Bupa Care Homes (BNH) Limited

Dene Place Care Home

Inspection report

Ripley Lane
West Horsley
Surrey
KT24 6JW

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

Summary of findings

Overall summary

This inspection was carried out on the 7 November 2017 and was unannounced. Dene Place provides nursing care and accommodation for a maximum of 30 older people. The home is owned and operated by Bupa and is a large detached property situated within National Trust grounds. At the time of our inspection 20 people were living at the service.

There was no registered manager in post on the day of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. Instead we were supported by the deputy manager and senior staff from BUPA.

People told us that there were not sufficient staff at the service. Through our observations we found that staff did not respond to people in a timely way as they were busy elsewhere. People were not always receiving support when it was needed by staff. There had been a lack of an activities coordinator at the service and care staff did not have time to fulfil this role.

People told us that staff did not have the time to spend talking to them and sometimes they felt that they were not listened to as staff were busy. People did not always have the choice as to when they got up and when they went to bed.

People told us that they did not have enough to occupy them. There were insufficient activities taking place. Relatives felt that their family members were bored.

There was a lack of consistent leadership at the service. There had been two changes of manager since the last inspection. As a result people, relatives and staff did not feel supported and they felt the service lacked management oversight. People and relatives did not always know who the manager was. Staff felt overworked and did not always feel valued.

Although there were systems in place to review the quality of care these were not always used to make improvements. Records were not always up to date and accurate. This resulted in a continued breach in relation to this. There were some aspects to the quality assurance that were effective in making improvements to the care provision.

People said that they felt safe with staff. Staff understood what to do in order to keep people safe from harm or abuse. All of the staff had received safeguarding training and knew what to do if they suspected abuse. There were robust recruitment systems in place to ensure that only suitable staff worked at the service.

Assessments of risks for people were undertaken when they first moved in and on a continuing basis. Other than the risk of falls where people were left unsupported by staff; staff understood the risks to people and

took steps to reduce the risks. Staff understood what to do if there was an emergency in the service such as a fire or a flood. There were evacuation plans in place for people and a contingency plan if the service needed to close.

Staff understood what they needed to do to ensure people were protected from the risk of infections. Staff were seen to adhere to good infection control practices. The service was clean and well maintained. Accidents and incidents were analysed and actions taken to reduce further risks.

Staff understood the principles that related to the Mental Capacity Act 2005. Where there was a doubt about a person's capacity appropriate assessments took place. Best interest meetings were held and where appropriate applications were submitted to the local authority if people were being restricted. .

Staff received a detailed induction and appropriate training for their roles. Regular supervisions were provided to staff to ensure they were providing the most appropriate care.

People had access to sufficient food and drink. Where people were at risk of dehydration and malnutrition there were care plans in place to address this. Health care professionals were consulted and guidance followed in relation to people's care.

The premises were set up to ensure that people could access all areas of the service independently.

The interactions we did observe from staff were kind, caring and respectful. People told us that they felt staff were caring and treated them with dignity. We saw examples of this on the day. Relatives and visitors were welcome at the service at any time.

Care plans were detailed and provided guidance to staff on what care was required to be delivered. People and their families were involved in the planning of their care.

Complaints were investigated thoroughly and improvements made where shortfalls had been identified. People told us that they would not hesitate to make a complaint if they needed to.

The provider sent us an action plan after the inspection to confirm what actions they had taken. A new manager was starting at the service and additional staff had been brought in to provide activities for people. We will check this at the next inspection.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. Staff had informed the CQC of significant events.

The service was last inspected on the 13 December 2016 where we identified a breach around the lack of capacity assessments, medicines were not always managed in a safe way, systems and processes were not in relation to quality assurances and records were not always up to date and accurate. We found on this inspection that some improvements had been made but there were still shortfalls.

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

The service was not always safe.

There were not enough staff at the service to support people's needs.

People were protected from risks to ensure their safety. Staff understood how to reduce the risk of infections. Actions were taken to reduce the risk of accidents and incidents.

Medicines were administered, stored and disposed of safely. Improvements were required to ensure that MAR charts were always completed in relation to 'as and when' medicines.

Recruitment practices were safe and relevant checks had been completed before staff commenced work.

