Larchwood Care Homes (South) Limited

Dungate Manor

Inspection report

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Tel: 01737244149

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Dungate Manor provides residential care for up to 39 older people, who may also be living with dementia.

The inspection took place on 17 August 2016 and was unannounced. There were 36 people living at the service at the time of our inspection.

The service had 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. The registered manager had been in post since November 2015.

We previously carried out an unannounced comprehensive inspection of this service on 16 July 2015. At that inspection three breaches of legal requirements were found in respect of staffing levels, the provision of safe care and person centred support. As a result the service was rated Requires Improvement and three requirement actions for the service to improve were set. Following that inspection, the provider sent us an action plan which identified the steps they intended to take to make the required improvements. Despite telling us that all the requirement actions would be addressed, we found that staffing levels had not increased and as such we found this to be a continued breach of regulations at this inspection.

In addition to the continued breach relating to staffing, at this inspection we also found three new breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

There were insufficient staff to both meet people's needs and maintain adequate levels of cleanliness across the service. As a consequence of staffing shortages, people experienced care that was too often rushed and task focussed. People had accepted a lifestyle of waiting for their support rather than receiving it when they wanted. For example, people either did not have access to or did not use their call bells because they understood that "Staff were very busy" and would "Come as soon as they could."

Recently, just one member of domestic staff was responsible for the laundry for 36 people and the cleaning of the entire three-storey service. As a result of insufficient housekeeping staff, the levels of cleanliness across of the service were unacceptable. People's rooms were dusty and communal toilets were unclean.

Some staff demonstrated a poor understanding of infection control and placed people at risk by their practices of leaving used continence items unprotected in communal areas and walking round the service wearing gloves used during personal care.

Changes at provider level had meant that monitoring of the service had not been consistent or sufficiently regular so as to ensure effective oversight of the service. Where development plans had been devised at

provider level, these had not been shared with the registered manager.

Staff routinely involved people in their care and understood the importance of consent. However, they lacked a good understanding about what processes should be followed where a person lacked the capacity to make a decision for themselves.

People enjoyed their meals had there was a plentiful supply of homemade meals and snacks throughout the day. Staff recognised the importance of supporting people to maintain adequate hydration and nutrition, but did not always ensure records for people at risk were contemporaneously maintained.

There were systems in place to recruit suitable staff and ensure they appropriately vetted before they started to work. Staff had access to a range of relevant training and were effectively supported to deliver their roles.

People were supported to maintain their health and systems were in place to manage their medicines safely. The management team had good links with other healthcare professionals to ensure a holistic approach to people's care.

People spoke positively about their lives at Dungate Manor and were complimentary about the personalised support they received. The provision of two enthusiastic and dedicated activities co-ordinators meant that people now had regular opportunities to engage in activities that were meaningful to them.

The culture within the service was open and positive and people, relatives and professionals respected the management and leadership of the service. People were confident about expressing their feelings and staff ensured that when people raised issues that they were listened to and people's opinions were valued.

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 insufficient staff employed to appropriately meet people's needs and ensure adequate levels of cleanliness were maintained. Appropriate checks were undertaken when new staff were employed.

People were placed at risk by the failure to fully complete outstanding fire safety improvements and poor infection control practices.

Staff understood the need to safeguard people from harm, but were not clear of the processes for reporting suspected abuse.

There were systems in place to ensure people safely received their medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff understood the importance of gaining consent from people, but appropriate best interests processes had not always been followed where people lacked the capacity to provide valid consent.

The service had systems in place to train and support staff.

People had choice and control over their meals and were effectively supported to maintain adequate nutrition and hydration.

The service linked well with other health care professionals to help keep people healthy and well.

Is the service caring?

Requires Improvement

The service was not wholly caring.

People were not always respected as individuals and experienced care that was task focussed and not respectful of

them as individuals.

The atmosphere in the home was friendly and people benefitted from receiving care from staff who were kind to them.

People had opportunities to be involved in discussions about their care.

Is the service responsive?

