Dunsfold Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Dunsfold on the 6 July 2017 and the inspection was unannounced. Dunsfold provides accommodation for up to 18 older people living with dementia. On the day of the inspection, there were 15 people living at the service. Dunsfold is a residential care home that support older people living with dementia and disabilities associated with old age such as limited mobility, physical frailty or health problems such as diabetes. Accommodation was arranged over two floors with stairs and a stair lift connecting each level.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection undertaken on the 12 January 2017, we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 in relation to the principles of the Mental Capacity Act 2005 not being adhered to. Risks associated with the environment and premises had not been mitigated or addressed. Staffing levels were insufficient and accurate records had not been maintained. The provision of meaningful activities was poor and the risk of social isolation had not been mitigated. The provider's quality assurance framework was not robust and they had failed to display their rating and notify the Care Quality Commission of significant incidences. Recommendations were also made in relation to the environment, care plans and following best practice guidelines. The provider sent us an action plan stating they would have addressed all of these concerns by February 2017. At this inspection we found the provider had made improvements to staffing levels, the environment and care plans. The provider was now displaying their rating and was notifying the Care Quality Commission of significant incidences. However, improvements were not yet fully embedded and the provider continued to breach the regulations relating to the other areas.

People, staff and relatives spoke highly of the registered manager and their leadership style. However, despite people's praise, we found areas of care which were not consistently safe or well-led. The management of falls was not consistently safe and robust risk assessments and guidelines were not always in place.

Improvements had been made to the provider's quality assurance framework; however, these improvements were not yet embedded or sustained. The registered manager and provider were also not proactive in identifying how ongoing improvements could be sustained. Shortfalls in the provision and delivery of care had not always been identified by the provider's quality assurance framework. We have identified this as an area of practice that needs improvement.

People told us they felt safe living at Dunsfold. Staffing levels had improved since the last inspection and action had been taken to improve fire safety at night. Staff worked in accordance with people's wishes and

people were treated with respect. It was apparent that staff knew people's needs and preferences well. Positive relationships had developed amongst people living at the service as well as with staff.

Systems were in place to ensure people were supported to receive their medicines on time by qualified and competent staff. Medicines were ordered and disposed of safely. People were supported to access health services and their health care needs were being met. People were safe and staff knew what actions to take to protect them from abuse. The provider had robust recruitment procedures in place to ensure that staff were suitable to work with people.

Staff knew the people they were caring for very well. They were able to communicate effectively with people and involved them in making decisions about their care and support. Laughter was heard throughout the inspection and there was regular informal banter between people and staff. The service had a cat that lived on site and staff recognised the importance that animals can bring to older people. People's bedrooms were now personalised and reflected their individual interests and choices.

People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and people were able to give feedback and have choice in what they ate and drank. Staff were knowledgeable about people's behaviours which might challenge. Care plans were in place that detailed people's history, health, medical and physical needs and preferences.

The registered manager was described as approachable by people, their relatives and the staff. People and relatives knew how to complain and said they would feel comfortable to do so.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Dunsfold was not consistently safe.

Robust risk assessments were not consistently in place. Risks associated with people falling had not been adequately addressed.

People received their medicines safely when they needed them. There were robust recruitment procedures in place and there were sufficient staff to keep people safe and meet their needs.

Risks associated with the use of call bells had been addressed and mitigated.

Is the service effective?

Good

Dunsfold was effective.

People were supported to have enough to eat and drink and to access health care services to maintain their health and wellbeing.

The principles of the Mental Capacity Act (MCA) 2005 were now applied in practice. Staff understood the importance of gaining consent before delivering care.

Staff received training and supervision to support them in providing effective care to people.

Is the service caring?

Good

Dunsfold was caring.

People were supported by staff that were kind and caring. Positive relationships had been developed between people and staff. Staff appeared to know people well.

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

Visiting was not restricted and people were supported to maintain relationships with people that mattered to them.

Is the service responsive?

Requires Improvement

Dunsfold was not consistently responsive.

Improvements were still required to ensure the provision of activities was meaningful.

Systems were in place for receiving, handling and dealing with complaints. People's care needs had been assessed and a care plan formulated.

Is the service well-led?

Requires Improvement

Dunsfold was not consistently well-led.

The provider's internal quality assurance framework was not consistently robust.

People and staff were positive about the management and culture of the service.

People were treated as individuals, their opinions and wishes were taken into consideration in relation to the running of the service.

Dunsfold Ltd

Detailed findings

Background to this inspection

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

The inspection took place on the 6 July 2017 and was unannounced. The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care home.

Before the inspection we checked the information that we held about the service and the provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection. On this occasion we did not ask 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 any improvements they plan to make.

