Rapport Housing and Care

Dene Holm

Inspection report

Deneholm Road
Northfleet
Kent
DA11 8JY

Tel: 01474567532
Website: www.rapporthousingandcare.co.uk

Date of inspection visit:
28 July 2022
01 August 2022

Date of publication:
27 September 2022

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Dene Holm is a residential care home providing accommodation and personal care to up to 47 people. The service provides support to older people, some of whom are living with dementia. At the time of our inspection there were 38 people using the service.

People's experience of using this service and what we found
Although the feedback from people living at Dene Holm and their relatives was mainly positive, we found systems to monitor people's safety and well-being were not robust. Risks were not always identified and acted upon. Accidents and incidents were not effectively reviewed and monitored to minimise the risk of them happening again. Safeguarding concerns were not consistently shared with the local authority and The Care Quality Commission (CQC) to enable thorough investigation. Systems to monitor people's medicines were not robust which meant people may not receive their medicines as required.

People were not always supported by sufficient, skilled staff. Due to staff shortages the provider employed a large number of agency staff who did not know people and the routines of the home as well as more permanent staff. Staff did not have comprehensive and accurate guidance around people's care needs as records were not updated regularly and contained contradictory information. The environment was not set up to meet the needs of those living with dementia and areas of the home were in need of refurbishment. This resulted in some areas being difficult to clean.

People's health was not always managed well, and people experienced delays in referrals to healthcare professionals. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. There was a lack of activities, and people who were cared for in their rooms were at risk of social isolation. People had limited opportunities to go out unless supported by their family or friends.

Systems to monitor the quality of the service people received were not effective. Action plans lacked detail and timescales for completion were not met. Audit systems were not robust and did not identify concerns. The provider did not have adequate oversight of the service and did not ensure staff in positions of responsibility had the induction, training and support they required.

People told us they enjoyed their food although people's dietary needs were not always managed well. People and their relatives told us that staff were kind and caring in their approach. Permanent staff knew people's needs well and individual interactions with people were pleasant.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection
The last rating for this service was Good (published 13 December 2017)

Why we inspected
The inspection was prompted in part due to concerns relating to safeguarding, management of risk, staffing and provider oversight of the service. A decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of safe and well-led only. During the inspection we found further serious concerns. The scope of the inspection was widened to include all key questions.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches at this inspection in relation to the management of people's safety, the reporting of safeguarding concerns, the care people receive, consent, records how complaints were responded to and the governance of the service.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below

Dene Holm

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by three inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Dene Holm is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Dene Holm is a care home without nursing care. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with CQC to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post although they had not been present in the home for over three months.

Notice of inspection
This inspection was unannounced. Following the first day of inspection we informed the service we would

return but did not give a date or time.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with seven people who lived at Dene Holm and gained feedback from seven relatives about their experience of the care provided. We spoke with 16 staff members, including members of the service management team, catering staff and domestic staff. We reviewed a range of records. This included 14 people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed. We looked at training data and quality assurance records.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● Risks to people's safety were not robustly monitored. Risk assessments and other documentation lacked detail and contained contradictory information regarding people's safe care. For example, incidents records for two people showed they were at high risk of falls. Their care records and risk assessments contained contradictory information in relation to their mobility, the equipment they used and the level of support and supervision they required. This was of particular concern due to the high number of agency staff employed at the service who may not be fully aware of people's needs.

● Dietary information and guidance were not always followed to keep people safe. One person's care plan stated due to choking risks they required their food to be of a minced and moist consistency but the person chose not to follow this. There was no information in relation to the person's capacity to make this decision or risk assessment regarding how they should be supported to eat safely. The person's dietary information recorded them requiring their food to be modified to a different consistency to that recorded in their care plan. We observed the person was served food which was not in line with either of these plans. A separate area of the person's care plan advised staff to offer the person raw vegetables in certain circumstances. The failure to follow this professional guidance put the person at risk of choking and aspiration.