Good

The service was responsive.

There were good systems in place to ensure people's needs were appropriately assessed and responded to.

People's individual routines and preferences were respected. People had regular opportunities to engage in activities that were meaningful to them.

People were confident about expressing their feelings and staff ensured that when people raised issues that they were listened to and people's opinions were valued.

Is the service well-led?

Requires Improvement

The service was not wholly well-led.

Provider monitoring systems had failed to ensure that improvements to the service were embedded and sustained.

The culture within the service was open and positive and people, relatives and professionals respected the management and leadership of the service.

The registered manager had systems in place to develop staff in order to support the delivery of good quality care.

Dungate Manor

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This was a re-inspection of this service to check whether the provider was now 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 an updated rating for the service under the Care Act 2014.

This inspection took place on 17 August 2016 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. The provider also completed a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of our inspection we spoke with 14 people who lived at the home, six relatives, seven staff, and the registered manager. We also spoke with two health and social care professionals who had been involved with the service. We reviewed a variety of documents which included the care plans for five people, three staff files, medicines records and other documentation relevant to the management of the home.

We last inspected the service on 16 July 2015 where the service was rated as Requires Improvement overall and three breaches of regulations were found.

Requires Improvement

Is the service safe?

Our findings

Our last inspection identified that both care and domestic staffing levels were insufficient to meet people's needs and to keep the service clean. As such we set a requirement action to ensure improvements were made. Following that inspection, the provider wrote to us to tell us that they had reviewed people's dependency levels and increased staffing levels with immediate effect. At this inspection however, we found that any increased staffing levels at that time had not been sustained. The same number of staff were working as at our previous inspection and again this was impacting on both people's care and the standard of cleanliness across the service.

People told us that they frequently experienced long waits before they got attention and we observed this to be the case during the inspection. One person told us "I ring my bell, but it takes an age for help to get here." We saw that another person's call bell was not connected, when we asked them about this they told us "They wouldn't answer it if I did use it, so there's no point having it plugged in." This person resided on the top floor of the service and when we asked how they called for help they replied "I walk downstairs and look for someone." During the inspection the person asked us for help and so we pressed the call bell and it took eight minutes before the registered manager arrived. The registered manager confirmed that all the other care staff were supporting other people and she knew there must be a problem as the person never normally called for help.

Support was task focussed because care staff did not have sufficient time to spend with people. We spoke with one person who was sitting in their room waiting for support to get washed and dressed. They told us "They could do with more staff, it's okay if you cooperate with them, but you do have to wait." We saw later saw another staff member checking people's rooms and when we asked why they told us, "We need to get people downstairs." At lunchtime we saw a member of staff use wet wipes to clean people's hands before their meal was served. When we asked them why they did this they confirmed that it was because there was not enough time to support people individually to wash their hands before lunch.

Five people living with dementia or complex medical needs were cared for in bed on the upper floors of the home. These people were vulnerable because staff were not always available to monitor their needs. We saw that other than when direct care was being provided, they spent most of day alone without any way of calling for help. We also found that whilst staff supported them to eat and drink, they did not always have time to complete the records which were in place to ensure their nutrition and hydration needs were met. Staff told us "We do keep a record, but the charts are stored in the office and we're very busy, so we complete them when we can." Another staff member also said "I always make sure the people in their rooms have regular food and drinks throughout the day, but like today, it's busy and I forget to record what I've done."

We observed staff rushing around all day and whilst the activities person was effective in engaging people in the communal areas in group activities, there was little interaction for those who were either unable or unwilling to participate. Staffing levels provided four care staff and one senior staff member during the day which as highlighted at our last inspection, was insufficient to provide person centred support. People in

their rooms told us "It's so nice to have someone to talk to, someone with the time to actually listen."

The registered manager used a dependency tool to calculate people's needs, but there was no evidence that this had been used to ensure staffing levels were appropriately set. For example, the registered manager had assessed that five people had high dependency needs at the time of the inspection and staff confirmed that these same people required full support with all care needs and two staff to support with personal care and mobilising. With the senior member of staff busy managing medicines and healthcare appointments and two staff members supporting the people with high needs, this left two care staff to support the other 31 people living in the service.

