Life Style Care (2010) plc

Deepdene Care Centre

Inspection report

Hill View, Reigate Road
Dorking RH4 1SY
Tel: 01306 732880
Website: www.lifestylecare.co.uk

Date of inspection visit: 8 June 2015
Date of publication: 14/08/2015

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?	**Inadequate**
Is the service well-led?	**Requires improvement**

Overall summary

Deepdene Care Centre is a purpose built care home that provides nursing and personal care for up to 66 people. Many of the people living in the home are living with dementia. The home is set across three floors.

At the time of our inspection 59 people were living at Deepdene Care Centre

This inspection took place on 8 June 2015 and was unannounced.

The home is run by a registered manager, who was not present on the day of the inspection. 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 and associated Regulations about how the service is run. During our inspection an interim manager and regional manager were overseeing the running of the home.

There was not a sufficient number of staff to meet the needs of the people who lived there. We saw staff rushing and not spending time with people.

Staff did not follow effective medicines management procedures which meant people may have received their medicines outside of recommended timescales.

Summary of findings

People were not kept free from harm by staff and the provider had not taken appropriate action to ensure they employed suitable staff to work in the home.

Staff did not follow infection control procedures which meant people did not live in a clean and hygienic environment.

Where restrictions on people were in place to deprive them of their liberty, staff had not always followed legal requirements to make sure this was done in the person's best interest. Deprivation of Liberty Safeguards (DoLS) applications had not been made appropriately.

Care was provided to people by staff who did not always display competency to carry out their role.

People were not always provided with a well balanced nutritious diet or given choice in the meals they ate.

Staff ensured people had access to external healthcare professionals when they needed it and the GP was actively involved in the home.

Staff did not always make people feel as though they mattered or treat them with consideration. People were not assured of their privacy and staff did not always respond to people's needs.

Complaint procedures were available for people and their relatives were involved in decisions around the running of the home.

Staff told us activities were organised for people. However we saw people sitting for long periods of time without social interaction from staff. Appropriate activities or a suitable environment for people living with dementia was not always provided.

Staff understood their responsibilities in relation to safeguarding. We were assured they knew how to report any concerns they may have.

Care plans contained information to guide staff on how someone wished to be cared for. However, we found staff did not provide responsive care or ensure all information was contained within care plans.

Quality assurance checks were carried out by staff and the provider to check the quality of the care.

Staff did not always feel supported by the current management arrangements or take an active part in the running of the home.

During the inspection we found some breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service has therefore been placed in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still 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 this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to 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 so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 always safe.

There was an insufficient number of staff to meet the needs of all people.

Staff did not always follow medicines management procedures.

Appropriate checks were not always undertaken to help ensure suitable staff worked at the service.

Staff were aware of their responsibilities in relation to safeguarding but risks to people had not been assessed or managed effectively.

Staff did not ensure the home was kept clean.

Is the service effective?

Inadequate

The service was not always effective.

Staff did not have a good understanding of Deprivation of Liberty Safeguards (DoLS) or the Mental Capacity Act. Best interest meetings and mental capacity assessments had not be carried out and inappropriate DoLS applications had been submitted.

Staff were not trained in an effective way so they were competent in their roles.

People were provided with enough food and drink throughout the day, although they were not always given a choice. Staff had not ensured everyone would know the specific dietary needs of individual people.

Staff ensured people had access to external healthcare professionals.

Is the service caring?

Requires improvement

The service was not always caring.

People were not always treated with the attention they should expect from staff. People had little social interaction from staff and staff did not respond to people's needs.

Staff support people to make their own decisions about their care. Staff welcomed visits from friends and family.

Is the service responsive?

Inadequate

The service was not always responsive.

People were supported to participate in activities; however there was a lack of individualised stimulation for people living with dementia.

People did not receive responsive care.

Summary of findings

People were able to express their views and were given information how to raise their concerns or make a complaint.

People and their relatives were involved in developing care plans.

Is the service well-led?

Requires improvement

The service was not always well-led.

Records were not always complete.

The home had been without the registered manager for some time and the regional manager and an interim manager had been brought in to oversee the running of the home.

Quality assurance checks were undertaken to check the quality of the service and additional provider staff had been brought in to make improvements.