● Risks in relation to people's health conditions were not always mitigated. Staff informed us there were five people living at Dene Holm who were diagnosed with diabetes. We asked the chef what adjustments were made when preparing food for these people. They told us with the exception of making custard with sweetener for everyone, no adjustments were made. One person's dietary information sheet stated their favourite foods were chocolate and sweets and they took their tea with sugar. An incident form from the month prior to our inspection stated the person's GP was having difficulty in getting their diabetes under control.

● People's weight was not consistently monitored, and action was not always taken where significant weight loss was noted. One person's records showed they had lost 23kg in seven months although no referral to the dietician had been made. There was no system in place to review people's weight regularly and ensure action was taken when required. No alternative ways to monitor people's weight were used where people could not be weighed. Staff had taken measurements of one person who could not be weighed in January 2022. No measurements had been taken since this time to determine if the person had maintained their weight.

● People were at risk of skin breakdown as pressure relieving equipment was not set up correctly. We identified three people's pressure relieving equipment was set to support at a far greater weight than required. Risk assessments did not guide staff in how to set the equipment correctly and checks were not completed to ensure the equipment was working effectively. This presented a risk that the equipment would not perform as effectively to protect people from skin breakdown

● Recording charts to monitor people's safety were not checked to ensure people received the care they

required. Two people's care plans highlighted they needed to be repositioned every two hours. Recording sheets stated there were far longer gaps between being supported to reposition. This meant people may at risk of developing pressure areas.

● Concerns with safety systems were not always promptly addressed. The call bell display was showing faults with the system on both days of our inspection. Staff had not identified these concerns in order to ensure people were able to use their call bells to summon assistance.

● Not all staff were aware of how people would be supported in the event of a fire. Some staff told us they would leave people in their rooms and await the fire service to rescue them. This was not in line with the provider's evacuation plan. Special evacuation mattresses were available to support people to get downstairs if the lift could not be used. Staff we spoke with had not received training in how to use these. The provider assured us these issues would be addressed promptly.

Learning lessons when things go wrong

● Accidents and incidents were not effectively monitored. No analysis was completed to identify trends and recommended actions were not always implemented or monitored to ensure they were effective.

● An incident form for one person identified they had been observed eating toiletries. The recommended action was to ensure the person's toiletries were locked away. However, during our inspection we found all the person's toiletries in open cupboards in their bedroom. A second person had sustained an injury whilst staff were supporting them with the hoist. The recommended action was for staff to complete moving and handling refresher training. However, training records did not evidence this had been completed.

● Robust action was not always taken to keep people safe when risks were identified. Incident forms showed a number of occasions where one person had placed items in their mouth which put them at risk of choking. Their care plan stated they should not have access to items such as paper, pens and jigsaw pieces. During our inspection we found all of these items in the person's bedroom. The person also had constant supervision from a staff member during the day. Despite this we observed they still gained access to objects which could have put them at risk. The management team took action when we alerted them to these concerns but had not identified them before we raised them as part of our inspection?.

Using medicines safely

● People's medicines were not safely stored and monitored. Medicines had been stored at higher than recommended temperatures for extended periods of time. Staff had reported these concerns to the senior management team, but action had not been taken to remedy this. This meant people's medicines may lose effectiveness. Medicines requiring additional control were not recorded in line with legislation when they were disposed of. This meant that the provider could not account for medicines as required.

● Records for one person who was prescribed thickener for their drinks contained contradictory information in relation to how their drinks should be prepared to minimise the risk of choking. The person's care plan did not highlight the need for thickened fluids and their dietary information stated they had thin fluids. This was of particular concern due to the high use of agency staff who may need to refer to this guidance. We found the person's prescribed thickener in an unlocked cupboard in the kitchen/lounge area. This presented a risk of choking to people should they try to eat the thickening granules.