A review of rotas for the previous month also highlighted that the above staffing levels were typical, but also that there were five whole days in August 2016 in which only one senior and three care staff were working in the service. The registered manager said that agency staff had sometimes been used, but it was not clear whether they had been requested for each of the occasions when the home was short staffed. Minutes from a relatives' meeting in December 2015 recorded that staffing levels would be increased when occupancy went up. In December 2015 there were 31 people living at the service. This had since increased to 36, but without any additional staff. The registered manager confirmed that they had to date not used agency staff to consistently increase numbers whilst they were recruiting permanent staff and said this was because permanent care staff told her they would prefer to cover the work themselves.

There were insufficient domestic staff to maintain the home to an appropriate standard. As was identified at our last inspection, parts of the service were again found to be dusty and in need of a deep clean. The floor in the top floor shower room was heavily stained and the toilet soiled. There was a strong smell of urine in one of the bedrooms that was also noticeable from the corridor outside the room.

The standard of overall cleanliness was raised with the registered manager who told us that the laundry assistant had left working at the service at the beginning of July 2016. Since that time the laundry and cleaning for the entire service had been undertaken by one member of housekeeping staff. With 36 people living in the service and a large building laid out over three floors one member of domestic staff was insufficient and this was reflected in the poor level of cleanliness throughout the home. The registered manager said that they had sometimes helped with cleaning people's rooms and they were actively recruiting a new housekeeper, but that no agency cleaners had been brought in to support the service and ensure it was kept adequately clean. The registered manager was unable to explain why this was the case.

The lack of sufficient care and domestic staff to meet the needs of people living at the home was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Appropriate checks were undertaken before staff began work. We saw criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). There were also copies of other relevant documentation including character and professional references, interview notes, proof of identification and Home Office Immigration certificates in staff files. This demonstrated that steps had been undertaken to help ensure staff were safe to work with people who used care and support services.

Our last inspection identified that people were placed at risk both by environmental hazards and because staff did not always follow the care plans in place to support people safely. As such we set a requirement action for the provider to ensure people were protected from possible harm. Following that inspection, the provider wrote to us to tell us the improvements they had made to keep people safe.

At this inspection, we found that the previously identified areas of risk had been addressed. People told us that they felt safe at Dungate Manor and repeatedly highlighted "Kind staff", "Good security" and "Safe grounds" as the being the things that made them feel safe. Similarly, relatives confirmed that they felt their family members were safe at the service. One told us "I have never found anything to worry about." Another also said they felt the service was "Very safe, we've been here for 6 years. Before coming in I looked at 12 other homes and this was the one, no need to look anywhere else, I had a good feeling and have not been disappointed."

Despite people saying that they felt the service was safe, we found that some areas of safety required improvement. The service was inspected by Surrey Fire and Rescue Service on 8 October 2015 where several fire risks and deficiencies had been identified. As a result of this, the provider had devised and sent us an action plan for dealing with the issues raised. We spoke with the registered manager about these. Some of the deficiencies raised had been dealt with but others had not. For example, we found a number of fire doors still had defective door closers; one was propped open with a stool. Other fire doors had been identified as being in need of maintenance as they no longer fitted tightly into their frames. This had not been done. We asked the registered manager why these safety issues had not been addressed in the ten months since the Fire Service inspection. We were told the manager had made the provider aware of the need for the work to be completed but had heard nothing.

People's health could be put at risk by poor hygiene standards and practices by staff who failed to follow infection control guidelines. For example, we witnessed two separate incidents in which a staff member failed to minimise the risk of cross-infection. On the first instance, the staff member left a person's room where they were providing personal care and proceeded to walk down a communal corridor without removing their gloves and aprons. They were seen to touch handrails and door frames in the process before returning to the person's room and continuing with personal care. On a second occasion, we saw the same staff member leave another person's room carrying an unprotected used continence item. This item was taken to another part of the service with the staff member touching multiple door handles in the process.