Deepdene Care Centre

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 checked 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 took place on 8 June 2015 and was unannounced. The inspection team consisted of three inspectors, an expert by experience and a nurse specialist. An expert by experience is a person who had personal experience of this type of home and a nurse specialist is someone who has clinical experience and knowledge of working with people who require nursing care.

We had asked the provider to complete 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 did not receive this form in time for this inspection as we carried out this inspection as we were responding to some recent safeguarding issues and concerns about the home.

As part of our inspection we spoke with nine people, 13 staff (which included registered nurses and care staff), four relatives, the interim manager, the regional manager and two social care professionals. We spent time in communal areas observing the interaction between staff and people and watched how people were being cared for by staff.

We reviewed a variety of documents which included 12 people's care plans, three staff files and some policies and procedures in relation to the running of the home.

In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law.

We last carried out an inspection to Deepdene Care Centre in February 2014 when we had no concerns.

Inadequate

Is the service safe?

Our findings

Staffing levels were not regularly assessed or monitored to make sure they met people's needs. The interim manager was unable to provide us with a current dependency tool to show how they determined how many staff should be on duty each day. They told us this was something they were working on. The interim manager said historically no agency staff had been used and as a result there were days when the home was short staffed. Agency staff were now employed by the interim manager to cover sickness or annual leave. We were provided with a 'staff build up' checklist which determined staffing levels based on the number of people living in the home. However, this did not take into account the higher needs of some people who may be living with dementia or who required complex physical care.

There were insufficient numbers of staff deployed in the home. We saw staff rushing and carrying out their duties in a task orientated way. We were told two people required one to one supervision throughout the day, however we saw one person did not always receive this. Staff told us, "It (one to one) usually happens." Because two people required one to one supervision, this meant only two care staff were available to care for 20 people living on one floor of the home.

People did not get reactive care because of a lack of staff. A relative said they often found there were not enough staff on duty and he helped clear tables at lunchtime. Staff told us they did not have time to interact with people because there were not enough staff on duty. They said it was a surprise to have five staff on duty today as this was not normal. One member of staff said, "Sometimes we just have two (staff). People are getting neglected." Other staff said, "There should be more staff. Usually only three staff here and sometimes two and we have to borrow staff from other floors. We can't give personal care and we can't cope." And, "The most pressure is on the top floor. At night there is only one carer. Some people are being put to bed earlier due to the staffing levels." Staff said they felt sometimes at night people may not be safe because only one nurse and one carer was on duty on each floor which meant call bells may not be answered promptly. We heard call bells were constantly ringing throughout the inspection with some ringing for eight to ten minutes.

People weren't being attended to in a timely manner because of a lack of staff. During lunch time one person was not given their meal in their room for an hour because staff were supporting other people. We heard one person call out for a long period of time trying to attract staff attention. People told us there were not enough staff especially at night and weekends and that the staff were over worked. One person told us, "I wait a long time when I ring the bell, I've complained about the wait."

The lack of deployed staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment practices were not in place and the provider recruitment policy was not always being followed. Staff recruitment records did not always contain the necessary information to help ensure the provider employed staff who were suitable to work at the home. We could not find in all files that staff had Disclosure and Barring System checks to identify if they had a criminal record. The provider had obtained references and checked staff employment history but in some cases references were not obtained from last employers and there were gaps in people's employment. We also noted nursing staff had not provided evidence to show they were on the Nursing and Midwifery Council register.

The lack of robust recruitment practices was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was evidence of good practice as well as shortfalls in terms of medicines management.

The medicines rooms across the three floors were found to be very clean and the cupboards were neatly arranged. In all the three rooms, there was a fridge to store medicines. Fridge temperatures were checked and recorded daily in a temperature monitoring file. People received the correct medicines. Staff demonstrated good practice in medicines administration by ensuring that the right medicines were given to the right person. One nurse demonstrated good practice by waiting patiently for each person to swallow their medicines. A relative told us, "He gets his medication as he should." However, we saw one nurse leave the medicines trolley open and unlocked when they went to administer medicines.

Medications were safely stored but not always checked by staff. The medicines trolley was clean and medicines

arranged for easy identification. When not in use the trolley was securely locked. However, we checked some medicines and found we could not tally one person's medicines as there was no initial record on the medication administration record (MAR) sheet indicating the quantity that was carried forward or supplied.