● Guidance about how and when to administer 'as and when' (PRN) medicines was not always available to staff. For example, PRN records were not available where people were at risk of constipation. There was no guidance for staff on how people's needs in this area would be known, at what point people may require PRN medicines or what the maximum dose should be. This meant people were at risk of their medicines not being administered safely.

● Homely remedies were not always accounted for in line with the providers policy. One person's records showed over the counter medicines had been administered twice in a day. This had not been recorded on the person's medicines administration chart to ensure staff did not give the person more than the

recommended maximum daily dose.

Preventing and controlling infection

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found the protective mattress covers for three people had become cracked or damaged. This had led to the mattresses being stained and having a bad odour. Similar issues were noted with a pressure cushion in the lounge area. This presented an infection control risk and impacted on people's dignity. People's mattresses were changed when we shared our concerns with the management team. In addition, we found some areas of the home were not cleaned to a satisfactory standard. We identified stained chairs and found handrails and some bedrails were sticky.

The failure to ensure people received safe care and treatment, medicines were safely managed and robust infection prevention and control measures were in place was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● We were somewhat assured that the provider was using PPE effectively and safely. The majority of staff wore masks correctly and consistently. However, we needed to repeatedly ask two staff members to adjust their masks as they were wearing these under their chin.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● People were supported to receive their visitors at a time which suited them and in line with government guidance.

Systems and processes to safeguard people from the risk of abuse

● People and their relatives told us they felt safe living at Dene Holm. One person told us, "I am safe here. It's because everything is familiar." One relative said, "I do feel (relative) is safe. They are always relaxed and happy with staff."
● Despite these comments we found safeguarding concerns were not always reported to the local authority or to CQC in line with requirements. Incident records highlighted two occasions in the month prior to our inspection where there had been physical altercations between people living at Dene Holm. On a separate occasion, staff found a person had locked another person in their room. It was not clear if this was with their consent. These incidents had not been reported to the local authority in accordance with safeguarding guidance. This meant the local authority were unable to investigate these concerns, review the actions taken and ensure lessons were learnt.
● Staff did not always recognise and act on safeguarding concerns. Incident reports identified three occasions where people had experienced unexplained bruising. In addition, one relative told us they had been distressed when an item of their loved one's jewellery went missing. These concerns had not been reported and there was no evidence investigations were completed in order to ensure people's safety.
● One person had raised a concern regarding their treatment by a staff member which they described as leaving them feeling frightened. No action had been taken to report the incident to the local authority safeguarding team or to investigate the staff member concerned. The staff member had moved on from the service since the incident. However, the lack of reporting meant there was a risk a staff member may have

moved to work in a different care environment.

The provider had failed to ensure safeguarding procedures were followed. This is a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staffing and recruitment

● We received mixed comments from people and relatives in relation to staffing. Comments included, "Most of the staff are good but there aren't enough of them", "I have always been able to find staff if I've needed to ask something. It's not the numbers, more their skills and knowledge of (relative) with so many agency" and, "There always seems to be enough staff when I'm there."

● We found insufficient staff numbers were deployed in order to keep people safe. One person's records identified they were at high risk of falls and should be supported at all times when mobilising. We observed the person was left in the lounge area with no staff present. When needing support to use the bathroom they moved around the lounge unaided for over 15 minutes which put them at risk of falling.

● A second person indicated they needed to use the bathroom although no staff were present to support them. They became increasingly anxious and vocal which upset other people in the room and created conflict. As staff were supporting other people, they were unaware of this issue. There were further delays in supporting the person to use the toilet due to the first staff member needing to find a colleague to assist them. We raised our concerns in relation to these incidents. The management team confirmed going forward they had rostered an additional staff member on each shift to enable a staff member to remain in the lounge when required.

● Staff told us the high use of agency staff impacted on the day to day running of the home and how people received their care. One staff member told us, "There's absolutely not enough staff. If it was permanent staff, it would be okay. The agency staff just don't get to know people." Staff rotas showed agency staff regularly made up the majority of the team on shift. We observed where permanent staff worked together the atmosphere was calmer and people's needs were responded to promptly. When there was an increased use of agency staff on shift, permanent staff were more stretched and did not have time to interact with people.

