure staff received appropriate professional development and supervision.

This was a continued breach of Regulation 18(1)(2)(a)(b) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to staffing.

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 procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

During this inspection, we found serious systemic problems in respect of the Providers failure to adhere to the principles of the MCA and the application of legislation which governs the use of DoLS within a care setting.

We found the service had consistently failed to ensure that MCA assessments were appropriately completed and that applications to deprive a person of their liberty were submitted to the local authority in a timely manner; this included granted DoLS authorisations which we found had expired without an application being made in the required time frame to renew the authorisation. This meant that due process had not always been followed to ensure that people living at Dean Wood Manor, and who were not free to leave, were accommodated lawfully. A DoLS matrix maintained by the service was confusing and not easy to read. This was because records had not been maintained or updated timely. This meant that staff did not have access to up-to-date information regarding who was subject to a DoLS.

We found consent forms for care and treatment were not consistently completed and many were blank. We found the service did not fully understand that consent to care and treatment must be obtained from people's lawful representatives, who might not be their next of kin. We found the service did not always follow due process in ensuring that decisions made on behalf of someone who lacked capacity, were done so in their best interests. For example, we found the home had a blanket approach to yale locks on people's bedroom doors. This meant that people's bedroom doors locked behind them and there was no assessment undertaken to assess that people had the required hand coordination and motor ability to unlock the door when they were in their bedroom. This meant people were unable to freely leave their bedroom or return to their bedroom during the day. This blanket approach meant that the home had not applied the principles of the MCA as no best interest decisions had been made to ascertain whether or not this was in people's best interest or lawful practice.

During our inspection, we observed inherent restrictions imposed upon people's movement. We saw people who used the service were prevented from moving freely around the home by means of both physical and environmental restraint. For example, we observed several members of staff inappropriately use physical restraint by placing their hands on people's shoulders to sit people back down into their chairs when they had indicated that they wanted to move elsewhere. We also observed that furniture and people's walking aides were used as a barrier to prevent people from getting out of chairs and mobilising. Towards the end of our first day of inspection, we completed a tour of the building at 18.50hrs, just before the day shift handed over to the night shift. During this time, we found 18 people who used the service had been moved into the West Lounge and we observed people were prevented from leaving the lounge whilst the staff changeover took place. We noted the impact that this had on people as there were several people displaying high levels of agitation during this time. We also saw that there was insufficient seating available in the lounge to enable everyone contained within the West lounge to sit down. One person who used the service was inappropriately seated on a wooden table. All the staff we spoke with confirmed that moving people into the West lounge was custom and practice at the home and that people were moved to the lounge whether they were agreeable or not. We ascertained from the staff that this was done at this time due to handover because there was insufficient staff at that time to supervise people in other areas of the home.

During our tour of the building, we heard a person shouting for help from inside their bedroom and we noted that their call alarm had been activated signalling that they required assistance. We waited outside this person's room to establish if staff would respond to their alarm in a timely manner. However, staff did not respond to either the shouting or the alarm. We attempted to enter the person's bedroom as we were concerned for their welfare but we were unable to do so as the room was locked. A member of the inspection team had to find a member of staff and alert them to the person's distress and calls for help and we requested that staff open the person's bedroom door. Two care assistant's responded and entered the

bedroom in the company of two inspectors. We found the person who used the service was seated in the middle of the floor in a state of undress. We established from the care assistants that responded that the alarm that had been activated was in fact an alarm connected to a falls crash mat next to this persons bed. We challenged the staff to understand why there had been a delay in responding to this person's alarm and we were told "They always do this". We found what we observed and the staff response distressing but before leaving this person's room, we ensured all of their personal care needs were met by the staff and that the person was not injured.

We raised our concerns with the management team at Dean Wood Manor and we raised an immediate safeguarding alert with the local authority.

After these incident's, we looked in more detail at the care records of the people who had been effected and we found no lawful justification as to why restraint was being used in this way. We concluded that people's human rights had been violated.

This was a breach of Regulation 11 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to consent.

We looked at how people who used the service were supported to eat and drink and the meal time experience. We did this by completing a Short Observational Framework for Inspection (SOFI) during lunch and tea time service. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with several visiting relatives. Comments included; "The food this is fantastic, I have no complaints. They have offered me the option of eating my meals here, so we can eat together". "Food is very good, they have a varied menu, my [relative] eats everything they put on and they seem to enjoy it".

We found that since our last inspection, improvements had been to ensure people with additional needs were appropriately supported to eat and drink. However, the overall meal time service remained chaotic and staff lacked supervision and direction to ensure other people who used the service received their food and drink in a timely manner. People were seated in the dining room at least 20 minutes before each mealtime service which meant some people did not want to sit for long periods and would get up and leave before eventually being brought back by a member of staff. We also observed that people being cared for in their rooms waited longer to have their meals than other people. This was because the deployment of staff during mealtimes was not effective.