MAR charts were not always completed and people may receive their medicines too often or not when they required it. There were unexplained missing gaps in the (MAR) on one floor. We saw the morning medicines on the one floor finished very late, not leaving enough time before the lunchtime medicines. The morning medicines round finished at 11:00am and lunchtime medicines round started at 12:30pm leaving only a one and a half hour gap. Some medicines require a four hour gap, such as paracetamol for example. This meant people may receive their medicines in too short a timescale. The nurse could not think how to improve this. They told us medicines had always been given within that time frame. We found the medicines rounds finished before 10:00am on two other floors. One nurse told us it took them a long time to carry out the medicines round because there was so much to do and care staff could not take over any of their duties. One nurse told us they rushed the medicines at night because there was not enough staff on duty.

We read people who required PRN (as required) medicines had protocols which described to staff how, why and when a PRN medicine should be given. We did not see, however, any guidance for staff to describe the ways in which people may display signs they needed PRN medicines. One member of staff said they would look at a person's face, or touch their arm to determine whether or not they were in pain.

Policies were not always up to date which meant staff may not be following current guidance. We read a homely remedies (medicines that can be bought over the counter without a prescription) policy and log in one treatment room, however it was dated 2012.

The lack of management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not ensure infection control procedures were followed. For example, we saw the sink in the treatment room was stained. We noted from a recent provider quality assurance visit it had identified 'certain areas had not been cleaned adequately' and bathrooms were used as storage rooms. We saw this in one bathroom, where trollies and wheelchairs had been stored. Action identified was to organise deep cleaning and for spot checks to be carried out. However we did not see any evidence that this had been arranged and completed from the areas we looked at.

People may be at risk of infection. The environment was not cleaned properly because there were insufficient numbers of housekeeping staff. The sluice rooms were dirty with a strong, unpleasant smell. Equipment stored in there was dirty, rusty and grimy. In one sluice the sink area was blocked by a chair and a commode and there was a jug that was heavily stained. We found the flooring between the bathrooms, hallways and kitchenette doorways was thick with grime. We found oil running down one wall. The seal around the fridge in a kitchenette was stained and filled with grime and sinks were stained.

People did not have individual slings for use with hoists and slings were used communally. Some people were walking around barefoot which posed an additional risk to them. The main kitchen for the home was dirty. The chef admitted he didn't have enough staff to maintain the cleanliness. He told us, "I know it doesn't get cleaned properly." Stoves and trolleys were dirty, greasy and in need of a deep clean. One member of staff told us, "One cleaner for the whole home is not enough, it can't be maintained. We (care staff) have to help, but we just can't manage."

The lack of infection control processes was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In the event of an emergency people had their own individual evacuation plan and we saw fire evacuation equipment available should the building need to be vacated. We were told people's evacuation plan should be included in their care plans but we found this not to be the case. We noted the evacuation plans had last been updated in February 2015, which meant one person who had moved into the home after that did not have one. In addition, the last fire risk assessment for the home was carried out over a year ago.

We recommend the provider ensures appropriate and up to date emergency information is available to staff.

Risk assessments were in place for people. We read people had been assessed for their risk of harm in relation to their mobility or use of hoists, for example. Risk assessments

Inadequate

Is the service safe?

and care plans were reviewed monthly and they included the risk level and appropriate action to take for staff. For example, some people had been assessed to be at a very high risk of developing pressure ulcers and preventative measures were in place to reduce the risk. People were nursed on air mattresses, which were set correctly according to the persons weight and people were being repositioned every two to four hours when in bed. Accidents and incidents were logged and we read the factors which caused accidents were recorded together with actions and any arrangements to avoid reoccurrence. However, we did find that one person liked to smoke had not had their risk assessment updated since August 2014.

People felt safe. One said, "Yes, I've been safe. I've never lost anything as all my clothes are labelled." Another told us, "I've felt very safe." Relatives said, "Yes, he's been very safe" and, "He is not getting out of bed anymore, they use a mattress and the bed rail to keep him safe." A further relative told us their family member's bed was in the centre of the room with mattresses each side in case they fell out of bed.