● The provider told us they had a system in place to assess the staffing levels required in relation to the needs of people living at Dene Holm. However, senior staff within the home were unaware of this tool or how this influenced staffing levels.

● Senior care staff told us they did not have sufficient time to complete the tasks assigned to them. This meant they had difficulties in ensuring people's needs were reviewed and care records updated. One staff member told us, "We are responsible for all the medicines rounds, allocating staff and running the shift. We don't have time for all the paperwork as well. It's just not possible." We observed demands and requests for support were constantly being placed on senior staff.

The failure to ensure sufficient, skilled staff are deployed to keep people safe is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● Safe recruitment systems were in place. Staff files showed appropriate checks had been completed prior to the commencement of employment. This included obtaining references, checking the right to work in UK and Disclosure and Barring Service (DBS) checks. (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed prior to them moving into the service. However, information gained during assessment was not always fully captured within care plans. One person's assessment contained details in relation to previous concerns. This information had not been fully transferred into the person's care plans and effective risk monitoring systems had not been implemented. This meant staff did not have comprehensive information in order to support the persons safety and well-being.
- Best practice guidance was not always followed. Oral Health Care for Adults in Care Homes had not been implemented. People's oral health care needs were not routinely assessed, and care plans did not give detailed information in relation to people's needs in this area. Staff had not completed training in supporting people with their oral care. One relative told us, "Sometimes her teeth look a bit yuk. She has dentures. We have raised concerns before about her teeth and cleanliness." We observed some people's teeth did not appear clean.
- People's needs were not consistently assessed using recognised tools to monitor risks of malnutrition, falls and skin integrity. Where these were completed the information was not used to inform and review care plans and risks assessments. For example, where people experienced falls their care plans and risk assessments in this area were not automatically reviewed. This meant people were at risk of avoidable harm due to the care needs not being continually reassessed.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Healthcare professionals told us staff did not always take prompt action to refer people to healthcare professionals and that information was not always shared consistently within the staff team. However, they felt these risks were reduced due to the high number of healthcare professionals visiting the service. Whilst care records highlighted where people had attended appointments, they did not give a detailed description of the outcome or of guidance provided.
- People were not always supported to access healthcare services promptly when they needed them. One relative told us, "I did raise a concern about the time it took for my mum to see a doctor. However, management was very helpful, and the issue was resolved." One person had been showing signs of illness for a prolonged period, action had not been taken to get the person reviewed by healthcare professionals. The person had last seen a healthcare professional in May 2022 yet continued to show signs and symptoms of concern. Medicines prescribed to the person in May 2022 had also been impacting on the person although this had not been reported to healthcare professionals.
- In other areas we found people were supported to access support from healthcare professionals. People's

records included information in relation to support from the GP, district nurses, opticians and dental services. People were supported to attend appointments with specialist services where required.

Adapting service, design, decoration to meet people's needs

● The service design did not always meet the needs of people living with dementia. Signage to help people orientate around the home was limited and was not always clear. For example, a room used for staff had a sign on the door describing this as a quiet room. This could cause confusion for a person living with dementia.

● The majority of people's room doors did not have names on or anything to help people recognise which was their room, such as pictures or any items of interest. This was further hindered by some doors not having room numbers displayed. We observed people going into other people's rooms during the inspection and saw evidence of this within people's records. Staff told us names had been removed some time ago to enable doors to be decorated. However, they had been removed throughout the service rather than in specific areas being worked on. No temporary solution to support people's needs had been considered and implemented.

● Areas of the home required refurbishment. Paintwork was badly scuffed making it difficult to clean effectively and some areas had been poorly decorated. Some items of furniture were stained and in need of replacement.