We spoke with 10 people who lived at the service, two visiting relatives, the registered manager, provider (owner), a chef and two care staff. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. After the inspection, we gained feedback from one relative and two healthcare professionals. Their comments can be found in the body of the report.

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

We lasted inspected Dunsfold in January 2017 where we rated the service as 'Requires Improvement.'

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Dunsfold. Observations of care demonstrated that people were comfortable in the presence of staff. People's behaviour also showed us they felt safe. One person told us, "I like the home and I feel safe." Another person told us, "I've been here a long time and I feel safe." Visiting relatives also confirmed they felt confident leaving their loved ones in the hands of Dunsfold care staff. One visiting relative told us, "She's very safe here and it is small and personal." However, despite peoples and relatives positive feedback, we found areas of care which were not consistently safe.

At our last inspection in January 2017 the provider was in breach of Regulation 15 and 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because staffing levels were not always adequate to meet the needs of people, and were not varied to reflect the changing dependency needs of people. Risks associated with the safety of the environment and premises had not safely been mitigated or addressed and the décor of the service required refurbishment. Areas of improvement were also identified in relation to access to call bells. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by February 2017. At this inspection, we found improvements had been made in relation to staffing levels, access to call bells and most of the risks associated with the safety of the environment had been addressed.

There were now sufficient numbers of staff to ensure that people were safe and well cared for. Improvements had been made since the last inspection in January 2017. The provider told us, "We've assessed staffing levels as if we are always at full capacity and have determined that we need three staff members throughout the day along with a chef to safely meet people's needs. If people are present with an additional need, we will go back to the funding authority to request additional funding for one to one care. We have done that previously." The provider and registered manager also confirmed that on the days when the chef was not working, an additional staff member would be deployed to cover cooking to prevent a staff member being taken off the floor who would have been providing care. Rotas confirmed this. Additional steps had been taken to ensure that staffing at night was safe and met the needs of people. At the last inspection in January 2017, concerns were identified that if the service needed to be evacuated at night, staffing levels would be insufficient to support a safe evacuation. Bedroom doors were not fire doors which meant the provider was unable to operate a 'stay put' policy. Improvements had been made. All bedrooms doors had been fitted with intumescent strips which meant they could now act as fire doors. In the event of a fire at night, the provider operated a zoned evacuation, which meant people would be moved to specific zones within the service whilst awaiting input from the fire service. The additional protection of the fire doors now meant that staffing levels at night had been assessed by the provider as safe. Staff, people and their relatives also felt that staffing levels were sufficient. One staff member told us, "Staffing is a lot better, we have employed a new staff member and we are working more efficiently now." Another staff member told us, "Staffing levels are much better." One person told us, "Staff are very busy but marvellous. You only have to ring the bell and they (staff) come at once." Another person told us, "I'm happy and safe with all the staff."

Action had been taken to address most risks associated with the environment and premises. At the last

inspection, concerns were identified with free standing wardrobes and hot water running above the recommended temperature as advised by the Health and Safety Executive. Sink fittings in some bedrooms were worn with exposed chipboard. This posed the risk of further deterioration and being unable to be adequately cleaned. Improvements had been made. All wardrobes were now fixated to at wall. This reduced the risk of them being accidently overturned or pulled down. Hot water temperature checks took place monthly and documentation reflected that temperatures had not exceeded 44c as advised by the Health and Safety Executive. The provider had organised for sink fittings to be replaced at the end of July 2017. Throughout the service were various slopes and ramps. At the last inspection, these were identified as significant trip hazard; this was because warnings on the flooring advising people of the slope or ramp were significantly faded. Concerns were also identified in relation to the stairway in the service. This was because the stairway overhung the hallway and a restricted head height was not marked as a danger. Improvements had been made. A sign was now in place which identified the stairways overhanging the hallway as a danger. Warning marks on the floor advising people of the upcoming ramp or slope were much more visible and action had been taken to ensure radiator guards were no longer lose or coming away from the wall. One radiator guard in the hallway leading to the lounge continued to come away from the wall and have a hole in it which posed a risk of people being able to touch the radiator. We brought this to the attention of the registered manager to take action. We were informed that the radiator guard was replaced a couple of days after the inspection.

People's individual ability to use their call bell was considered as part of their care plan. At the last inspection, a recommendation was made which asked the provider to review all call bell risk assessments and the availability of call bells within the service. This was because; people didn't consistently have access to their call bells. Improvements had been made and the provider told us, "We have reviewed everybody's ability to use to call bell and if they can, we have ensured they have access to a call bell. If we have accessed that they can't, then there won't be a call bell within their room." Where people had been assessed as safe to use their call bell, we found their call bell was accessible within their bedroom.