There were effective safeguarding procedures in place to protect people from potential abuse. Staff were aware of their roles and responsibilities.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the necessary skills and knowledge to meet their assessed needs.

People had enough to eat and drink and there were arrangements in place to identify and support people who were nutritionally at risk.

Staff understood how to apply legislation that supported people to consent to treatment. Where restrictions were in place these were in line with relevant guidelines.

People had access to healthcare services and professionals were involved in the regular monitoring of their health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not always have to spend with people. People felt that staff did not always have time to listen to them. People did not always have a choice around when they wanted to get up or go to bed.

Staff did treat people with dignity and respect. We did see occasions where staff were kind and attentive.

People were involved in their care planning and other aspects of care were delivered in line with what the person wanted.

People's relatives and friends were able to visit when they wished.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive.

There were not sufficient activities for people to be involved in. People told us that they were bored.

Care plans were written in a person centred way and included guidance for staff around how care was to be delivered. Staff understood what care was required.

Complaints were investigated and improvements made where necessary. People told us they would make a complaint if they needed to.

People received kind and compassionate care at the end of their lives.

Is the service well-led?

Requires Improvement

The service was not well-led. There was a continued breach from the previous inspection.

There had been a lack of management oversight at the service. People, relatives and staff did not feel that there was sufficient consistent leadership at the service.

There were aspects to the quality assurance that were not effective. There were audits taking place that did identify were improvements were needed and these were actioned.

Notifications that were required to be sent to the CQC were being submitted.

Dene Place Care Home

Detailed findings

Background to this inspection

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

This was an unannounced inspection which took place on the 7 November 2017. The inspection team consisted of two inspectors, one specialist nurse 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 service.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the service. We reviewed notifications sent to us about significant events at the service. A notification is information about important events which the provider is required to tell us about by law. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is because we were following up on breaches from the previous inspection. The PIR 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.

During the visit we spoke with the deputy manager, other senior members of the management team, 10 people, four relatives and seven members of staff. We looked at a sample of eight care records of people who used the service, medicine administration records and training records for staff. We looked at records that related to the management of the service. This included minutes of staff meetings and audits of the service.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in December 2016 we found that the management of medicines was not always safe. On this inspection we found that this had improved and people's medicines were being managed appropriately by staff.

People told us that there were not enough staff. One person told us, "It [the service] could always do with more staff." One relative told us, "[The service] has been a bit short staffed recently." People told us that staff were often rushed when they were providing care. One person said, "Staff do come when I ring a call bell but there is sometimes a bit of a wait."

There were not always sufficient numbers of staff deployed to ensure that people were kept safe. During the morning of the inspection there were several occasions where people were left on their own in the lounge despite, according to their care plans being at risk of falls. The provider informed us that the member of staff who would normally support people in the lounge was the activity coordinator who currently off work. Staff told us that that the absence of this member of staff impacted on the care delivery. One told us, "At the moment there are not enough staff. I don't feel you can give people the quality time. People want to have a chat but we are rushed off our feet. People are getting up late." We observed that the morning personal care for people did not finish until just before lunch was served. Another member of staff said, "People don't get the required assistance with their needs. People stay in bed longer and this delays lunch at times." A third member of staff told us, "From our side there's not enough [staff]. Everyone needs two staff (to assist them with care) apart from two [people]. A lot [of people] need assisting with their food. Sometimes the bell is ringing for 10 minutes. We don't finish the morning personal care until 12:00."

Staff told us that due to the activities coordinator not currently being at work this meant that there was more pressure on care staff to provide activities. One member of staff said, "We do our best but we can't provide activities as we are too busy. We could do with an extra carer to do them." We found that staff were pulled away from their normal duties to do activities for people. For example one member of housekeeping staff was supporting people in the afternoon with activities which took them away from their housekeeping duties.

There was one person at the service who required support each day to undertake exercises that had been recommended by a health care professional. However these exercises had not been taking place as staff told us that they did not have time. One member of staff said, "We do the exercises now and again but we have not got enough time." This meant that the person was not receiving the appropriate support at all times that was necessary for their health. Another person was sat in the lounge and asked a member of staff if they could go to bed. Staff were not available to attend to the person for another 15 minutes. Another person was in their room left alone in their chair for 15 minutes as staff were busy. This was despite their care plan stating that they should not be left alone in their chair.