Staff were aware of their responsibilities in relation to safeguarding and could recognise signs of potential abuse. Staff were able to give us examples of the types of abuse that may take place and how they would act if they had any concerns. Guidance was available for staff to follow if they wished to report anything. One member of staff said, "I've had training, I'm always checking to see if people are okay. When their friends and relatives come in I check they are safe." Another member of staff told us there was a flowchart in the nurses station for them to follow and a third member of staff said, "I know that I have to protect people from harm. If something happens I need to report it to the manager or the nurse in charge. The interim manager maintained clear records about the safeguarding concerns that had been reported to her and could evidence these had been appropriately referred to the local authority and the Care Quality Commission (CQC). This helped to ensure people were safeguarded because concerns were investigated thoroughly and subject to external scrutiny.

Inadequate

Is the service effective?

Our findings

Where people may not be able to make or understand certain decisions for themselves, staff had not followed the requirements of the Mental Capacity Act (MCA) 2005. We found mental capacity assessments had not been carried out for people. Mental capacity assessment forms were in people's care plans, but they had not been completed fully. For example, we read one person had bed rails. This decision had been made despite the fact they had no excessive movements in bed and were unlike to try and climb out of the bed. No evidence of a best interest meeting and decision around this was in the care plan. We read people had do not attempt resuscitation (DNAR) forms in their care plans, but it was not clear whether people who had made this decision had the legal right to do so. Some people were given medicines covertly (such as hidden in food or drink) and there was documentation which had been signed by the GP, the pharmacist and relatives however there was no evidence to show that this was done in the person's best interest. One member of staff said, "I've had training in MCA but I'm not up to date about the decision process. If a person doesn't have capacity you need to look at the best interest of the person. I gain consent by giving choices and respecting their decisions."

Deprivation of Liberty Safeguard (DoLS) had been submitted for some people but not always appropriately. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. We found people were restricted to areas of the home. For example, all major external doors and most internal doors were locked and had key coded access. However, we found applications may not always have been made appropriately to the local authority. For example, we did not see applications for locked doors. One application had been made for a person who could not eat chocolate and for other people who may refuse personal care.

The failure to follow legal requirements is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were cared for by staff who did not always seem appropriately trained or confident for their role and planning. We saw two staff transfer one person with a hoist from a wheelchair into a chair in the lounge. During this time the staff did not speak, reassure or tell the person what they were doing. The procedure took about 10 minutes and it was clear staff were struggling with the sling and the straps. In the end we saw four members of staff attempting to transfer the person. We then saw staff transfer this person back into their wheelchair just three quarters of an hour later. This meant people may receive unnecessary transfers which could be uncomfortable or distressing.

A new member of staff told us they had difficulty remembering all of the courses they had been on and was confused at what the training had covered as the courses were short and it was difficult to take everything in. For example, the moving and handling course.

One staff member said they had received enough training and induction for their role. They told us they read people's care plans to get to know people. However this member of staff did not know one person they were caring for was diabetic. Other staff said they had good training but would like more clinical training such as wound care and practical training on moving and handling. A member of staff told us, "I've had all the training and I'm up to date. Some training is good. The nurse does supervisions with me and I had one last week." However, none of the staff had much knowledge of dementia and what this meant. One person was seen walking around all day, and at times becoming aggressive, however staff avoided this and did not seem to understand what they needed to do to relieve this person's anxiety. Their response was to move them away from other people. A nurse said, "I feel safe working here, but need more training to enhance my practice."

Staff did not receive regular appraisals to give them the opportunity to meet with their line manager on a one to one basis to discuss their role, progress or any training requirements. We read 27 staff out of 43 had received a recent appraisal.

The lack of supporting staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People gave us mixed feedback on staff. One person told us, "The staff, especially the new ones are not well qualified." A relative said, "The staff are definitely well qualified to do the job." People said, "They do communicate with me about my care" and, "I do interact with staff and they do, if they can."

Inadequate

Is the service effective?