Dunsfold provided care and support to some people living at high risk of falls. Guidance produced by the National Institute for Health and Care Excellence (NICE) advises that falls and falls related injuries are a common and serious problem for older people. They can be a major cause of disability. People's individual risk of falls was calculated which considered their mobility, special risks, toilet needs, age and medication. This identified if people were at low, medium or high risk of falls. However, monthly reviews of people's falls risk assessment failed to assess how many falls they had experienced that month and whether the assessed outcome and need remained effective. For example, one person's falls risk assessment identified they were at low risk of falls and had been at low risk for the past six months. However, incidents and accidents dating back six months (Since January 2017) reflected that on one occasion they were found lying on their back in another person's bedroom. On three other occasions they were found with skin tears, one of which required 111 to be called. A discharge summary from hospital on the 17 June 2017 identified that they had been admitted to hospital with a head injury and required stitches. Following each incident, their monthly review of their falls risk assessment failed to consider if the current measures in place remained satisfactory. The provider was responsive to our concerns and agreed to review all falls risk assessments.

A number of people had sensor mats in place. Sensor mats are used as an aid to alert staff if someone who is at high risk of falls has gotten out of bed or out of chair. Despite sensor mats being in place, there was no assessment on the need or use for a sensor mat. Guidance was not in place on whether the sensor mat was only needed at night, whether it should be unplugged during the day or what to do in the event of the sensor mat going off. Staff told us that sensor mats were primarily used at night as most people stayed in the lounge during the day. One person receiving respite care, had a sensor mat in place and staff told us they were at high risk of falls. However, there was no assessment around the use of the sensor mat, why it was

required and how staff should utilise the sensor mat to reduce the risk of falls. A falls risk assessment had also not been completed and there were no guidelines in place around the risk of falls. We asked the registered manager where we would find information relation to the use of sensor mats. The registered manager confirmed that assessments were not in place.

Staff told us how they supported people and reduced the risk of falls. One staff member told us, "We make sure the environment is clear of any hazards, check on people regularly and if a sensor mat goes off, we go to the person immediately and provide support." Although staff were able to describe how the risk of falls were mitigated. Risk assessments failed to provide sufficient guidance, and assessments around the use of sensor mats were not in place.

Dunsfold provided care and support to people receiving respite care. On the day of the inspection, three people were receiving respite care. One person had only been at the service for two days whilst two other people had been at the service for approximately three weeks or more. Pre-admission assessments had been completed but care plans were not yet in place. The registered manager was open about this shortfall and identified they hadn't had time to formalise the care plan yet. Staff utilised the pre-admission assessment as a guideline on the level of care and support those people needed. However, where people had specific risks, guidelines and risk assessments were not in place. Upon arrival at Dunsfold on the day of the inspection, one person told us they didn't have their glasses or teeth. Their glasses were found at lunchtime, however, this meant they went the morning without their glasses but their teeth were not located. The registered manager told us that this person was known to lose their teeth. At lunchtime, they were supported to have a meal of chicken, mashed potato and vegetables without their teeth. We queried if any steps were taken to ensure the person was safe to eat certain foods or if they required their meals to be adapted (cut up or softened) whilst they were without their teeth. The provider told us, "All food is cooked well, so any meats wouldn't be tough." Staff were aware the person was known to lose their teeth, however, no guidance or risk assessment was in place to demonstrate what steps should be taken to ensure the risk of choking is mitigated when the person is eating without their teeth.

Failure to provide safe care and treatment of people is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were cared for by staff that the provider had deemed safe to work with them. Prior to their employment starting, identity and security checks had been completed and their employment history gained, as well as their suitability to work in the health and social care sector. This had been checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with adults at risk.

Dunsfold had safe systems for administration of medicines. One person told us, "The medication is done well." All medicines were securely stored. Full records were maintained of medicines brought into Dunsfold, given to people and disposed of. All staff who supported people with their medicines did this carefully and did not rush people. They gave people the help they needed to take their medicines, including drinks of their choice. They checked each person had fully swallowed their medicine before signing that the person had taken their medicine. Where people were prescribed medicines on an 'as required' basis, there were clear protocols outlining the reasons a person needed their medicine and how often it was to be given in 24 hours. Systems were in place to assess people's pain levels and ensure appropriate pain relief was provided to people when required.

Appropriate steps had been taken by the provider and registered manager to reduce the potential risk of people experiencing abuse. Staff members demonstrated a good understanding of the different types of

abuse and provided clear explanations of the actions they would take if they thought abuse had occurred. They knew where to find information on how to report any concerns to the local authority, who lead on any safeguarding concerns, if they needed to report an incident of concern. Staff confirmed that they had received training in safeguarding people and records confirmed this.