Used continence items were not stored appropriately which posed the risk of infection. We found another used incontinence product left in a shared toilet without being placed in a protective bag. Discussion with staff on duty highlighted that the risks of doing this had been shared with staff the previous day. At lunchtime we also observed that not all staff were wearing the appropriate personal protective equipment for the roles they were performing.

The infection control audits completed at the service had failed to appropriately manage the on-going concerns with infection control. For example, the audits had not addressed continued cleanliness issues across the service and shortages in housekeeping staff. Furthermore, it had not been highlighted that 14 of the 20 staff employed had completed infection control training within the last year, despite it being the provider's policy that yearly updates were mandatory for all staff.

The failure to appropriately assess, prevent and control the spread of infections and the failure to maintain the safety of the premises was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Individual risks to people such as pressure sores, weight loss and falls were managed. Each person had a detailed plan of care that identified their risks and action was taken to reduce the likelihood of occurrence. No people had pressure wounds at the time of the inspection and the GP spoken with had no concerns about illness of injury resulting from the care provided. Records were maintained in respect of accidents and incidents that occurred within the service and appropriate action had been taken in respect of these.

People told us that they felt safe with staff and that they were treated with kindness. One person said "If I was worried about anything I would soon let them know" and another commented that "Staff open and willing to listen." Relatives told us that they had no concerns about the way their family members were treated by staff.

Staff were confident about their role in keeping people safe from avoidable harm and demonstrated that they knew what to do if they thought someone was at risk of abuse. All staff confirmed that the registered manager operated an 'open door' policy and that they felt able to share any concerns they may have in confidence. Staff were less clear about how to report abuse to outside agencies and were unaware that the local authority being the lead agency for safeguarding. We highlighted this to the manager who said they would remind staff of the flow chart of safeguarding contacts that was available to them. The registered manager understood the process and demonstrated to us that appropriate safeguarding referrals were made as required.

Medicines were managed safely and there were processes in place to ensure people received their medicines appropriately. People told us that they received their medicines when they needed them and if they were in pain then staff would administer prescribed pain relief.
We spoke with senior staff about medication management. We asked how medicines were acquired, administered and disposed of. We examined the Medicines Administration Records (MAR) for 15 people living at the home. We also observed the dispensing of medication and examined the provider's medication management policy. Staff told us there was regular training provided in medicines management and training records confirmed this. The service had a system for routinely checking staff competencies in how they managed medicines.

Staff did not sign MAR charts until medicines had been taken by the person. There were no gaps in the MAR charts. We noted MAR charts contained relevant information about the administration of certain drugs, for example, cardiac medicine. Staff were knowledgeable about this and the medicines they were giving. For example, we noted one person's pulse was taken before administering a particular medicine. It was not given if the person's heart rate fell below a pre-determined level. This was consistent with advice given by the person's GP. Any information concerning people's allergies were clearly shown on the MAR charts. In addition, each person taking 'as needed' medicines, such as pain killers, had a 'PRN' protocol held with their MAR chart. This described the reason for the medicines use, the maximum dose, minimum time between doses and possible side effects.

All medicines were delivered and disposed of by an external provider. We noted the management of this was safe and effective. Medicines were labelled with directions for use and contained the date of receipt, the expiry date and the date of opening. Creams, dressings and lotions were labelled with the name of the person who used them, signed for when administered and safely stored. Other medications were safely stored in a lockable cabinet. We noticed, on one occasion, the medicines trolley was left unlocked and unsupervised and this was brought to the staff member's attention who immediately recognised their error. Medicines requiring refrigeration were stored in a locked fridge which was not used for any other purpose. The temperature was monitored daily to ensure correct storage.

We noted regular and detailed medicines management audits had been undertaken by the provider, including daily inventories of medicines given. We noted issues identified as a result of these were acted upon.

Requires Improvement

Is the service effective?