During our last inspection of Dean Wood Manor, the home was being refurbished. The refurbishment programme had not been completed sympathetically to take into account the needs of people who used the service. Communal areas had been painted the same colour scheme throughout, and toilet doors had been painted the same colour as people's bedroom doors. During this inspection, we found some improvements had been made and that bedroom doors and bathroom doors had now been painted distinctive colours and that signage was now displayed to help people orientate themselves. However, overall improvements were not sufficient to ensure that all aspects of the environment were dementia friendly.

We looked to see how the service supported people with their on-going health and support needs and found the service aimed to work 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. However, one registered nurse we spoke with told us that it can often be challenging dealing with GP

practices as there were six different surgeries providing a service to the home.

Requires Improvement

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 to ask whether they thought the service was caring. However, we were able to speak with a number of visiting relatives. Comments included; "I was a bit put out when I placed [relative] here as lots of building work was going on and it was very noisy, but a relative told me to look at the staff not the building. I have done and can't fault them, they are very caring, they even bought [relative] a birthday present off their own back, which you don't expect". "I'd say the staff are caring. I've never had any issues and the carers do their best. They all work very hard." "Like most places sometimes things go wrong. I've had a few occasions to raise some concerns, like finding [relative] in wet clothes when I visit, but when I spoke to staff things were quickly sorted". "I can't praise the staff enough. I take my hat off to the whole lot of them".

We looked to see how the service promoted the principles of equality, diversity and inclusion. We were shown a policy document 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 significant gaps in equality & diversity training completed by staff and staff we spoke with lacked an overarching awareness and underpinning knowledge. For example, when discussing specific people who used the service, staff refereed to people as 'wanderers', 'walkers' and 'poorlies'. We also observed that some staff did not actively engage with people before a task was completed. For example, we observed two members of staff moving a person from an armchair into a wheelchair using a hoist. There was minimal communication with the person who used the service and there were no words of comfort or reassurance offered before the task was initiated.

We also observed some of the interactions between staff and people who used the service were not always appropriate. For example, one person who used the service had slid from their armchair down onto the floor. We saw one member of staff approach this person but they did not get down to their level and attempt to speak with them on the floor. Instead, this member of staff stood over the person and was asking questions. This person who used the service clearly lacked comprehension of what was being asked of them. Soon after a second member of staff arrived who did get down onto the floor to speak with this person and offered support and reassurance before assisting them back into their armchair.

We reported on a similar issue following our last inspection. The conduct of some members of staff and the manner in which they engaged with people who used the service, demonstrated a continued lack of understanding towards people who were living with a diagnosis of dementia.

During our last inspection we also reported on staff having little regard for the appropriateness of TV channels that played on communal televisions. For example, TV programmes which showed scenes of violence and people in distressed states is not appropriate viewing in a care setting for people living with dementia. However, during this inspection, we again observed that people who used the service were placed in front of TV channels which showed distressing scenes that were not conducive to a therapeutic and caring environment. We saw that staff did not engage with people to offer any choice or to ascertain whether or not they might like to watch such programmes.

This was a continued breach of Regulation 10(1) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to dignity and respect.

However, during our inspection, we did observe a number of positive interactions between staff and people who used the service. For example we saw how one member of staff was dancing with a person who used the service whilst they were enjoying listening to music. We also saw staff comforting people when they were upset.

We looked at Dean Wood Manor's approach to end of life care and found that since our last inspection improvements had been made. The home was now taking part in a pilot scheme working with Wigan Hospice to support people nearing the end of life, their families and staff.

Wigan Hospice attended the home when a person who used the service was nearing the end of life. Hospice staff would discuss with the home and people's families what support could be provided. For example, clinical support in setting up a syringe driver, identifying when medication may be required, to speaking with families and staff to explain what is happening to their loved one. We saw that new discreet signs had been introduced which could be attached to people's bedrooms doors. These signs would indicate that a person was approaching end of life and would prompt staff to ensure their EoLC needs were being met and that the environment was as peaceful as possible.

We saw that people's pastoral needs were being met through links with local faith groups. We saw that people of faith were supported to participate in regular communion which was held at the home.

We saw a regular programme of resident & relatives meetings were now established within the home. Minutes of meetings were recorded and these demonstrated that a variety of topics were discussed during meetings.

Requires Improvement

Is the service responsive?

Our findings

We asked a number of visiting relatives about how responsive they thought the service was. Comments included; "Communication is good, I come each day and by the time I have got to [relative] room, three or four staff will have told me how [relative] is or about any issues that may have happened". "Personally speaking I am very happy with everything, I can visit anytime, sometimes I will nip in if passing as well as coming at my usual time each day". "I raised some concerns about the bedding in [relatives] room and the manager sorted it out almost immediately."