We reviewed the staff rotas for the service. We found that apart from the lack of activity staff there were always the correct numbers of care staff and nurses according to the how the providers had assessed

people's dependencies. However more work needed to be undertaken to ensure that staff were deployed effectively so that people were provided support in a timely way. The provider told us that more work needed to be undertaken to ensure that staff were deployed more efficiently and that they were trying to address this.

As staff were not always effectively deployed to support people's needs this is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said that they felt comfortable in asking for pain relief if needed. The provider ensured the proper and safe use of medicines for people. The medicine administration records (MAR) for people had a photo of the person, a list of their allergies and details of the person's GP. There were no gaps on the MAR charts. Temperatures of the medicine storage room was checked and documented every day to ensure the medicines were kept safe. Where medicines were no longer in use they were destroyed in line with the providers policy. There were 'as and when' protocols in place so that staff had guidance for when pain relief was needed for people.

People told us that they felt safe with staff at the service. People were protected from the risk of abuse. Staff told us that they understood the signs to look for to ensure people were protected from abuse. One told us, "You need to take good care of them [people]. You note everything. You become their confidante so that they can feel they can talk to you if they are worried about anything. If anything is off then I would raise this with the manager." All of the staff had received safeguarding training and were aware of the safeguarding policies in place. One health professional told us that they felt the service was a safe place and that they had never had any worries about how staff may treat a person. We observed that people felt comfortable in the presence of staff. We saw that each month any safeguarding concerns were reviewed and actions taken to ensure that lessons were learned and actions were taken to reduce the risks to people.

With the exception of the identified risk of falls not always being managed due to the lack of staff; assessments were undertaken to identify other risks to people. One relative told us that their family member had a fall due to getting out of bed on their own in the night. They told us that there was now a motion detector in their room and a crash mat. They told us, "They [staff] really have done everything they can to try to keep her safe. They do get there quickly when the motion detector triggers the warning bell."

Staff used hoists and sliding sheets to transfer and reposition people. Each person was assessed by the nurse to ensure that they had the correct slings and we found that each person had their own slings. There were sufficient hoists and these were serviced regularly. People at risk of falling out of bed had their beds fitted with bedrails. The bedrails were fitted with bumpers to prevent entrapment and there were bedrails assessments. Action plans were in place to manage the risks identified. All people in their own rooms had a call bell on the table next to them which they could reach. Staff understood the risks to people and how to reduce them whilst supporting their freedom. One told us, "We encourage people to walk and make sure they have their walking aids with them." Another told us, "You need to make sure that the area is safe for people to move around. When you are moving people in a wheelchair you make sure that their feet are on the foot plate."

Equipment was available to assist in the evacuation of people. Fire exits were clearly marked and free from obstruction and fire evacuation plans were displayed throughout. Staff understood what to do in the event of a fire. One told us, "If there is a fire you get to the meeting point. The allocated member of staff would find out where the fire is. We check that everyone has been moved safely." There were personal evacuation plans for each person that detailed how staff needed to support the person in an emergency. There was also a service continuity plan in the event that the service had to be closed for example if there was a flood or a fire.

People would either be taken to a nearby service or hospital if more appropriate. Entry to the service was via staff and visitors were asked to sign the visitors' book. Where clinical risks were identified appropriate management plans were developed to reduce the likelihood of them occurring including around wound care, diabetes care and other health care concerns. Where wounds had been identified regular photos were taken of the wound to track the progress. We identified that pressure sores were healing as a result of the intervention from the staff.

People were protected against the risk of infection as appropriate measures were in place. Staff were seen to wear personal protection equipment (PPE) where needed. Gloves and aprons were available for staff throughout the service. Staff were seen to wash their hands regularly and there were hand gels available for everyone at the service to use. Staff understood how to ensure that people were protected from the risk of infection. One member of staff said, "When we wash people's laundry we ensure that soiled items are kept away from non-soiled items. This is to reduce the risk of cross contamination."

Lessons were learned and improvements made when things went wrong at the service. Accidents, incidents and safeguarding concerns were recorded with actions taken to reduce the risk of them reoccurring. For example one person had a skin tear on their body. Staff were reminded to use the palm of their hands when applying cream to reduce the risks of future skin tears. Another person had developed a pressure sore. The tissue viability nurse had been contacted and actions taken to reduce the risk of the pressure sore getting worse. Another person had fallen from their bed. A risk assessment was undertaken and bed rails put in place to reduce this risk.

