Bupa Care Homes (BNH) Limited

Dene Place Care Home

Inspection report

Ripley Lane
West Horsley
Surrey
KT24 6JW

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12 February 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Dene Place Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Dene Place Care Home is registered to provide nursing and personal care for up to 30 people. There were 19 people living at the service at the time of our inspection.

The was no registered manager in post at the time 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. We were supported by the new manager who has submitted their application to the CQC to become the registered manager.

We undertook a focused inspection following concerns that were raised in relation to people not having a choice over when they wanted to get up and concerns around the safety of the care being provided. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Dene Place Care Home on our website at www.cqc.org.uk.

Staff were not effectively deployed around the service to ensure the safety of people. As a result people did not have choices around delivery of care. At times people were waiting for staff which put people at risk.

People were not always protected from the risks of unsafe care. Where risks had been identified staff were not always ensuring that the most appropriate care was being delivered. This included staff not updating wound care plans and not always completing care records when needed.

We identified that a safeguarding incident had not been appropriately investigated with actions taken to reduce further risks. After the inspection we were notified by the manager that this incident had now been addressed. We have made a recommendation around this.

Quality assurance was not effective and sufficient actions had not been taken by the provider in relation to the standards of care. The provider had not met breaches in regulation from the previous inspection.

People were supported to take their medicines as prescribed. People's medicines were managed safely and appropriately by staff.

There were appropriate plans in place in the event of an emergency. Staff were following good infection control practices. Robust recruitment of staff took place before they started work.

There was a new manager at the service and staff told us that they had started to see improvements in the leadership.

After the inspection the provider notified us that they had sent in a 'Service Recovery' team to the service to support the manager with the improvements needed. We will check on these improvements at the next inspection.

The service was last inspected on the 7 November 2017 where breaches were identified in relation to the lack of person centred care, the deployment of staff and the lack of robust leadership and governance. At the inspection on the 7 November 2017 the service was rated as Requires Improvement.

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 safe.

Staff were not appropriately deployed at the service to support people's needs.

Risks to people's care was not always being managed in safe way.

People were not always protected against the risk of abuse and neglect. Staff understood what they needed to do to protect people but staff were not always following the policy in relation to safeguarding.

Staff were following good infection control practices. In an emergency staff understood what they needed to do.

Medicines were administered, stored and disposed of safely.

Is the service well-led?

Inadequate

The service was not well- led.

The provider did not always have systems in place to regularly assess and
monitor the quality of the service the home provided. The provider had not met breaches in regulation from the previous inspection.

People and staff were aware of the inconsistent approaches to care in the staff team.

The new management of the service were described as good and staff could see improvements.

Appropriate notifications were not always being sent to the CQC. This has now been done.

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. We carried out an unannounced comprehensive inspection of this service on 7 November 2017. After that inspection we received concerns in relation to people not having a choice over when they wanted to get up and concerns around the safety of the care being provided. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Dene Place Care Home on our website at www.cqc.org.uk.

The inspection team consisted of three inspectors. Prior to the inspection we reviewed the information in relation to the incidents the provider notified us of. We were also provided information from the Local Authority in relation to concerns that they had identified at the service.

During the visit we spoke with the manager, five people and four members of staff. We looked at a sample of four care plans of people who used the service. We also looked at medicine administration records, repositioning charts and food and fluid charts for people and audits that had been undertaken by the provider.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in November 2017 we found that staff were not always effectively deployed to support people's needs. We found on this inspection that improvements were still required as people were not always receiving support when needed.

Staff were not effectively deployed at the service to ensure people's needs were being met. We arrived at the service at 06.10 and found that night care staff had prepared six people's breakfasts in advance. We asked one member of staff how it was decided whose breakfast they were going to prepare. They told us that that they had been given instructions at the handover when they came on duty that they had to give breakfast to those people that required support to eat. They said, "Before I finish work (at 08.00) we have to feed at least three people." We asked them what they would do if the people were asleep and they said, "I would gently wake them." We saw that people's preferences had been recorded around when they wanted to have their breakfast. Only one person, out of the breakfast that we saw prepared at 06.10, had requested that they had this before 08.00.