At our last inspection of Dean Wood Manor, we reported on issues relating to the poor quality of care plans and a lack of involvement of people and their relatives in the process. During this inspection, we found improvements had been made but these improvements had not yet been sustained and were not embedded into everyday practice across the home.

We looked at a sample of care records 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 a variety of documents relating to both nursing and personal care. These included a pre-admission assessment, a variety of assessments, weight charts, information relating to continence, mobility, skin integrity and nutrition. Each care plan contained a 'map of life' which provided details of people's background history, family details and other significant events. Care records also included 'daily record' documentation where day-to-day events were recorded.

The vast majority of people who used the service at Dean Wood Manor were not able to actively participate in planning and agreeing their own care and support. This meant that care planning documentation was completed solely by staff from the home. However, we found that care plans did not always demonstrate that people's lawful representatives had been consulted. We also found that information contained in people's care plans was contradictory and confusing as to what care was required to meet the person's needs. This was because people's records contained gaps and omissions and care planning documentation had been written in the first person. This meant eliciting the current clinical picture was difficult. Reviews of people's care needs were not always completed in a timely manner and in response to people's changing needs.

Throughout our inspection, we found limited evidence of meaningful person-centred activities taking place. Since our last inspection the service had employed an activities co-ordinator but their role had not been embedded into the service. We observed well intentioned attempts being made to occupy people who used the service through the use of traditional activities such arts, crafts and board games. We also saw that dolls were being used to help and comfort a number of people who used the service. However, we found these activities were not part of a structured programme or person-centred to evidence best practice and therapeutic activity. We saw that an unused bedroom had been converted into a hobbies and activities room but this appeared to be underused. A new mock bar area which resembled a 'snug' in a public house had also been built but again, this space was not utilised and was not being used for its intended purpose.

We found insufficient progress had been made in working towards nationally recognised evidence based guidance in the care and support of people living with dementia and failed to consistently demonstrate that people's care plans were sufficient to meet their needs.

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

We looked at a notice board in entrance to the home and found this contained useful information about living with dementia and the kind of support that was available. However not much thought had been given to layout of the information and the board appeared cluttered. This meant that useful information such as local dementia cafés and support groups could be missed.

We looked at the complaints policy and complaints log. The services own complaints policy 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. Since our last inspection, we found that appropriate records were now maintained in relation to complaints. Records indicated that the manager sought to resolve complaints informally but there was a framework to manage and escalate formal complaints as appropriate.

We also saw the home had received a number of compliments. These included letters of thanks from external professionals as well as relatives and friends of people being cared for at Dean Wood Manor.

Inadequate

Is the service well-led?

Our findings

Since our last inspection of Dean Wood Manor, a new manager had been appointed. They had applied to CQC to become the registered manager and at the time of our inspection, this application was being assessed. 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 & Social Care Act 2008 and associated Regulations about how the service is run.

Relatives we spoke with told us they thought the new manager had a positive impact since joining the service. Comments included; "[the manager] coming here was a good move, the place has come on leaps and bounds. [The manager] is a very fair person and doesn't take sides". "The new manager is good. They are out and about around the home and always available." "The place is getting better since the new management team have started. Things appear to be improving".

Staff we spoke with gave a mixed response in relation to the changes since our last inspection. Comments included; "Lots of staff have left and there have been some difficult times. The new manager is doing their best though". "Things have changed too quickly and too fast. Staff don't know whether their coming or going. It's very stressful at the moment". "Loads of staff have left and some have been sacked. The changes are for the better though because things needed to improve". "I've no complaints about how things are now because it's about the residents and what works for them".

In addition to the new manager, a regional manager from within the Dovehaven Care Group had been working at Dean Wood Manor to provide oversight of a service improvement plan which the Provider had implemented following our last inspection. However, we found that clinical and operational oversight provided by the regional manager and Providers of Dovehaven Care Group, was inadequate. Overall governance was ineffective and there was a continued lack of co-ordinated leadership which directly impacted on the quality of care being provided. In particular, we found governance arrangements for clinical audit and questioning of practice was wholly inadequate.

We therefore found the Provider had failed to ensure effective governance systems for assurance and audit, and had failed to continually evaluate and seek to improve governance and auditing practice.

This is a breach of Regulation 17(1)(2)(a)(e) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to good governance.

We found improvements had been made in the way accidents & incidents were monitored and recorded and we saw that remedial action was taken to reduce the likelihood of such events occurring again in the future.

We saw that improvements had been made in relation to the frequency in which staff meetings were being held. We saw that minutes of meetings were recorded and that a variety of topics were discussed included

care planning, medication, nurse validation and staffing rotas. Staff we spoke with told us they considered staff meetings to be valuable and that they felt able to contribute to agenda items.