Good

Is the service effective?

Our findings

People and their relatives had confidence in the staff and told us that the care they provided was effective. One person told us, "They are very good and always talk to me." Visiting relatives felt that staff were competent and people spoke highly of the food provided.

At our last inspection in January 2017 the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the provider was not working within the principles of the Mental Capacity Act. Areas of improvement were also identified in relation to making the environment dementia friendly and seeking guidance from a reputable source about detailed catheter care plans. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by February 2017. At this inspection, we found improvements had been made.

People's rights were now protected as the provider acted in accordance with the principles of the Mental Capacity Act (MCA) 2005. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Mental capacity assessments were now in place. Consideration had been given as to the types of decisions people could make and the decisions where people lacked capacity. For example, one person's had been assessed as unable to make a decision about handling their finances or consenting to a GP appointment. Staff understood the importance of obtaining consent and we observed this in practice. For example, staff gained consent from people before supporting them to transfer. Staff also empowered people to make their own decisions. We observed that staff encouraged people to make decisions on where they wanted to sit and what they wanted to do.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest and were unable to come and go as they pleased unaccompanied. Staff confirmed they had received training on DoLS and training records confirmed this. At the last inspection in January 2017, we identified that conditions attached to DoLS authorisations were not consistently being met. Improvements had been made. Care plans had been updated to include any information on the DoLS conditions. One person's condition as part of their DoLS authorisation was for, 'the managing authority should update their care plan to ensure they are reflective of the MCA. For example, care plans should clearly differentiate the type of decisions (person) has mental capacity to make.' We found clear mental capacity assessments were now in place. Another condition included for, 'the managing authority should explore opportunities to take (person) out from the home if they so wish.' We reviewed this person's daily notes from the 26 May to 6 July 2016; however, we found no reference to the person being offered the opportunity to go out. Staff told us they regularly offered the

person the opportunity to go but sometimes declined. Documentation did not reflect that. We brought this to the attention of the registered manager to ensure that documentation reflected when the person was offered the opportunity to go out with support from staff.

Guidance produced by the Alzheimer's Society advises that a safe, well designed and caring living space is a key part of providing dementia friendly care. A dementia friendly environment can help people be as independent as possible for as long as possible. At the last inspection in January 2017, a recommendation was made asking the provider to seek guidance from a national source on the design of dementia friendly environments. Improvements had been made. Dementia friendly signage was now in place. Consideration had also been given to lighting throughout the service. Guidance produced by the University of Stirling dementia centre advises of the importance of lighting in dementia care homes. The dementia centre advised that, 'poor lighting can increase anxiety and may lead to trip and fall accidents if people cannot make sense of what is ahead of them.' At the last inspection in January 2017, we found there was a reliance on centre light fittings. Improvements had been made. The registered manager told us, "We have got in place new bed side lights and lamp shades. They have all been coloured coordinated, so the ceiling lamp shade and bedside light all match." For example, one person's quilt cover, bed side light, tiles around their sink and ceiling lamp shade all matched. The registered manager added, "We've focused on making the rooms more homely whilst addressing the issue with the lighting."

Care and support was provided to a number of people living with a catheter in situ. At the last inspection in January 2017, we asked the provider to seek guidance from a reputable source about detailed catheter care plans. Improvements had been made. Catheter care plans and guide lines were now in place. These included information on the warning signs of the catheter being blocked or bypassing and when to contact the district nurses. During the inspection, we observed that staff had identified that one person's catheter was potentially pulling on them and causing discomfort. They sensitively supported the person to the bathroom to check on the catheter.

Guidance produced by the Alzheimer's Society advised that 'eating and having a good meal is part of our everyday life and important to everybody, not least to people living with dementia.' We spent time with people during lunchtime. People were offered the opportunity to go to the dining room or remain in the lounge. Some people requested to remain in the lounge whereas others were supported to access the dining room. Tables were neatly laid with flowers, condiments and cutlery. People received appropriate assistance to eat and drink and staff demonstrated patience and understanding when assisting people, ensuring that they were ready for the support provided and were enjoying their meals. One staff member was supporting a person with eating and drinking, they sat down next to them, maintaining eye contact, explaining what they had and asking whether they were enjoying it.

People spoke highly of the food provided. One person told us, "I really enjoy the meals here." Another person told us, "The food is nice enough and mealtimes are pleasant." A third person told us, "The food is good and there is enough to drink." People's dietary needs were reflected within care documentation. For example, the type of diet people required and if they needed support with their meals. People were weighed regularly and documentation reflected that people were maintaining a stable weight. On the day of the inspection, no one was requiring a soft or pureed diet. However, staff advised that if they noticed concerns with a person's dietary intake, they would request input from the dietician or Speech and Language Therapist (SALT).