● People's rooms were not always personalised or homely. Some people's rooms contained few personal items and were sparsely furnished. Personal items such as clothes were not always treated with care in the way they were stored.

The failure to ensure people's needs were assessed, monitored and reviewed, health care advice sought and followed and the environment was suitable to meet people's needs was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Where adaptations had been completed these were done to a good standard. For example, kitchen areas in lounges enabled staff and people to be together when making drinks etc. We observed one person who appeared disorientated be supported by staff to help with the washing up. This appeared to calm the person and gave them the opportunity to chat with staff. The garden area had been designed to enable people to sit outside should they wish. Surfaces were even and there were areas of shade.

● People were able to access all areas of the home via a lift. Handrails were fitted to support people with mobility issues and doorways were wide to enable wheelchair access. People had access to adapted showers and baths.

Staff support: induction, training, skills and experience

● Staff did not always have the training and experience or receive support relevant to the roles they were undertaking. The registered manager of the service had been away for three months at the time of our inspection. The deputy manager and senior care team were leading the service in their absence. However, the provider had not ensured they had the support, training and skills to manage the service safely and effectively. This included failing to ensure the team had completed a full induction to ensure a full understanding of the management systems required.

● Although staff had received training in their roles this was not always effective. For example, staff had completed training in safeguarding and the MCA. Despite this, they had not ensured safeguarding concerns were reported to the relevant authority or that capacity assessments and best interest decisions were completed when required.

● Staff did not always receive training in key areas of their role. Staff responsible for preparing food had not completed training in preparing foods of a modified consistency. They were unaware of the standard

guidance in place and how these kept people safe.

The failure to ensure staff received a comprehensive induction, training and support relevant to their roles was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they felt supported by the deputy manager and senior care staff. They told us they felt able to speak openly about concerns and felt they were listened to where these could be addressed internally by the home's management team.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (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 MCA 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA , whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The principles of the MCA were not followed. Capacity assessments were not always completed for individual restrictions such as bed rails or sensor mats. In other areas the specific decision being assessed was not always clear. For example, one decision was listed as, 'Do you know where you are and why you are here'.
● Best interest decisions were not completed where capacity assessments had determined people lacked capacity to make specific decisions. Members of the management team told us they were not aware a best interest decision was needed in these circumstances. This demonstrated a lack of understanding of the principles of the MCA and meant consideration had not been given to less restrictive options.
● DoLS applications had been made to the local authority as required. However, staff were not aware of conditions in place. One person's records recommended additional considerations of specific areas of their care due to previous concerns. Staff we spoke with were not aware of these conditions and no additional reviews had been completed to assess the persons safety.

The failure to ensure the principles of the Mental Capacity Act were consistently followed was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us they enjoyed the food and there was always a choice of options. One person told us, "The food is the best thing here." A second person told us, "It's good, better than I could make."
● Despite these comments we found people were not always supported with their food safely. We have reported on this within the safe area of this report.
● We observed people were offered different options. We saw people eating items not listed on the menu

which had been prepared for them on request. One person was finding making a decision difficult, so staff gave them both options to enable them to choose. People were routinely asked if they had had enough or they wanted anything more. People had access to drinks and snacks throughout the day. Each lounge had a small kitchen area where people and staff could make drinks.

● Where people required support to eat this was done at the person's own pace. Staff sat with people whilst supporting them and made conversation where appropriate. Staff supported one person to eat by putting their food in a bowl. This reassured the person there was not too much food and they proceeded to finish their lunch.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question as Good. At this inspection the rating has changed to Inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity

- People and their relatives told us staff were kind. One person told us, "They are wonderful people. Staff are absolutely on their mark." One relative said, "Staff are really good, they are really caring."
- Despite these comments, the wide-ranging concerns identified during our inspection did not demonstrate a caring approach which placed people at the centre of their care. The provider had failed to identify and address the deterioration in the standard of support people received. This showed a lack of care and compassion from the provider in supporting people to live in a safe and nurturing environment.
- We observed individual interactions between staff and people were generally kind. However, we observed some agency staff were not always caring in their approach. For example, one person was anxious to leave the building and was stood waiting for an agency staff member to open the door. The agency staff member told the person, "See this line here? You are not allowed to cross this line without permission." They did not spend time offering the person reassurance or enquiring why they may want to leave. On other occasions we observed agency staff referring to people by their room numbers rather than their names. We shared these concerns with the management team who assured us they would be address with staff.
- In other instances, staff demonstrated a compassionate approach when supporting people. We observed one person had a dementia doll and spent their time caring for their 'baby'. Staff supported the person with this, acknowledging the presence and importance of the person's baby. When another person was upset and said no one liked them the staff member responded by giving them a hug which was warmly received. They gave them reassurance and spent time with them until they felt better.
- Staff spoke of people with affection. One staff member told us, "I love my job because of the residents. They make the stress of coming to work worth it." A second staff member said, "The residents are what keep me here."

Supporting people to express their views and be involved in making decisions about their care

- The provider had failed to assess people's quality of life and their overall experience of the care they received whilst living at Dene Holm. Whilst steps were being taken to involve people and their relatives in their care, the provider had failed to ensure this was being completed in a holistic way. Examples of this included a lack of understanding around the importance of people's life histories, activities not being available or designed around people interests and people's rooms not being personalised to their tastes.
- We received mixed responses regarding the involvement of people and their relatives in their care. Comments included, "We've recently been invited to reviews but it felt a bit like a tick box exercise.", "We went and looked at the care plans and I made a few comments which they included" and, "I didn't know

there was a care plan."

● People and their loved ones were not always involved in making decisions regarding their care. The management team told us this formed part of their action plan. They had started the process of sharing people's care plans with relatives and involving people where possible. Some people's care plans did contain information in relation to people's preferences such as their preference of staff gender supporting them, foods and how they liked to dress. However, this was not standard practice across the home.

● Permanent staff knew people's day to day needs and preferences well. Staff spoke with people about their families, using their names and knowing their relationships. One staff member sat with a person and asked if they had watched the football at the weekend as they knew they enjoyed watching sport on television. Another staff member took time to sit and sing with someone. During the inspection we heard people and staff laughing together and sharing jokes.

● We have made further comments in relation to the personalisation of people's care and risks to their safety within the safe effective and responsive areas of this report.

Respecting and promoting people's privacy, dignity and independence

● The majority of interactions with people were respectful. However, on arrival at the service at 6am we found two door guards on people's bedroom doors were making a piercing bleeping sound as the batteries needed to be changed. Staff told us they had been beeping for most of the night and had kept people awake. No action had been taken to resolve this and staff had not alerted the on-call maintenance person to the concern. This demonstrated a lack of respect for people's comfort.

● People's privacy was respected. Staff knocked on people's doors when entering and ensured doors were closed when supporting people with their personal care. A dignity screen was used for one person when the district nurse came to adjust their dressing.