Guidance was available for staff on how to look after people, however we found this was limited . We read one care plan which detailed what the person was at risk of. However, there was little information for staff on how to manage this and we read this person needed daily exercise to reduce their behaviours. One member of staff told us, "I know (one person) has mixed behaviour, but I haven't read their care plan. I know they need medicines to calm them down or to take them outside. That's the only way to handle their aggression." People who exhibited behaviour that may cause themselves or others harm had been assessed and behavioural charts were in place. However, it was documented that some people required more stimulation and activities to help calm them down. People with complex nursing needs had relevant care plans in place. For example, people with diabetes had care plans for their blood sugar management.

We recommend the provider ensures guidance to staff contains as much information as required and links with best practice.

People were provided with drinks and snacks throughout the day. However, staff did not support people to eat food in an unhurried manner which would make their mealtimes more enjoyable. For example, we saw one member of staff feed one person both their main course and pudding in seven minutes. One lady was given her food at a table in the corridor, but was not prompted by staff to eat it. We noticed she eventually walked away without eating. A relative told us, "There are enough staff about, but at mealtimes they need more staff." Another relative said, "When I am here I will feed him, but it is difficult for them (staff) to spend a long time giving him his meal."

Choices were not always offered and people weren't always provided with food to keep them healthy. The chef knew people's dietary requirements. However those who were vegetarian or needed a soft or pureed diet were not provided with a choice of meal. Although some people were involved in decisions about what they ate as we read people had discussed meals at a recent residents meeting, the chef told us the menu was being reviewed but he did not have a copy of the new menu or a record of what suggestions people had made. We were told that food was sometimes pre-packed and we saw this in the freezers. We saw part of the lunchtime meal came from a tin and although there was fresh fruit and vegetables in the cool store we noted some of these were past their best by date. One person said, "The delivery of food only comes twice a week. Sometimes we run out of fruit at the weekend."

Risks to people with complex needs were identified but staff did not understand the need to keep robust records. We looked at the check list in one kitchenette which showed which people had a specific dietary requirement. We noted no-one had been identified as being diabetic, although four people living on this floor were. We talked to staff about one person. They told us, "We aren't giving them anything with sugar in. Look, they have porridge for breakfast, that doesn't have sugar and they have a soft diet for lunch which doesn't have sugar." However, there was no evidence to back this up. We asked them what would happen if a new member of staff who didn't know people looked at the check list. We were told, "Oh, we'd tick it then to show who was diabetic."

We recommend the provider reviews the food provided to ensure a balanced, nutritious is offered and to ensure all records were up to date in relation to people's dietary needs.

Nutritional needs of people were monitored as staff recorded the food and drink intake of people who were on fluid and food charts. Records showed people's weight was monitored monthly or weekly depending on their risk of losing weight. The nursing staff demonstrated a good knowledge in managing nutritional needs and why it was important to record food and fluid intake and weight.

People told us, "The food is usually okay", "If you don't like what's on the menu, they will try to do something else" and, "We get water and/or juice all day." Other's said, "The food is good, variable and you could have an alternative, like sandwiches." Relatives told us, "He gets fresh water every day and after breakfast they get a good variety of fruit", "They are very accommodating food wise here." One relative told us the food always looked nice and their family member had always been satisfied with the food.

People had access to external health care professionals. For example, dietary and nutritional specialists. The speech and language therapy team, who provided guidance for staff to follow, were involved for people who had swallowing problems. We read people had involvement from the physiotherapist, podiatrist, diabetic nurse

Inadequate

Is the service effective?

specialist, optician and mental health team. However, there was a shortfall in the aspect of not involving the tissue viability nurse for advice in the management of the person who had a pressure ulcer.

We recommend the provider ensures that people using the service are referred to appropriate external health care professionals in a timely manner.

Staff ensured people's daily health needs were met. The GP came to the home once a week to review people who were not well or whose health needs had changed. For example, they were involved in the management of ailments such as urine infections, chest infections and for medication reviews. One person told us, "They will get the doctor for me." Another said, "I am given painkillers, I couldn't cope without them. I have asked the doctor to see a specialist about my (medical) complaint." And a relative said, "They do organise visits from the chiropodist, the dentist and he has his nails cut." One visitor told us, "They (staff) have done so much for her. She is much better and going home tomorrow."

Requires improvement

Is the service caring?

Our findings

One relative told us staff were, "Very caring and have taken an interest in her interests." Other said staff provided their family member with kindness and dignity. People told us, "They do wash me every morning and they asked if they could use my Christian name" and, "I do find the staff quite good at treating me." And a further said, "The staff are extremely kind, caring and tolerant. I'm still very contented with the kindness of staff. Where do they get their patience from?"