Our findings

People said they were encouraged to make choices and that consent was sought before their care was delivered. One person told us "Staff always ask me before giving me care" and we saw this to be the case.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). 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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that whilst people were involved in their care on a day to day basis, limited formal consideration of consent had been given where people lacked the capacity to make decisions for themselves. For example, we saw in three care plans that the person was recorded as having no mental capacity. There were however, no completed capacity assessments to demonstrate how these judgments had been made.

A staff member also told us that one person received medicines covertly, that is without their knowledge or permission. We looked at this person's care plan and MAR chart. We noted the care plan detailed the person's moods 'could be variable.' The care plan detailed that 'When they are in an aggressive mood, they will refuse or spit out medicines. Occasionally staff will need to covertly medicate and give tablets with yoghurt. This is noted by GP in their best interests.' We looked at the Best Interests Decision Assessment held in the care plan. There was no GP input in this, nor was there any mention of covert medicines. In addition, there had been no formal mental capacity assessment undertaken to establish the need for covert medicines. This was not consistent with the law. We spoke with the registered manager about this who told us the person did not possess mental capacity and that covert medicine was necessary. In the light of this and in line with recent changes in the law, the person should have been referred for an assessment for Deprivation of Liberty Safeguarding (DoLS) assessment. The purpose of DoLS is to ensure that someone, in this case receiving medicines against their will and knowledge, is only deprived of their liberty in a safe and appropriate way. This is done when it is in the best interests of the person, has been agreed by families and professionals and there is no other way to safely care for them. The registered manager confirmed that this had not been done.

Staff were unable to demonstrate that they understood the principles of the Mental Capacity Act. The registered manager also told us that whilst the provider monitoring had identified the need to complete best interests asessments, she was awaiting support in this area.

The failure to provide care and treatment in accordance with the Mental Capacity Act 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff were well trained and competent in their roles. For example, one person commented "'They know what they are doing, trained well to look after us no doubt about that." Similarly, relatives told us that they had no concerns about the training abilities of staff. One highlighted to us, "Impressive carers, well trained in how to look after residents."

Some people did however highlight some communication difficulties with some staff where English was not their first language. We discussed this with the registered manager who was aware that this could be a problem and had highlighted additional training for one member of staff and requested they work with another staff member whilst they developed. Due to the current staffing shortages at the service however, this issue was still having an impact on people.

Training and support were provided to ensure care staff undertook their roles and responsibilities in line with best practice. Staff told us that they completed regular training in areas such as safeguarding, moving and handling, fire safety and dementia awareness. Training records confirmed that staff had access to relevant ongoing training.

New staff told us that they had completed an induction programme which included shadowing other more experienced members of staff. The provider's development plan for the service had recognised the importance of introducing the Care Certificate and set an action for all staff to complete it. The Care Certificate is a nationally recognised set of standards that health and social care workers should adhere to in order to deliver caring, compassionate and quality care.

Whilst staff did not have individual development plans, they told us that they were able to request additional training if they had particular areas of interest that they wanted to develop. For example, one staff member told us that they had undertaken an advanced course in dementia. Staff told us that they felt well supported by the registered manager and had regular supervision. We found that supervision sessions and yearly staff appraisals for all staff had been undertaken or planned, in line with the provider's policy.

Most people had choice and control over their meals and were effectively supported to maintain adequate nutrition and hydration. People said that they enjoyed the food and had choice over the meals they received. For example, one person told us, "The food is very good. Good choice and you can choose the portion size." Another person commented; "I like the food, you get what you like."

People told us that their specialist dietary needs and preferences were respected. One person commented that "I can't eat some food, particularly fried so they cater for me. If I don't like it I tell them and will get something else." Another person told us that they were allergic to cow's milk and said that "They manage that very well." We found that the chef was aware of this and also the person's records contained a nutrition care plan outlining the person's specialist dietary needs and how staff should manage it. Meals, including those that were pureed or textured were attractively presented to people.