● Staff understood the need for people to maintain their independence. One staff member told us, "We should let the residents do what they can for themselves and not rush them. They need to keep moving and doing these things to keep them going." Staff encouraged people in areas such as maintaining mobility and arranging people's food so they were able to eat independently.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- Care plans were not person- centred and did not guide staff on people's preferences. Care records were repetitive in the information they held and did not contain guidance for staff on how to support people's physical and emotional needs. This was of particular concern due to the high number of agency staff being employed who would not have comprehensive information to refer to.
- One person who had lived at Dene Holm for over six months did not have a care plan or risk assessment in place. This meant staff did not have information or guidance regarding things which were important to them, risks to their safety and well-being or how they liked their care to be provided. The person was known to be taking medicines which required specific guidance. In addition, the person's records indicated they experienced times of anxiety although no guidance was available for staff about how to support the person with this. A second person's care plan was less than two pages long and did not explore the different areas of support the person may require in any detail.
- Personalised information such as people's life histories, past occupations and hobbies and interests were not always recorded. In the majority of cases staff were unaware of this information. This meant they were unable to use this to personalise people's support or to generate conversation about things that were familiar to people.
- Reviews of people's care were not completed consistently and accurately. For example, one person's care plan stated they needed to wear their glasses at all times. This had been reviewed as no changes being required each month. However, when we asked staff why the person was not wearing their glasses, they told us the person had refused to wear them for some months. There was no evidence of what different options had been explored to support the person in this area, especially as they were at high risk of falls. A second person had returned from hospital with their hearing aids missing. This had not been identified by staff for six days after their return.
- Records in relation to the care people wanted at the end of their life lacked detail. Standard phrases such as needing to respect people's wishes were used although there was no personalised information regarding what their wishes were. Information regarding who to contact and if any funeral arrangements were in place was recorded. However, details such as who they may wish to be with them, any specific requests such as favourite music or any religious wishes they would like observed were not included.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in

relation to communication.
● The accessible information standards were not followed. Details in relation to people's communication were not always detailed such as how to support people when making choices. Where people found verbal communication difficult there was a lack of information for staff in relation to people's body language and other indications about how the person may be feeling. Guidance in relation to people's dementia and how this impacted on their communication was not considered.
● There was a lack of information within care plans regarding if people required support with sight or hearing loss. Information was not available to aid people's communication such as large print menus or pictorial prompts.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● People told us there was a lack of planned activities. One person told us, "There are no activities, and no entertainment in the evenings. We just come in, sit down, eat, and go back to our room. There is nothing to do." A relative told us they were invited to organised events such as a jubilee party and that staff would sometimes put music on for people to sing along to. However, on a day to day basis there was often nothing meaningful to occupy people's time.
● There were limited activities for people to take part in and no activity programme in place. The management team told us they had not had activity staff within the home for some months. They said whilst staff would try to do a few things with people, they recognised this was an area which needed to be addressed. However, no steps to determine possible alternative provision had been considered. We asked if visiting activities providers, volunteers or entertainers supported the service. The management team told us they felt people would enjoy this, but they did not have the time or funds to arrange these things.
● People sat in lounge areas and spent the majority of their time sleeping or looking at the television. In one lounge the volume of the television was very low making it difficult to hear. Music was playing in the adjoining lounge and a person was shouting loudly. This created an atmosphere of anxiety. Staff did not demonstrate an understanding of how the differing sensory elements may impact on people living with dementia.
● People who were unable to leave their rooms were at risk of isolation. With the exception of providing people's care, staff did not spend time with people in their rooms socially. One person's care plan stated they were at risk of social isolation and recommended staff spend time reading to them or holding their hand. The person's daily records did not reflect this happened. A number of people spent the majority of their day walking around the building. There were no personalised points of interest arranged to encourage them to take a break.
● At the time of the inspection care staff were responsible for providing activities. However, they had not completed training in this area and told us they found it difficult to engage people. We observed staff engaged with people for short periods of time singing songs or asking questions. People appeared to enjoy this although staff did not have time to do this with everyone.
● People did not have the opportunity to go out unless supported by their family or friends.

The failure to ensure people received personalised care in line with their needs and preferences was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● Complaints were not routinely recorded and investigated. During the inspection relatives relayed complaints, they had raised including missing jewellery, missing glasses and oral hygiene. These concerns were not logged within the complaints file.

● The complaints log contained one complaint during 2022 in relation to a person reporting potential abuse. The persons relative had been contacted but never received the letter as this was sent to the wrong address. No further action was taken to investigate the concerns in order to ensure people were safe. The management team at Dene Holm were unaware of the concerns. Following the inspection this complaint was initially incorrectly investigated. We questioned a number of findings in relation to this which prompted a more accurate response.
● The management team told us they were aware of a further complaint which had been reviewed and responded to by the provider. They were unable to tell us the detail of the complaint. They had not received information regarding the outcome or any learning from the concerns. The failure to monitor complaints meant there was a risk lessons would not be learnt, and concerns would be repeated.