However, people were not made to feel as though they mattered. For example, we saw staff ignore people in rooms, despite them calling out for periods of time. One person was sitting in the dining room for some time after everyone else had been moved into the lounge. We saw staff walk in and out of the dining room and not acknowledge this person. Most people were seen to be dozing or sleeping during the morning due to lack of interaction from staff.

People were not protected from avoidable harm and did not receive person-centred care. There was no system of protecting those who were in their rooms from other people walking in and out throughout the day. We saw this often caused distress to people. A member of staff told us, "Because of the lack of staff we put people at risk. We can't give proper care, people become more agitated, more aggressive." One person had a full catheter bag, which was only emptied by staff when we alerted them to it. We found one person had a serious pressure ulcer which staff had not been monitoring or recording properly. Staff had not followed the guidelines for wound management. For example, there were no photographs to monitor healing progress. Although staff should have been changing the dressing every three to four days there was no evidence in the dressing chart to show it had been done between the 10th and 24th May. One nurse demonstrated their knowledge on how to prevent and manage pressure ulcers but said more training was needed to enhance their practice on how to prevent or manage these. However another nurse had told us the pressure wound had healed and they had no concerns about this person and their risk of pressure wounds. It was only because of the concerns raised by one nurse specialist that the seriousness of this person's pressure wound was highlighted to staff. Another person had fallen out of bed and staff had subsequently moved their bed into the centre of their room. However, this presented the risk this person could fall out of either side of the bed. There was no call button in their room and staff were unable to locate it.

People were not always treated with consideration. We saw one member of staff 'pull' a person along who was walking with their frame. We saw two people asleep in armchairs in the lounge with their heads almost resting on the arm of their chair. Two members of staff attempted to transfer one person from their wheelchair to a chair. They were unable to wake the person sufficiently in order to do this but continued to try to put the sling on them and the straps around their legs. During this time the person remained asleep. After about five minutes attempting to put the sling on this person the nurse came into the room and said, "Put her back to bed, she's too tired." We heard one member of staff describe a person's lunch to them. They put a spoonful of food into the person's mouth and then said, "Right, carry on." Two member's of staff stood beside individual people to assist them with their meal, rather than sitting at their level and a further member of staff was seen not giving a person sufficient time to finish what was in their mouth before they put another spoonful in front of them, or the straw for their drink into their mouth. During their meal the member of staff did not engage with this person. People who ate lunch in their rooms or the lounge we given both their main course and pudding at the same time, which meant the custard in the pudding would be cold by the time they came to eat it. The main lounge on the top floor had a large television on the wall. However because of the way the chairs were arranged some people could not see it.

Staff did not respond to people quickly enough and there were times when we were aware there were no staff about to see to the needs of people. We saw one person in their room with their lunch untouched in front of them. They were asleep. Staff only became aware of this about 45 minutes later. We heard one person calling out from their room, "Please help me, I'm begging you, please help me." After 25 minutes, we did not see any staff going to assist this person, even though staff had walked in and out of their room to hang clothes. Throughout this period another person had kept walking in and out of this person's room. Staff had gone to fetch them but had not reassured the person calling out. They only responded to this person's calls when an inspector intervened. One person, who preferred to sit in their room had their chair placed alongside their wardrobe facing away from the door which

Requires improvement

Is the service caring?

meant all they could look at was their wall. We read in their care plan they needed hourly checks but we noted they were not checked for at least two hours. This person had no access to a call bell.

People were not provided with privacy. We saw on the top floor people constantly walking in and out of other people's rooms. One person who was in bed got very agitated and another became distressed. We heard and saw how one person got into other people's beds. Staff told us when this happened at night the person whose room it was would be taken to sleep in another room.

People were not always shown dignity. We saw staff putting plastic aprons on people automatically at lunch time without asking them. We did hear one member of staff ask one person, however another member of staff shouted over, "Yes, put an apron on him." One person had the apron caught over their ear but staff were unaware of this. We were shown around by a member of staff who did not knock on people's doors before entering. One person was seen lying in their bed with the bottom sheet hanging off the bed. Other people were asleep under very thin sheets and no blankets and there was stained carpet's in rooms and a strong smell or urine in some areas of the home. We saw some people did not have anything on their feet and walked around barefoot all day.