We saw that snacks and drinks were available throughout the day. Just before lunch one person told staff that they were really hungry and without hesitation the staff member offered to make them a sandwich whilst they waited for the main meal to be served. Staff were aware which people were at risk of dehydration or weight loss and we saw charts in place to monitor their food and fluid intake.

People were supported to maintain good health. The service had good links with other health care professionals to ensure people kept healthy and well. Care records documented that people attended regular health checks with their doctors, dentists, opticians and chiropodists. During the inspection we met with one visiting professional. They were very positive about the quality of care provided at Dungate Manor

and said that staff always followed their advice. They told us that senior staff had a good knowledge of people and communicated effectively with them which enabled affective diagnosis of people's health needs.

Requires Improvement

Is the service caring?

Our findings

People were mostly complimentary about the care they received and repeatedly praised care staff. For example, one person said "I can't fault any of the care. Good kind people here." Another told us; "I'm happy with my care. People are there for me. They work hard to look after us." People also talked about the "Gentle way" staff supported them to move and ensure they felt secure when using the hoist. Relatives expressed gratitude about the care their family members received. As such, one relative commented "I can't fault the care. Never heard anyone snap. Sensitive, caring treatment."

Despite people telling us that they were treated with dignity and respect, we observed that some staff failed to fully respect people. In particular we noticed that staff did not always fully communicate with those people with reduced mental capacity. For example we saw that one person was hoisted, placed in a wheelchair and taken to the toilet without staff engaging with them about what was happening.

Too frequently, we observed that staff were so busy that the support they provided was task focussed. For example, we saw some occasions where staff walked past people without acknowledgement, supported them to eat without interaction and used sanitary wipes to clean people's hands in an undignified way. One person also specifically expressed frustration to us because a staff member had combed their hair that morning without consideration to the shampoo and set they had had the day before. The person described the hairstyle they had been pleased with as "Ruined."

There was a lack of thought given to people's home. At our last inspection we highlighted to the registered manager that the paintwork in a person's room was damaged which was upsetting to them. Despite it being acknowledged at the time that a nicely decorated room was important to this person, the repair work had still not been completed. The person again expressed dissatisfaction that their room had taken so long to be refurbished. The registered manager told us that she had put this on the maintenance list, but it had not been followed up. Nobody had thought to advocate on behalf of the person nor understood the impact this was having on them.

Despite the above examples, we also found an overall friendly atmosphere observed many examples of the positive relationships between people and the staff who supported them. We overheard laughter and jokes and also noticed when staff were quietly attentive to people who were confused or anxious. We saw that people with capacity were able to make choices about how and where to spend their time. For example one person wanted to go and sit in the garden and staff supported them to go outside and accompanied the person to a seat. Similarly, another person requested to eat their lunch in the lounge and a portable table was brought in to facilitate this request.

There were systems in place to involve people in the planning of their care. People and their relatives spoke positively about their involvement with the care planning process. One person said that they had requested to only be supported by female staff and that this had always been respected. Another person told us that staff had asked them about their end of life wishes and were clear about how they wanted to live their final days. A relative also commented, "We have a six-monthly meeting about care and they do listen to what I

say." Another relative said; "We talk about care regularly. Staff listen, we have talked about the things that are important to her such as music and wearing a dress rather than trousers."

People's privacy and dignity were respected. We saw that staff routinely knocked on people's doors and requested permission before entering their rooms. Staff ensured bedroom doors were closed before delivering care. People told us how much they appreciated having clean freshly laundered clothes to wear and being supported to have their hair done and teeth cleaned.

People were encouraged to personalise their rooms and bring their own furniture from home. Some people had daily newspapers that were delivered to their rooms in the morning. People were able to make decisions about their care including when to get up, go to bed and how to spend their time during the day. Visitors were welcomed in the service and confirmed that there was no restrictions on their visits. One person talked to us about how they have "Family picnics and Chinese meals. Staff get a room ready for us."

Good

Is the service responsive?

Our findings

Our last inspection identified that people did not always experience care that was person centred and people lacked sufficient opportunities to engage in activities that were meaningful to them. Consequently we set a requirement action for the service to improve. Following that inspection, the provider wrote to us to tell us about the changes they would make to make the service people received more person centred.