We found that one person had been woken by staff at 06.00 to provide them with a morning wash and put back to bed. Another person had been given their wash and had fallen back to sleep in bed. One member of staff said, "I have been asked to wash at least two people before we go." They said that they were asked to do this to assist the day staff before they came on duty. Another member of staff told us, "We are under pressure with two night staff. It's hard to feel like we are doing the best job." There was a new manager at the service who told us that they were aware that day staff were struggling to provide morning personal care. They said that they had asked the night staff to, where appropriate, give people a wash before they went off duty to take the pressure off of the day staff. They said that this could mean that people would be supported with a wash and then put back to bed as we had already identified with one person. This routine was designed to meet the needs of staff rather than to effectively meet people's care needs or preferences. There were at least five people at the service that had requested female only carers with their personal care. We found that this was not always being accommodated particularly at night. There had been only been one female carer rotered on to work at night on the day of the inspection. We reviewed the rotas and found that over a period of a month there were 16 days where only one female carer had been rotered on to work.

Our observations were that staff were rushed and at times left people unsupported. For example one person according to their care plan was at risk of falls. We found them in another person's room disorientated. We supported them back to their room and alerted a member of staff. The member of staff that attended to support the person told us that they had been busy elsewhere providing support to other people in their rooms. This put the person at risk as staff were not providing support in a safe way. One person told us, "They don't have as many staff on now. There are a lot of changes in staff." We found that morning care was still being provided to people at 11.30. At 12.00 we heard a member of staff say to another member of staff, "He [the person] will have to wait a bit for help going downstairs for his activities because I am supporting another person." At this point the activity was finishing meaning the person had missed the opportunity to take part.

During the activity in the morning a member of staff had called for assistance as a person was at risk of sliding off of their chair. It was another 20 minutes before a member of staff was able to assist. One person told us, "I would like some more staff because the poor boys and girls are rushed off their feet."

We saw from records that people were having to wait long periods of time for their call bell to be answered. A member of staff told us that the policy in the service was that call bell needed to be responded to within 10 minutes. One person said, "(I have wait) half an hour sometimes." On 4 December 2017 a call bell audit had taken place and it was identified that 13 out of the 17 times the call bell was used people had to wait over 10 minutes for staff to respond. On four occasions people had to wait over 20 minutes. Despite these findings by staff a further audit had not taken place. The manager told us, "There is a problem with call bells but in the last week there have been improvements." They told us that they were introducing a 'back up pager system' where the manager and other senior staff would be made aware if the call bell was not being responded to.

The service was a large house with rooms on three different floors. Although, based on the dependency needs of people there were sufficient numbers of staff, more consideration needed to be given around how staff were deployed to ensure that people were getting the right support when they needed it. We saw from the accident and incident records that over a period of four weeks there had been nine unwitnessed falls with three people that were at risk of falls. Staff told us that there were not enough of them to support people. One told us, "There is not enough staff to do everything we need to do."

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

After the inspection the provider sent us an action plan. It stated that they had begun to review how staff were deployed. We will check this on our next inspection.

We asked people whether they felt safe at the service. One told us, "It depends on who you get. Some are more caring than others." Another person said, "(I feel safe) because the carers and night staff are always around. I don't want for anything; I can't fault it at all." A third told us, "The staff, they are around if something goes wrong and they step in. They mostly come quickly if I call. My call bell is always left where I can reach it. I do feel safe here."

Despite people's comments we found they were not always protected from the risks of unsafe care. For example, there was one person that had fallen from their bed on a number of occasions. Staff had placed a crash mattress beside their bed which needed to be removed once they were out of bed and sitting in their chair in their bedroom. We found that the crash mat had not been removed and we saw the person trying to navigate around the mattress when they tried to stand up from their chair. Their care plan stated that their room needed to be, 'clutter free' due to the risks of them falling over. This had not been done on the day of the inspection which put the person at risk. The manager told us on the 31 January 2018 they had asked staff to undertake 30 minute checks on two people whilst the people were in their bedrooms. The manager told us that staff needed to record when each check took place. We found that these checks had not been taking place since the 3 February 2018. We saw from the incident reports that one of these people had fallen since the checks had ceased.