Care and support was provided to people living dementia. Staff were knowledgeable about the people they supported and specifically how to support people with behaviour which might challenge. One staff member told us, "We support one person who does want to leave and will often try and work out ways to get out. In

March 2017, they left the service and were found down the road. Since then, we have measures in place. We check on them regularly and if they do want to leave, we usually offer a cup of coffee and they come inside with us or we go on a walk around the garden together." Another staff member told us, "One person can refuse personal care. When they refuse, we will leave them to calm down and then return later and usually they are then happy to accept personal care." Guidelines were in place which considered how to manage behaviours and supported staff to provide effective care.

People had access to healthcare professionals when required. Each person had a multi-disciplinary care record which included information when GPs, dieticians, SALT and other healthcare professionals had visited and provided guidance and support. A local GP visited the service every Friday to provide guidance and support alongside individual consultations. The provider and registered manager told us, "We have had this arrangement for a while now and it is really helpful to have that rapport and regular input."

Staff told us they were well supported and had received the training they needed to be effective in their role. When starting employment with the service, staff were subject to a robust induction programme which was based on the Care Certificate. This is a set of standards for health and social care professionals, which gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. There was a full and intensive programme of training which included essential training for staff. Training included, moving and handling, infection control and safeguarding. All staff had received training in dementia care and staff spoke highly of the training provided. One staff member told us, "I feel really valued and supported here." Staff also identified how they felt they provided effective dementia care. One staff member told us, "We treat our residents how we would want to be treated."

Mechanisms were in place to support staff to develop their skills and improve the way they cared for people. Staff were encouraged to pursue National Vocational Qualifications (NVQs). Documentation confirmed that some staff were completing their NVQ level two, three and five. Staff received regular supervision. Supervision is a formal meeting where training needs, objectives and progress for the year are discussed. Staff told us they felt supported within their roles and felt able to approach the registered manager with any queries, concerns or questions.

Good

Is the service caring?

Our findings

People and relatives told us staff were kind and caring. One person told us, "Staff are kind on the whole." Another person told us, "The girls are lovely here." A third person told us, "The staff are funny and kind." A visiting relative told us about a new member of the staff team who they felt had been very caring towards their loved one. Another relative told us, "The staff are very caring. You can tell they are caring by the way they talk to people and they have good banter with my loved one."

At the last inspection in January 2017 we identified areas of improvement in relation to lack of dignity for people's personal belongings. This was because one person's bed had been made with a soiled quilt cover. A recommendation was made and we found improvements had been made.

People were cared for by kind, caring and compassionate staff who knew them well. Staff spoke with compassion for the people they supported. One staff member told us, "I really enjoy helping people. I get a lot of job satisfaction from this job." It was clear that staff knew people well and had spent time building rapports with people. Staff were able to tell us about people's likes, dislikes, personality and life history. One staff member told us, "One person used to be a minister, so in the afternoon, they often preach to people. We have quite a few people here who have religious beliefs, so they really enjoy it and people gather round to listen to them preach." Another staff member told us, "We support one person who likes to call everyone Joanie. We are not sure why and we have tried to explore who they know who was called Joanie, but we haven't worked that out yet. One day, we were sitting talking and they said to me, 'one day you will make a good mother.' I thought that was lovely comment."

Guidance produced by the Social Care Institute for Excellence (SCIE) advises on the importance of meaningful touch in providing person-centred dementia care. Throughout the inspection, staff demonstrated a clear awareness of the importance of human touch. Staff held people's hand and responded to hugs openly and positively. A visiting relative told us, "Staff are very good and often gave (person) a kiss and a cuddle."

People's wellbeing was taken into account by staff. We heard staff constantly asking people if they were okay or if there was anything they needed. Staff regularly noticed if people were not drinking and gently sat down next to them to try and encourage them to drink or ascertain if there was a drink they would prefer. We spent time with one person who told us that their favourite drink was coffee. Throughout the inspection, staff asked if they would like a cup of coffee and they also approached staff for a hot drink. Laughter was heard throughout the inspection and it was clear staff and people enjoyed informal banter. One person told us, "More interesting than being is some old people's homes and we have a sense of humour." Another person told us, "I get some laughs which is great."