People told us that they received good care at Dungate Manor and some people said how the support they had received had enabled them to become more independent. For example, one person told us that they had previously had a stroke and lost the ability to swallow. They went on to tell us that they had, "So much improved since being here and were pleased with the care." Similarly, a relative commented that when their relative had moved to the service they required two staff to help them. They added, "Now they are far more mobile and can do things for themselves."

Each person had a personalised plan of care which provided information about people's support needs. Care plans contained detailed information about people's care needs and the actions required in order to provide safe and effective care. For example, we noted one person was prone to the development of pressure sores. They had been referred for assessment by the provider to community nurses, who had recommended the provision of pressure relieving equipment. They also advised the close monitoring and assessment of contributing factors, such as mobility and nutrition. We saw staff had followed this guidance and support.

We found another person had difficulty in communicating due to the onset of dementia; they frequently became tearful because of this. We noted their Mental Health and Cognition Care Plan contained useful guidance about how to improve communication without causing unnecessary upset and distress to the person. It had been devised in conjunction with the person's family.

People's choices and preferences were documented. The daily records mostly showed that these were taken into account when people received care, for example, in their choices of activities. Care plans and individual risk assessments were reviewed monthly. Most of the care plans contained information about people's personal and social histories; it was possible to 'see the person' in these documents.

People had regular opportunities to engage in activities and outings that were meaningful to them. Two activity coordinators now provided a full programme of activities seven days a week. This was an improvement to the service since our last inspection. People told us how much they enjoyed participating in the different activities for example, one person said "I love joining in with the singing." Another also commented; "I love colouring and they got me these adult colouring sheets and coloured pencils. I spend a lot of time doing it." Relatives were also keen to comment about the benefits they had noticed from the improvement in activities. One relative told us "There are always activities now" and another said "My family member really enjoys taking part in the activities."

We saw there was a good hub of activity within the service and people were engaged and enjoying what was

going on. We saw that the daily activities were advertised around the service and people said they received a weekly flyer which informed them of the events taking place. There were photographs of people participating in activities such as bingo, quizzes, exercise sessions and skittles displayed around the home which were talking points and provided people with the opportunity to reminisce. One of the activity co-ordinators told us that they were supported by people from the wider community, including a registered Pets as Therapy dog [PAT dog], visiting singers and musicians.

The activities coordinator was enthusiastic about increasing community participation and talked to us about the outings that had taken place and the hope of sourcing a vehicle which would enable people who were less mobile to enjoy trips out too. A pupil from a local school had come to Dungate Manor for six months as part of the Duke of Edinburgh award scheme. The activities coordinator said they were keen to extend links with local schools and organisations in order to create a greater sense of community within the service. Communion services were also held regularly and people could receive visits from lay readers attached to the nearby church.

It was evident that the increased activities had improved people's wellbeing. For example, we were told that one person had initially been withdrawn when they moved to the service. A staff member went on to tell us how they always made the person know they were welcome, but never forced activity participation on them. One day they suddenly answered a quiz question and since that point they have been an active participant in the daily activities. Another person had previously enjoyed playing bingo, but chose not to play due to their failing eye sight. The activities coordinator made them a large set of bingo cards and they had played the game ever since.

People were confident about expressing their feelings and staff ensured when people raised issues that they were listened to and people's opinions were valued. People told us that they had no real concerns. They went on to say that when they had mentioned something then it was sorted quickly. One person was keen to tell us that "I have no complaints, I speak to the manager every day, so would mention anything then."

Copies of the complaints policy were clearly displayed in the entrance of the home and people and were aware of who to contact in the event of any concern. Relatives spoken with said that any problems they ever had were sorted really quickly. One relative told us "Whenever we have needed to discuss something, they have been very approachable and get done what needs to be done."