People were protected from being cared for by unsuitable staff because robust recruitment procedures were in place. Staff told us about the selection procedure that they went through to ensure that they were safe to start work. Staff told us that they were interviewed for the job and had to provide two references and had to undergo police checks. All staff had undertaken enhanced criminal records checks before commencing work and references had been appropriately sought from previous employers. Application forms had been fully completed; with any gaps in employment explained. The provider had ensured that staff had the right to work in the country and screened information about applicants' physical and mental health histories to ensure that they were fit for the positions applied for.

Good

Is the service effective?

Our findings

At the previous inspection in December 2016 that staff were not always following best practice in gaining consent from people. There were not sufficient assessments in place to assess people's capacity around a particular decision. This was a breach of regulation11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that this had been addressed and assessments were now in place. This breach has now been met.

The Mental Capacity Act 2005 (MCA) is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day to day matters. Staff had received training in the Mental Capacity Act (MCA) 2005 and how they needed to put it into practice. One member of staff said, "There are five points. We need to do everything in their best interest. Those who have capacity need to make choices themselves. If someone has not got capacity we need to make choices for them." We saw assessments had been completed where people were unable to make decisions for themselves. . These assessments were specific to particular decisions that needed to be made for example in relation to bed rails and lap belts for wheelchairs. Records showed that staff ensured family members were involved when the 'best interests' decision was made on the person's behalf about their care and support. People told us that they were asked to give their consent to their care. One person said, "They know what I need and they get on with it. I am perfectly happy with that."

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people 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. Staff understood where people may be restricted and understood that this would only be appropriate if the person lacked capacity and it had been decided that it was in the person's best interests. One member of staff referenced the use of bed rails being a restriction. We noted that DoLS applications had been completed and submitted in line with current legislation to the local authority for people living at the service. People who were not subjected to a DoLS authorisation were not restricted in any way.

Care and support was planned and delivered in line with current evidence based guidance. BUPA's 'Resident Care' standards incorporated relevant guidance that was specific to the services they delivered. For example from the National Institute for Health and Care Excellence, British Journal of Nursing, Royal College of Nursing, Mental Capacity Act 2005 (MCA) and NHS England. We found that the care being provided was effective and produced positive results for people. For example where it had been identified that a person was losing weight steps were taken to monitor this. The person was being weighed more regularly, there was a food and fluid chart in place and the GP had been consulted. As a result the person had gained weight.

Staff were sufficiently qualified, skilled and experienced to meet people's needs. All new staff attended induction training and shadowed an experienced member of staff until they were competent to carry out their role. One member of staff said, "The induction is so much better now. Staff do at least two weeks of

shadowing before they support on their own." Staff had undergone the service mandatory training including moving and handling, infection control and health and safety. Nurses were kept up date with the clinical training including wound care, catheter care, skin integrity, end of life care and falls prevention. Senior staff had been sent on management training so that they were more competent in leading the staff that were providing care.

Care staff had received appropriate support that promoted their professional development and assessed their competencies. Staff told us they had meetings with their line manager to discuss their work and performance. We saw that staff had meetings with their manager to discuss their performance, learning and development. We saw that appraisals with staff took place annually. Clinical competency assessments took place with the nursing team that included guidance on skin tears, a discussion around good practice and objectives set.

People told us they were satisfied with the food on offer. One person told us, "I am glad I can eat in my own room and choose what I want to eat."

We observed that throughout the day people were offered drinks and snacks in between meals. During lunch people were offered a selection of hot meals and alternatives offered if people wanted something different. The dining room tables were pleasantly laid with serviettes and a menu on each table. People who required adapted cutlery were provided with this to support their independence at meal times. Meals were well-presented and additional work was being undertaken to improve the appearance of soft and pureed meals. In the evening there were 'Night bites' available for people including sandwiches, desserts and fruit. The chef told us, "Food is such an important part of residents' lives." They told us that no one at the service had any cultural needs in relation to meals but if they identified this they would ensure they had meals specific to their needs. The chef had information in the kitchen about people's dietary needs and this was kept updated regularly by the nurse in charge. People regularly left feedback on the meals provided and where possible the chef altered the meals to accommodate their feedback. For example one person had asked to not be served corned beef hash and an alternative had been offered to them.