Where risks had been identified appropriate care was not always being delivered. One person had pressure sores on their foot that required careful monitoring. There was a wound care plan in place however staff were not always following this. The person required repositioning in bed every two hours. We saw from the records that this was not being consistently done. For example, on one day there was a gap of eight hours

before they were repositioned and on another day there was a gap of five hours. This was putting the person at risk of their pressure sore not healing. The manager had identified that there were not sufficient photos of the wound to monitor its progress. They told us that steps were being taken to address this. Where people required topical creams to be applied staff were not always recording when this had been done. For example one person required an application of cream twice a day. Between the 13 January 2018 and 11 February 2018 there were only 14 entries to say that cream had been applied where there should have been 60 entries. One person was at risk of choking and the guidance from the Speech and Language Therapist was that they should be on a soft diet. The person told us that they were unhappy with being on a soft diet. We saw that they were eating toast for breakfast. A member of staff told us that they did not follow the soft diet guidance for breakfast but they did with the person's lunch. There was no consistency to how the person was being supported with this risk. The member of staff told us that they would follow this up.

Where people were at risk of malnutrition and dehydration and required their food and fluid to be recorded this was not being done consistently by staff. For example one person's food chart had not been completed with what that they had eaten since breakfast. On another occasion there was no mention of whether they had any breakfast. There was no target information on the fluid charts to assist staff in ensuring that the person was drinking sufficiently. The lack of recording was putting people at risk as staff could not demonstrate that the correct and safe care had been delivered.

As care and treatment was not provided in a safe way and people were left at risk this is a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection the provider sent us an action plan that stated that, "Individual resident risks for example choking, wounds and falls to be reviewed with appropriate care plans and referrals as required." They advised that they would monitor people's repositioning charts and food and fluid charts." We will check this on the next inspection.

People were not always being safeguarded from the risk of abuse. Prior to the inspection, anonymous concerns were raised to us regarding a person who had their call bell taken from them by a member of staff. Although this had been investigated internally neither CQC or the Local Authority had been made aware of the incident. After the inspection the manager sent in the notification to the CQC. We asked staff about safeguarding. One said, "Understand people are vulnerable, observe everything and record it." Although staff had received training in relation to safeguarding they were not always putting this into practice.

We recommend that the provider follows best practice in relation to investigating allegations of abuse and takes all reasonable steps in safeguarding the welfare of people.

There were appropriate plans in place in the event of an emergency. In the event of an emergency such as a fire each person had a personal evacuation plan (PEEP) which was reviewed regularly by staff. These were left in the reception area and could be accessed quickly and easily if needed. We noted PEEPS also contained information on how long each person would need to be safely evacuated, either during the day or at night. There was a business continuity plan in the event the building needed to be evacuated. People would need to be evacuated to hospital because of the nature of their conditions.

People were supported to take their medicines as prescribed. The temperature of the room where medicines were stored was taken and recorded daily. There were medicine administration records (MAR) for each person that held an up to date photo, details of any allergies and their GPs details. The MAR charts were completed appropriately with no gaps and a weekly stock check of medicines took place. There were 'as and when' protocols in place for staff with guidance for signs to look out for should the person become

unwell. We observed the nurse administering medicines to people. The nurse asked each person if they could give them their tablets and explained what the medicine was for. The nurse said to one person, "It's your [medicine] to give you strong bones." The nurse asked people how they were feeling. The nurse gave encouragement while giving eye drops and checked that this had made the person feel better.