The registered manager showed us a log of complaints and compliments and it was evident that any concern was recorded, whether it was made verbally or in writing. In addition to the formal complaints log, the registered manager also showed us a 'grumbles book' which she used to record minor issues that were raised, but which people did not wish to pursue formally as a complaint. We saw that complaints were acknowledged and investigated, in accordance with the complaints procedure.

Requires Improvement

Is the service well-led?

Our findings

People had confidence in the management of the service and said that they felt valued and listened to. People told us that the registered manager was visible and approachable in her leadership of the service. For example, one person said "I see the manager, always there, open door and welcoming." Similarly, another commented "The manager is always walking about, a nice person." Professionals told us that effective communication was a particular strength of the management team. This view was echoed by relatives who confirmed that if there was ever a problem with their family member that they were contacted immediately.

In spite of the positive feedback about the internal management of the service, we found that there had been a lack of structured monitoring of the service and this had contributed to shortfalls not being addressed. For example, despite the previous requirement action having been made to increase care staffing levels and the cleanliness of the home, these had not been effectively monitored to ensure sustained compliance. Where audits had been completed on behalf of the provider, the reports of these had not been immediately shared with the registered manager in order to ensure improvements were made swiftly. Similarly, where the registered manager had raised issues such as fire safety with the provider, there was no on-going communication about how the work was being progressed. In addition to the continuing breach in respect of staffing, this inspection has also identified three further breaches of Regulations which does not demonstrate good management of the service.

The service is a large and old building which requires on-going refurbishment and maintenance to ensure it remains fit for purpose. Despite repeated comments about the service looking "Tired", there was no clear action plan about how renovations would take place. Similarly, the service now provided support to many people living with dementia and yet there was no plan about how to make the environment more dementia friendly.

Whilst staff were aware which people were at risk of dehydration and malnutrition, it was identified that corresponding records were not always contemporaneously completed. It was not clear who checked the total consumption at the end of each day. The wellbeing of these people was dependent on staff ensuring they received adequate nutrition and hydration and accurate record keeping was an important part of this process.

The failure to operate effective systems which assess, monitor and improve the quality and safety of services and maintain complete and contemporaneous records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The culture within the service was open and positive and people, relatives and professionals respected the management and leadership of the service. People living at Dungate Manor and their families or representatives were asked for their views about their care and treatment. These were sought via satisfaction questionnaires on a yearly basis. We looked at the most recent of these, which received the views of twenty residents and five relatives. There were high satisfaction levels amongst people and their

families, particularly in the area of quality of care and staff attitudes.

The registered manager had a good understanding of their legal responsibilities as a registered person, for example sending in notifications to the CQC when certain accidents or incidents took place and making safeguarding referrals. The registered manager was also knowledgeable about the people who lived at the service, the staff employed and displayed an openness and transparency about the areas that needed to improve. Records relating to the management of the home were well maintained and confidential information was stored securely.

The registered manager had systems in place to develop staff in order to support the delivery of good quality care. Staff received ongoing supervision and appraisal which was linked to their personal development. Staff were involved in the decisions about the home and their feedback about the running of the home was also sought. There were regular staff meetings and we read in the minutes how staff were encouraged to speak openly with the management team and each other about how to work effectively together as a team. Policies and procedures were in place to support staff so they knew what was expected of them. Staff told us they knew where the policies were kept and could refer to them at any time.

Internal audits were used to identify trends in care provision, for example in the number of people falling at the home and other incidents and accidents. Others included audits of the effectiveness of pressure relieving aids and moving and handling equipment. These audits were focused on discovering potential triggers for adverse events and putting measures in place to prevent re-occurrence. They were concise, relevant and up to date.

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 11 HSCA RA Regulations 2014 Need for consent The failure to provide care and treatment in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure to maintain adequate fire safety at the service. The failure to maintain adequate infection control standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failure to assess, monitor and improve the quality and safety of services. The failure to maintain a complete and contemporaneous record of people's care and treatment.

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 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of staff to meet the needs of people and to adequately maintain the cleanliness of the home.

The enforcement action we took:

Issued a Warning Notice