Staff shared information effectively about people's needs. One health care professional had provided additional guidance in relation to the care of a person. The nurse had ensured that all of the staff were aware of this up to date guidance. One member of staff said, "Nurses and care workers work so well together." One health care professional told us, "Staff know people very well. Staff always follow the guidance I give and staff call me appropriately. They [staff] always update me when there has been a change [to a person's health.] One relative told us, "If I ask about her [their family member] staff know her current situation."

People had appropriate access to health care services in their ongoing care. There was evidence in care plans that a wide range of professionals were involved including the tissue viability nurse, GP, speech and language therapist, physiotherapist, optician and dentist. Staff were aware of what they needed to do to monitor a person's health. One told us, "We keep an eye on people. [The person] gets a little confused, so when that happens we check for a UTI [urinary tract infection]. We would go to the nurse to follow it up." We saw that this had taken place.

The premises were not purpose built however a lift had been installed to ensure that people could move from floor to floor. The corridors were wide which allowed people who used wheelchairs and walking aids to move around freely. People were involved in the discussions around the decoration of the main lounges and appreciated being involved. One person told us that they liked the spaciousness of the building as it made it easy for them to get around in their wheelchair.

Requires Improvement

Is the service caring?

Our findings

People said that staff were kind and considerate. One person told us, "Staff are very caring." Another told us, "They [staff] are doing a very good job and I am very happy to stay here." One relative told us, "I am perfectly happy with staff and the care. The staff are very good, very accommodating and patient." Another relative told us, "I can't speak highly enough of [member of staff], she does an enormous amount." One health care professional told us, "People always looked very well cared for."

However despite these positive comments people and relatives did feed back that staff did not have enough time to spend talking to them. One person told us that staff did not have enough time to listen to them. They said, "They [staff] are always so busy. They would listen if we asked them but they haven't got a lot of time." One relative told us, "You do not see care staff sitting in the lounge chatting to people." Another relative said, "Staff are kind but I wish there were more staff in evidence when residents are in the lounge. They [staff] only pop in and out." Staff told us that they did not have much time to talk to people. One member of staff said, "We don't spend much time talking to people as we are so rushed."

Although people were asked how they wanted their care to be delivered this was not always accommodated. People told us that they went to bed earlier than they would like and that they were not happy about that. They said that staff assisted them to bed earlier as staff were busy. One person said, "We go along with it and don't ask."

As care was not always centred around preferences this is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were aspects of care delivery that was based on the person's preferences. One person requested that only female staff provided personal care and we found that this was happening. We looked at care plans in order to ascertain how staff involved people and their families with their care as much as possible. Care plans were reviewed regularly by staff and signed by people, relatives or representatives. We found evidence that people and/or their representatives had regular and formal involvement in ongoing care planning. We asked staff to describe people and their needs. They described them as per the information in their care plan and also gave us information about their background.

When staff provided personal care to people this was provided behind closed doors to protect people's dignity. We observed staff to knock on people's doors before they entered. When staff spoke with people they did this in a polite and respectful manner. One member of staff told us, "Make sure doors are closed when personal care is taking place. Observe the wishes of the resident."

There were not many opportunities to observe care due to staff being busy providing care to people in their rooms. However when we observed care from staff in the communal areas this was kind and caring. We heard one member of staff enter the room of a person with a cup of tea. The person said, "Thank you very much you are very kind." The staff member asked, "Do you feel comfortable? Shall I sit you up a bit?" We saw that other staff stopped and addressed people when they walked past them in the corridors and asked them

how they were. When people were transferred into their seats staff checked that they were comfortable and fetched them a drink when they had finished. Staff told us what it meant to them to work at the service. One told us, "I love my job. It feeds the soul." Another told us, "We are so attached to residents." A third told us, "I look after them [people] like someone I love."

People were able to personalise their room with their own furniture and personal items so that the rooms felt more homely. We saw that family and visitors were able to visit the home whenever they wanted and people appreciated this. One family member wrote to the service stating, 'Thank you very much for your kind welcome and tray of tea when we came to visit.'

Requires Improvement

Is the service responsive?