People were protected against the spread of infection within the service. The environment was clean and smelt pleasant. Bathrooms were clean and tidy, sluice rooms were locked and the laundry room was tidy and organised. Handwashing prompts were seen around the service and staff were observed washing their hands regularly. Staff had received training in infection control which they put into practice to keep people safe. One person told us, "They [staff] keep my room to a very high standard. I have seen them wash their hands." Another told us, "Everyday [staff name] wash all the floors, they keep everything nice and clean."

Appropriate checks were undertaken before staff began work. We examined staff files containing recruitment information for five staff members. We noted criminal records checks had been undertaken with the Disclosure and Barring Service (DBS).This meant the provider had undertaken appropriate recruitment checks to ensure staff were of suitable character to work with vulnerable people. There were also copies of other relevant documentation including full employment histories, professional and character references, interview notes, immigration status and professional registration details for nurses in staff files.

Inadequate

Is the service well-led?

Our findings

At the inspection in December 2016 and November 2017 we found that the quality assurance that took place was not robust. There was a lack of robust leadership and staff at the service were not working together effectively. We found on this latest inspection that the required improvements had not been made and further concerns were identified. There is a history of non-compliance and lack of action by the provider to improve the care people receive.

People and staff were aware of the inconsistent approaches to care in the staff team. One person told us, "Staff are mostly friendly, the others [staff] are just doing their job." One member of staff us told us, "I want to challenge myself but some staff don't have the right approach and things need to change." They told us, "What we need is the right collaboration with existing staff and new ones across the whole team."

There were not effective systems set up to assess and monitor the care being provided by staff. People and their relatives had opportunities to attend meetings to provide their feedback. We saw from minutes of the last meeting held in December 2017 that they were concerned about the length of time it took for call bells to be answered. As a result an audit of call bells took place in December 2017 but this had not been followed up on. The manager told us that when they joined the service call bell response times was still an issue.

Staff had opportunities to feedback their views about the quality of the service they provided. However this was not being used to make improvements. We saw from a meeting in January 2018 that staff had raised concerns about getting people up early and providing breakfast when people were not ready. Despite this feedback from staff this was still happening when we inspected. At a meeting in December 2017 and January 2018 there were reminders to staff to ensure that they completed daily notes and charts but again this was still an area of concern. We found on this inspection that people's positioning charts, food and fluid charts and cream charts were not always being completed. There were no appropriate systems in place to ensure that these records were being completed.

There were aspects to the quality assurance that were not effective. Where shortfalls had been identified, action was not always taken to rectify this. The provider had undertaken 'Monthly Home Reviews' in November 2017, December 2017 and January 2018. On each of these audits it had been identified that there were gaps in the wound care records. Despite this we found that this was still happening when we inspected.

As systems and processes were not established and operated effectively this is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection the provider notified us that they had sent in a 'Service Recovery' team to the service to support the manager with the improvements needed. We will check on these improvements at the next inspection.

There were aspects to the quality assurance that were effective in making improvements at the service. It

had been identified from the 'Monthly Home Review' in November 2017 that a catering audit and night visit checks needed to be undertaken. We found that this had been completed. Improvements had been made to the environment including updated flooring.

A new manager had been recruited to the service four weeks prior to the inspection. Whilst in the short time that they had been there they had identified the shortfalls; they had not had sufficient time to embed improvements. Prior to this new manager starting it was the provider's responsibility to identify the shortfalls and failings and to make effective improvements both pro-actively and as a result of our last inspection report. People were positive about the manager. One told us, "I have met her once. I have found her to be approachable and friendly."

Staff told us that they had seen improvements with the new manager starting. One told us that they felt able to approach the manager and nurse in charge with concerns about the people they cared for. They said, "There are improvements being made. I feel very confident (with the manager)." Another told us, "The new manager is making changes, I think it is getting better here."

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. We found that notifications were not always being submitted to the CQC despite the requirement to do so. There had been instances of alleged safeguarding concerns that had not been notified to the CQC although this has since been done.

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.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that care and treatment was provided in a safe way and people were left at risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that systems and processes were established and operated effectively.

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