Guidance produced by Age UK advises on the importance pets bring to older people and the registered manager had recognised this and enabled people to have pets. The registered manager told us, "A 'resident', who previously lived here, had a cat. Sadly they passed on, but the cat remained living with us. The 'residents' love the cat; he's very much a lap cat." Throughout the inspection, staff and people made a

fuss of the cat. Staff regularly asked people if they wanted to stroke the cat and clear guidance was in place for those who wished to feed the cat.

People told us they were able to maintain relationships with those who mattered to them. Visiting was not restricted; people were welcome at any time. Throughout the inspection we observed friends and family continually visiting, taking people out and being welcomed by staff.

Staff had a caring approach with people and supported their individual needs. When one person became anxious and distressed, staff spoke to the person in a gentle manner; they engaged with them; providing reassurance to good effect. They held the person's hand and sat with them until their distress had reduced. Staff understood the importance of promoting people's independence. With pride, the registered manager and staff told us how one person was actually moving out of the service into supported living in the community. The registered manager told us, "At Christmas time they were very unwell and came to live here. Over time, they have improved and we have promoted their independence, so much so, that they no longer need residential care. It is a big achievement."

Guidance produced by the Social Care Institute for Excellence (SCIE) advises on the importance of choice and control for older people within care homes and empowering people to retain their identity. Staff recognised the importance of supporting people to dress in accordance with their lifestyle preference and promote their identity. Ladies were supported by staff to paint their nails and one person showed us their painted nails, they commented, "The girls did it. Looks lovely doesn't it." Staff also supported men to shave.

Systems were in for people to be involved in decisions about their care and treatment. Each month, the registered manager completed a monthly review in partnership with the person and/or their representative. This review considered how the person was, what achievements had been made, whether the care plan was working, any areas of concern and the person's views. One person commented, 'I am very happy with the garden. I love sitting out there when the sun is shining.'

Requires Improvement

Is the service responsive?

Our findings

People we spoke with told us that they received personalised care which was responsive to their needs and that their views were listened to and acted on. People told us they were comfortable living at Dunsfold and one person told us, "I am very happy here." Despite, people's praise, we found an area of practice which was not consistently responsive.

At our last inspection in January 2017 the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the provision and availability of meaningful activities was poor and steps had not been taken to reduce the risk of social isolation. Areas of improvement were also identified in relation to care plans demonstrating how people's individual dementia needs were met. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by February 2017. At this inspection, we found improvements had been made in relation to care plans and reducing the risk of social isolation. Steps had been taken to improve the provision of meaningful activities. However, this remains an area of practice that needs strengthening.

The Alzheimer's Society state that spending time in meaningful activities can continue to be enjoyable and stimulating for all people, particularly those living with dementia and that taking part in activities based on the interests and abilities of the person can significantly increase their well-being and quality of life. A programme of activities was available which included music sing along, bingo, arts and crafts, floor games and social afternoons. The registered manager told us, "Every day, we allocate a member of staff to do activities in the morning and afternoon. We have a programme but obviously the activities depend on people's moods and what they would like to do. If they don't fancy doing a certain activity, we will offer something else." Resident meetings were utilised as a forum to gain feedback from people on the activities and what activities they would like to do. Minutes from the resident meeting in May 2017 reflected that residents were asked if there were any other activities they would like to do or whether they would like to change the activity programme. Feedback included that people wanted to sit in the garden now that the weather was better. Staff told us how they had implemented a seating area in the front garden and during recent weeks, most people had been spending their afternoons enjoying the sun and sitting in the garden. On the day of the inspection, a number of people were asked if they would like to go outside. Together staff and people sat outside, having a sing along and watching the world go by. Some people along with their relative walked the garden at the back of the service whilst other enjoyed sitting in the sun. For people who preferred to stay indoors, staff enquired if they would like to watch a film or certain TV programme.

People had individual 'work and playing' care plans which identified their interests, hobbies and what activities they enjoyed. A number of care plans identified that people did not like group activities. For example, one care plan noted, 'I generally like to do my own activities and enjoy my own company. If the weather is good, I will spend hours in the garden, walking, sweeping, tidying and fruit picking.' The care plan then added for 'staff to encourage (person) to participate in all activities within the home to keep them motivated.' The registered manager told us how they always asked people if they wanted to join in any group activities as some people may want to one day. However, the care plan failed to identify what to do in the event of the person not wanting to join in the group activity. Staff had clearly identified the interests of

people, yet these interests were not consistently incorporated into the activity programme or utilised to promote meaningful activities for people. For example, a number of care plans we reviewed identified that people enjoyed gardening and spending time in the garden. Although people were encouraged to sit outside and go for walks in the garden, there had not been consideration to setting up activities around gardening. We brought this to the attention of the provider who agreed that trialling a gardening club could be beneficial. Visiting relatives also raised concerns over the lack activities and stimulation. One relative told us, "My main concern is lack of activities. People are often asleep in front of the television." Another relative told us, "It is a shame there isn't more for them to do here." A third relative told us, "There are never any activities here, people are usually sat in front of the TV. We've queried why they can't employ an activity coordinator as it would benefit people. (Person) is always saying they are bored and the lack of stimulation is not good for them. Today is the first time, we've ever seen people sitting outside." People who used the service had mixed opinions about the activities provided. Some people told us that activities were not for them and they enjoyed reading the paper or watching the television. One person told us, "I am bored sometimes but mainly it is fine." Whilst another person told us, "I like the sing a-longs." Another person told us, "We do quite a few good things."