People's clothes were not always laundered properly. The laundry staff told us they were responsible for washing all clothes and bedding and admitted the ironing wasn't done properly because they didn't have time.

The lack of person-centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visitors were made to feel welcome. It was evident relatives were welcomed into the home and could call unannounced. We heard relatives talk to people and staff in a relaxed and friendly manner. One relative told us, "They make you very welcome."

We did see some positive examples of care from staff. We saw one member of staff kneel at someone's level and support them to take their medicines. They chatted to this person throughout. Another member of staff gently woke one person to see if they wished a drink. Most carers were rushing, but a few were observed taking their time whilst providing the care.

Inadequate

Is the service responsive?

Our findings

Although activities were available there was a general lack of stimulation for people. The interim manager told us the activities co-ordinator was on leave and care staff were responsible for organising activities. We saw little of this happen during the day however. We did not observe any specific activities suitable for people living with dementia and staff were not able to give us examples of appropriate activities. There were little sensory items for people to touch or feel and a lack of appropriate signage for people living with dementia. We noted the last activity planner displayed for people was dated April 2015.

People were socially isolated. During the morning we found people sitting in lounge areas with the television on, but no other stimulation. Most people were asleep in their chairs. The interim manager told us there was a mini-bus outing each week, but this had not happened for several weeks, although they could not explain why. A member of staff told us, "I sing with people sometimes, but there is nothing going on most of the time." One member of staff told us, "Some people don't go out because they don't like getting in the lift." Staff had not considered moving these people to alternate, more appropriate rooms. A relative told us during the last few weeks things had gone, "Down hill" in the home. They told us there were no social activities and a lack of stimulation for people. One member of staff said, "There haven't been any activities for three weeks due to no staff." Another member of staff told us, "There isn't enough for people to do."

The environment was not always suitable for people living with dementia. We found not everyone had a memory box outside of their room, or some form of identification specific to them to help them find their room independently. One member of staff told us they orientated people to their rooms by trying to get them to remember their room number. As a result we saw one person walk into someone else's room. Some rooms were un-personalised and sparse. We saw one sensory item in the small lounge area of the middle floor, but there was little else of interest to stimulate people. The small lounge was not used at all throughout the day as the majority of people were not independently mobile and were not able to access it. Staff told us people chose their meals the day before. However this meant people living with dementia may not always remember what they had asked for.

The lack of involving people was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people did tell us, "I now have an electric wheelchair and I get out into the garden." And, "I get talking newspapers, for me there is enough to do. I need to get out sometime and need a staff member, which is not always possible." A relative told us, "For those who can enjoy it, there is enough to do. They do go out weekly for lunch.

Information about people's lives were not always recorded in care plans. People's life story was not always completed so staff would know something about the person and their life before moving into Deepdene Care Centre.

Staff were not checking people regularly to see if they were providing responsive care. One person required prompting and supervision to eat their meals as they were at risk of malnutrition. However, we noted the last nutrition screening that had been completed for this person was February 2015. This person was also at high risk of developing pressure sores but again the last recorded assessment was February 2015. Another person's care plan including information about swelling to this person's ankles. In May 2015 it was written this person's legs should be elevated, however we did not see this during the inspection. The person's table was pushed up against their knees which would have made it difficult for them to move their legs. One lady refused food each time it was offered to her by staff. Staff told us they did not keep records for this person as they would eat at lot on occasions and nothing at other times. However, when we spoke to the nurse she was unaware that this person's food and fluids were not recorded. The person's care plan and MUST assessment showed they were at high risk of malnutrition and required regular encouragement to eat. There was no guidance for staff as to how to support them with food and drinks. We asked to see another food and fluid chart for a person we had observed eating very little. The charts were in place although by 4.00pm they had still not been completed for lunchtime.

The lack of assessment of needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was evidence to show that people and their relatives were involved in the care planning. There was a section in the care plan where relative's involvements was recorded. A

Inadequate

Is the service responsive?

member of staff told us they always involved people or their relative before they wrote or reviewed any care plan. We read in care plans that people's choices and preferences were clearly stated. One relative said, "They involve me in the day to day aspects of his care. They rang me when he fell, they were very quick at that." Another told us, "We have a care plan meeting with discussion and communication is fine." A further relative said they were involved in their family member's care and thought the care was focused on individual needs.