Our findings

People did not always have the opportunity to participate in activities. We asked people what their thoughts were on activities. One person told us they were happy to just watch television, but all the other people we spoke to told us that they would like a range of activities, which they said they were not getting at the moment. One said that without those activities, "It makes the day drag." Another person said that they, "Would like to be kept more occupied." A third person said of the availability of activities, "It's not good enough." A relative told us, "We've had no entertainer for eight weeks. She's [their family member] bored and not stimulated. I brought in a crossword which she enjoyed, but I can do that." People told us that in the past they had gone out to the garden centre but that this had not happened for a long time.

There was no activities coordinator at the service as they were on long term leave. The provider had not taken adequate steps to fill this post in the member of staff's absence. Apart from external entertainers that came to the service there was very little activity taking place. Staff told us that the lack of activities had an impact on people. One member of staff said, "People get bored. Their [people's] spirits are down." Another member of staff said, "They [people] need mental stimulation." Other comments from staff included, "The carers don't do many activities. We know we should do more, but we don't" and "We know we should be doing more." They said that they were unable to as they did not have time.

On the day of the inspection one member of staff was assisting people to make poppies. However this activity did not last long and the member of staff was overheard saying that they did not know when the next activity was. One relative was heard telling a member of staff, "It's boring here. Mum goes to sleep during the day, then can't sleep at night." Another relative was heard saying, "They get bored during the day. It's a long day for them." In the afternoon there was an external entertainer providing music in the lounge. There was no evidence that people who were being cared for in their rooms were provided an activity.

As the provider did not always support people to follow their interests or encourage them to participate in activities this is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Pre-admission assessments provided information about people's needs and support. This was to ensure that the service was able to meet the needs of people before they moved in. People and their relatives were involved in their care planning. Care plans outlined individuals' care and support needs including personal hygiene, medicine, health, dietary needs, sleep patterns, safety and environmental issues, emotional and behavioural issues and mobility. The care plans also contained detailed information about people's actions required in order to provide safe and effective care. One person's care plan stated that 'When out of bed likes thick socks and slippers, likes a fleecy blanket as feels the cold.' We saw that the person had this. Another person had epilepsy and we saw that there was guidance for staff to follow should the person become unwell. A third person's care plan stated that they required their food to be cut up at meal times and we saw that this was done. The same person liked to wear a particular piece of jewellery that was important to them and we saw that they had this on.

Staff were aware of people's up to dates needs and communicated changes well. We saw that one person had one shoe removed whilst sitting in their chair. All the staff we spoke with were aware that the health care professional had recommended this to assist in the healing of a sore. One member of staff told us, "In the beginning we will read the care plans, but you get so used to people. If it is someone new the nurse tells you all about them and the care they need." Staff had a daily handover to discuss people's needs including their clinical care.

People who we spoke with told us that they did not have any reason to complain. They did not know specifically who they would approach if they had a complaint but did say they would not hesitate to raise concerns. When complaints were received these were investigated and used to improve the quality of care. One relative had complained that their family member's hair looked unkempt. An apology letter was written to the family and additional personalised care training was provided to staff. Another relative complained that a dressing was not on their family member's leg. Staff were asked to be more vigilant with this and an apology was given to the family. One member of staff told us that if a person wanted to raise a complaint, "I would ask them to speak to the nurse."

People were supported at the end of their life to have a comfortable, dignified and pain-free death. Relatives fed back to staff how they felt about the care their loved ones received at the end of their lives. One relative wrote to the staff at the service stating, 'Thank you for supporting [the family member] in the last ten months of his life. All of you were kind and respectful, chatty and friendly…which brought us comfort.'

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection in December 2016 we found that there were shortfalls around the audits that were taking place. We found that the audits had not always identified concerns that we had identified at the service. We also found that records were not always kept up to date and were not always accurate. At this inspection we found that there were still gaps around how care was being recorded and the lack of robustness of the quality assurance processes in place. In addition to this the service was not being effectively managed.

People and relatives were not clear on who the management team were at the service. One relative said, "Management are non-existent". Another said they had, "Not a clue about management". A third relative said, "I don't know who the management team are and I haven't met the new deputy manager". The relative said they would like a manager who was more visible around the service.