Steps had been taken to improve the provision of meaningful activities. Staff were actively supporting people to spend time in the garden and watch films and TV programmes of their choice. Staff were allocated the role of activities and an activity programme was in place. However, relatives continued to have concerns around stimulation and not all steps had been taken to provide activities based on people's likes and interests. Improvements had been made, yet these were not embedded into practice. We have identified this as an area of practice that needs improvement.

Guidance produced by Social Care Institute for Excellence advises that older people are particularly vulnerable to social isolation and loneliness owing to loss of friends and family, mobility or income. Social isolation and loneliness have a detrimental effect on health and wellbeing. At the last inspection in January 2017, concerns were raised that one person was on bed rest due to poor skin integrity, however, there was no clinical need for bed rest and the risk of social isolation had not been mitigated. Improvements had been made. Guidance was now in place which advised that if the persons skin integrity did deteriorate, for staff to support them to sit out in the lounge for a couple of hours to minimise the risk of social isolation. When, the person did require bed rest, guidance dictated for staff to spend time reading the paper or book and to make sure the radio was on. Guidance advised that the person liked to listen to classical music and identified the importance of talking to the person and ensuring they had their soft toy to hand which provided reassurance and comfort.

Guidance produced by the Social Care institute for Excellence states that personalising people's bedrooms can provide them with reassurance and remind the person with dementia what room they are in. At the last inspection in January 2017, we found that some people's bedrooms were bland and lack personalisation. Improvements had been made. Steps had been taken to personalise people's bedrooms. Pictures and drawings were now displayed on people's bedroom walls. The registered manager told us, "We asked relatives to bring in any pictures or objects the persons like, so we can display that in their bedroom." One person was an avid Chelsea fan, so their bedroom had been personalised with Chelsea memorabilia.

People's needs were assessed prior to them moving into the service and this information was used to develop care plans. Care plans covered a range of areas including; maintaining a safe environment, communication, behaviour, eating and drinking and personal care. They considered the person's strengths and needs along with the prescribed care required. For example, one person's behaviour care plan noted, 'I can become quite verbally aggressive towards staff if am not happy. But I will always go back to my room for quiet time alone. I have been known to be physically aggressive towards staff by scratching and slapping

them.' Their prescribed care was recorded as, 'Staff to be aware that (person) can become physically and verbally aggressive towards them if they are not happy. (Person) will go to their bedroom and have quiet time, reading a book or watching TV which calms them down.'

Guidance produced by the Alzheimer's Society advises that people living with dementia can often experience difficulties with orientation around their home and in relation to time. At the last inspection, we asked the provider to review their care plans to demonstrate how people's individual dementia needs were met. This was because care plans lacked information on how people's dementia presented and how staff should respond if the person was not orientated to time or place. Improvements had been made. The registered manager had implemented the 'This is me' booklet for everyone. The 'This is me' booklet was designed by the Alzheimer's Society and is a tool to enable staff members to see the person as an individual and deliver person-centred care that is tailored specifically to the person's needs. The booklets included information on what was important to the person and things that may upset or worry me.

On the days of the inspection, England was subject to a heat wave and the weather was extremely hot. Action had been taken by staff members to ensure they provided responsive care and reduced the risk of dehydration or heat stroke. For people who enjoyed spending time in the garden, staff supported people to wear sun cream. Ice lollies were also provided to people and people were actively encouraged to drink plenty of fluids.

There was a complaints procedure in place and people told us they would talk to the registered manager if they were unhappy. One person told us, "No complaints here." A visiting relative confirmed they had no need to complain but wouldn't hesitate in raising a complaint if they needed to. The service had not received any formal complaints in over a year.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives described Dunsfold as homely and personal. One relative told us, "Although there are posher and more comfortable homes this is a caring home." Staff spoke highly of the registered manager and their leadership style. One staff member told us, "I feel very supported here and the registered manager is very good." Whilst all feedback was positive and we could see that changes were taking place, these changes were not yet embedded into practice.