People could make complaints if they wished and there was a complaints policy displayed for people to follow. We read 16 complaints had been made about the service over recent months. We saw these had been responded to and resolved in a timely manner. One person told us, "I've not complained, but would." A relative said, "We've never needed to complain."

People, relatives and staff were involved in the running of the home. Residents meetings were held and we read the last one had discussed the food. "There are meetings for residents to discuss the meals. They do listen."

Requires improvement

Is the service well-led?

Our findings

Effective management and leadership was not demonstrated in the home. The registered manager had not been at the home for several weeks and the home was being overseen by an interim manager and a regional manager. We did not see the interim manager on the top floor of the home at all during the day. One person said, "I don't see the temporary manager." Staff told us they felt supported by colleagues and didn't have, "A problem" with the interim manager. However, one member of staff said, "Sometimes I want to give up (talking about the lack of staff). How can you do the job properly, that's why there is so much sickness, we have told management, we are starting to have agency but they don't know the residents and spend the day asking us what they should do?"

We received mixed responses from everyone about the current management arrangements. We were told, "I will speak to the manager, if needed", "The manager's door was always open and there was a nice atmosphere about. It's slightly different now", "The manager was a nice person." However some people told us, "Continuity in the kitchen is needed. Things are disorganised here. I don't think the home is run very smoothly at present", "Communication could be better" And, "There does not seem to be any management structure." A relative said, "The staff don't seem to like the temporary manager." A member of staff told us, "The manager was very supportive, happy to work here, but sometimes not happy to work during the night due to low staffing level."

Records held in the home for people were not robust which meant new staff who may not know people might not provide appropriate care. We read in one person's care plan they were diabetic. The care plan recorded that this person was on a normal diet, but later it was noted they were on a soft diet. This person had body maps within their care plan which recorded bruising in December 2014 and April 2015, however there was no information on whether or not the bruising had healed and how it was caused. Care plans did not clearly identify always which wound was being referred to in notes. We read one care plan in which staff had written a person had a wound on their left hip and others had written it was their right hip. Poor record keeping had been identified during a recent provider quality assurance visit but effective action had not been taken to improve this as we found missing or incorrect information in records we viewed.

There was no clear management or line-manager arrangements in place which meant people and staff were left alone without senior qualified nursing staff in charge. We noted the nurse on one floor had left the building to collect a prescription. We asked care staff who was in charge whilst they were absent. Staff were unable to immediately tell us who was in charge. We were then told it was a new member of staff, but it was clear from their face they were unaware of this.

Staff did not always show an interest in being involved in the running of the home. Staff had general meetings as well as meetings specific to their role. For example, nurse meetings or catering meetings. However, we noted few staff attended. For example, only six staff attended the last general meeting. We read from the last nurses meeting notes it was agreed meetings were to be held every two weeks, however there had been none since March 2015. A recent care assistant meeting only had five attendees.

The lack of good governance and records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, relatives and stakeholders were encouraged to give feedback about their experiences . The results of the last residents and relatives satisfaction survey were provided to us. This was carried out in May 2014. At that time people were happy with the care provided. However, we noted in the relative's responses in relation to the standard of care, there were comments about frequent staff changes and a need for more carers.

There was a monitoring system to check the quality of care being provided. The management and provider team carried out a number of checks and audits, which monitored the quality of areas such as accidents, medicines and care plans. Actions were set on areas that required improvements and there was evidence that these were being worked on by the current interim and regional manager. They informed us they had a 'team' of staff in place to start working on improving the service. For example, a trainer and a governance lead.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider had not ensured good planning and delivery of care.** **The provider had not ensured all care plans had an assessment of needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider had not ensure the involvement of people.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider had not followed legal requirements in relation to consent.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not ensured staff followed cleanliness and infection control practices.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Action we have told the provider to take

The provider had not ensured staff followed safe medicines practice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured good governance arrangements within the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not ensured enough staff were deployed at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider had not followed appropriate recruitment processes.