There was a lack of consistent management at the service. There had been two management changes since the last inspection in December 2016 which had an impact on how staff felt the service was being managed. One member of staff told us, "Nothing is stable. We work like a robot and there is pressure from management." Another told us, "We haven't had a manager. Every member of staff is trying to pick up extra duties to try and move forward." A third told us, "Management don't listen. It makes me feel unvalued and unsupported. Everyone is in charge. Too much management and they are always changing things. One manager wants us to do one thing and the next another." A fourth said, "We need a manager and more staff." This had an impact on the quality of the care being provided.

There were staff that felt supported by their colleagues. One told us, "We are working as a team. It's a good team and we help each other." Another told us, "I do feel listened to by nurses and [the deputy manager]."

The provider was providing additional management support to the service. Regional managers, quality managers and BUPA home managers from other services had been visiting the service regularly in the absence of the Dene Place manager. However this was not providing consistent leadership.

Although there had been residents and staff meetings these were not always used to make improvements. In a 'Residents and Relatives' meeting in September 2017 people and relatives mentioned that more personalised activities needed to be introduced. We found on this inspection that this had not improved. People told us that they had asked 'several times' for the pictures to be put back up in the lounge from where it was decorated. We found that the pictures had still not been put back up on the day of the inspection. The regional director told us they were aware that this had not been done and would have this addressed. At a meeting in October 2017 it was suggested that the staff levels would increase by one care staff to provide activities to people. This had not been implemented by the time of our inspection. One member of staff told us staff had suggested that an additional carer was rostered on for activities but felt the managers were not listening to them.

Records were not always being maintained or updated. One person needed to be re-positioned every two to

three hours. The person did at times get up out of bed however the positioning charts did not indicate this. The chart was not always completed so it was not easy to identify when the person was in bed and when they were not. Their care plan stated that, 'Can move independently in bed' however staff confirmed that the person needed to be repositioned. Another person's care plan stated that they were on a food and fluid chart. We could not locate this and staff confirmed to us that the person was no longer on a food and fluid chart. The care records for a person who needed to have regular mouth care three times a day were not being completed in relation to this and as a result staff were not sure whether or not this was always being done. We identified that re-positioning charts at night were not always being completed. This meant that there were no assurances that people were being moved when they needed to be.

As there was a lack of effective management, systems and processes established and operated effectively and records were not always accurate this is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider contacted us after the inspection with an immediate action plan to address the shortfalls. They told us that an experienced manager that had worked at another BUPA service would work at Dene Place. They told us that they would apply to be the registered manager. They told us that an additional care staff would be rostered on to provide activity provision for people. They told us that they would increase the checks to ensure that records were completed appropriately. We will check this on our next inspection.

There were aspects to the quality assurance that were effective. Daily clinical 'Walk arounds' took place with the clinical lead to look at areas including wound care, health care professional referrals and other clinical needs. Medicine audits took place regularly. It was identified that there was an overstock of a medicine which had now been resolved. Care plan audits identified that one persons' medical history was missing however this was now in place. Nutritional and catering audit reviewed people's weight loss and malnutrition. Night time checks were undertaken by management to ensure that people were receiving appropriate care. The manager checked with people on these night checks that they were not woken up when they did not want to be. There were monthly home reviews undertaken by the quality team. We saw that they had identified the need for a fire evacuation test to be undertaken and we saw that this had been done.

Surveys were completed by people in December 2016 and improvements were made as a result. BUPA 'You said' and 'We did' feedback was provided to people including redecoration of the rooms at the service, new music CDs were introduced to the lounge and vegetarian meals had been improved.

There was evidence that the provider was working with external organisations in relation to the care provision. For example the provider had signed up to email alerts from the MHRA (Medicines and Healthcare products Regulatory Agency). If there was a medicine that needed to be withdrawn or any other clinical product then the service would be notified of this. The provider worked alongside other health professionals including the local GP surgery, TVS, the local Hospice and community health care. This was to ensure that the most appropriate care was being provided to people.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. Staff had informed the CQC of significant events when appropriate.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that that people were supported to follow their interests or to participate in activities. Care was not always centred around preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure that staff were always effectively deployed to support people's needs

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	There was a lack of effective management, systems and processes were not established and operated effectively and records were not always accurate

The enforcement action we took:

We issued a warning notice in relation to this regulation.