At our last inspection in January 2017, the provider was in breach of Regulation 17 and 20A of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because systems for assessing and improving the quality and safety of the service had not always been effective. Accurate records had not always been maintained and the provider had also failed to display their rating on their website. At the last inspection in January 2017, the provider was also in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This was because they had failed to notify the Care Quality Commission of a number of incidences. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by February 2017. At this inspection we found some improvements had been made in relation to accurate records, the provider was now displaying their rating and they had notified us of significant events at the service. However, these improvements were not yet sustained or embedded and the provider's quality assurance framework was not consistently identifying shortfalls.

A governance framework was in place and the registered manager and provider had access to a range of tools to help them monitor, review and assess the quality of the service. These included satisfaction surveys; annual management review form, care plan audits, medication audits, maintenance programme and provider visits. Improvements had been made since the last inspection in January 2017. The quality of the provider visits reports had improved. On a monthly basis, the provider visited the service and looked at the following areas: premises, documentation and talking to people and staff. However, these monthly visits were not consistently identifying shortfalls or how improvements could be sustained and embedded. For example, the monthly provider visits from March, April, May and June 2017 had failed to identify that best interest decisions had not been made following an assessment of capacity where it had been identified that a person lacked capacity. Internal quality assurance checks also hadn't identified that the management of falls could be improved. The provider's monthly visits had also failed to identify that the monthly reviews of risk assessments was not always robust. For example, the mental health risk assessment for one person identified they were highly dependent. Documentation advised they were to maintain their 'mental health by staff to encourage to mix with other residents. Staff to provide activities and keep the brain active and alert.' The evaluation was noted as 'Person will decline to join in the activities.' Documentation reflected that this risk assessment was reviewed monthly but there was no evidence or detail as to whether the actions required remained effective or what interventions have been helpful or unproductive. We found this was a consistent theme across the care plans we reviewed. Although the provider and registered manager had access to a range of tools to enable them to improve practice and have strategic oversight of the service. We found these tools were not consistently being utilised to drive improvement, embed positive changes and identify shortfalls.

Regular health and safety checks took place and an environmental audit was in place which considered risks associated with the environment. The risk assessment identified that windows should only open 'six inches to prevent anyone falling out.' Guidance produced by the Health and Safety Executive advises that 'where vulnerable people have access to windows large enough to allow them to fall out and be harmed, those windows should be restrained sufficiently to prevent such falls. Window restrictors should: restrict the window opening to 100 mm or less (three inches or less). The daily notes for one person reflected that one night, they were found on two occasions, trying to climb out of a bedroom window. We brought these concerns to the attention of the registered manager who confirmed that all windows were restricted not to open more than 100mm. Despite these reassurances, the provider's quality assurance framework had failed to identify this shortfall within their environmental risk assessment and audit.

Steps had been taken to improve the governance framework and quality assurance checks. However, these improvements were not yet embedded or sustained. We have judged the impact on people to be low, however, this remains as an area of practice that needs improvement.

A wide range of policies and procedures were in place. Policies covered areas from safeguarding to Mental Capacity Act (MCA) 2005. Improvements had been made since the last inspection in January 2017 and all policies had been reviewed to reflect up to date legislation.

Dunsfold provides care and support to people living with dementia. The provider's website reflected, 'Here, at Dunsfold, we are specialists in Alzheimer's and dementia.' At the last inspection in January 2017, we queried with the registered manager how they assured themselves that they provided good practice dementia care and what best practice guidelines they followed. They were unable to comment. Improvements had been made. The provider and registered manager had implemented a best practice folder which was readily available for staff. This included guidance from the Alzheimer's Society. The provider told us, "We also put leaflets in the folder. For example, if we support someone with diabetes, we have leaflets on the signs of high and low blood sugars."

People, relatives and staff spoke fondly of the service. One staff member told us, "I really enjoy working here." One person told us, "I am happy to be here and I feel safe. The staff are really nice, they really are. They work hard." Staff described the key strength of the service as communication and the caring nature of staff. The registered manager told us, "A key challenge for us the past six months has been lack of support at times from other agencies and professionals. Our biggest achievement has been providing care to the residents. Especially, as we have supported one resident who now is leaving Dunsfold and moving onto independent living."

People, staff and relatives were actively involved in developing the service. Satisfaction surveys were sent out every six months and used to develop and improve the service. Staff and resident meetings were held on a regular basis and acted as a forum for people to raise any concerns or queries. Minutes from the last staff meeting in June 2017 reflected that medication, team work and ensuring that people had access to sun cream when spending time in the garden were discussed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that people were protected from the risk of harm. Regulation 12 (1).