The failure to ensure complaints were investigated, responded to and monitored was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care;

- There was a lack of provider leadership and oversight. Despite the registered manager being away from the service, the provider did not visit or give remote support to the service during the two days of our inspection. Staff we spoke with were unclear of the individual roles of senior staff within the organisation. Staff told us they felt the provider had, 'left them to get on with it' since the registered manager had been absent.
- Quality assurance systems were ineffective in ensuring people received safe, effective and responsive care. There was no systematic audit process in place which meant shortfalls were not identified and acted upon promptly. There were no audit schedules to review systems such as care planning, risk assessments, catering, daily notes or compliance with the MCA. Significant concerns in relation to people's safety, the care people received, and guidance provided to staff were identified during this inspection.
- Where audits were completed this did not lead to improvements in the service people received. Provider medication audits from November and December 2021 identified concerns in relation to systems in place. However, this did not include a review of PRN protocols and systems or the management of homely remedies. This meant the issues found during our inspection were not identified and continued to put people at risk. The audit had identified the recording of stock levels of some was not always accurate. Despite this having been marked as resolved, we identified the same issues during our inspection. Although mattress audits were completed monthly these did not cover every room. The meant the concerns regarding the damaged and stained mattresses we observed had not been identified by the provider.
- Action plans in place did not lead to the desired levels of improvement in the care people received. The local authority had completed a quality review in April 2022. This found concerns in relation to the systems and management of the home. The provider implemented an action plan to address these concerns. A review of progress made against the action plan was completed by the provider in July 2022. As part of this process three care files were reviewed and found improvements had been made. As detailed within this report, we found care plans to be contradictory, lacking in guidance and not always accurate. The action plan stated the first care plans to be reviewed should be those people funded by the local authority rather than prioritising those at the highest risk.
- Records were disorganised and did not contain a detailed description of the care people needed or received. Daily notes were handwritten and difficult to read. Information was generic rather than including information about how people had spent their time, any concerns or things people had enjoyed. The design of the care plan meant that if there were any changes staff were required to re-write the whole plan. This led to staff adding changes to the review page which presented contradictory information and guidance.

● Accidents, incidents and complaints were not monitored by the provider to ensure continuous improvement and minimise the risk of them happening again. Accidents and incidents were logged but not reviewed to identify possible trends such as times of day, specific staff or specific areas of the home. The management team told us they had intended to complete this but had not yet had the opportunity. The provider review of the action plan reflected this was now happening and reduced the risk rating in this area to low. The provider had not completed a review of the complaints system which meant that concerns had not been identified and acted upon.
● The provider had failed to ensure the Care Quality Commission were notified of significant events within the service in line with their statutory responsibilities. This included incidents between people living at Dene Holm and other safeguarding concerns. This meant we were unable to effectively monitor risk and the actions taken.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● People told us they felt able to speak with the management team. One person told us, "The (deputy) manager seems to be approachable. The thing the service does well is that everyone is friendly." One relative said, "This place is well managed, given all the difficulties. The (deputy) manager is very approachable. There is a lot of dignity and care here."
● Whilst individual interactions between people and staff were positive, the systems within the home did not promote a person-centred culture which consistently achieved good outcomes for people. Senior staff had no structured way to review people's care and discuss risks such as health care needs or changes to their well-being. This meant decisions were left to individual staff members who often did not always have time to review and act on concerns. A 'Resident of the Day' system was in place designed to ensure each person's care was reviewed monthly. However, this was not consistently completed.
● The provider had failed to ensure staff had the skills they required to fulfil their roles. No support or mentoring systems had been established to provide guidance for staff in the absence of the registered manager. No one working at Dene Holm had previous experience of managing a care home. The management team demonstrated a will to learn and a commitment to people living at the home. However, a member of the team with significant responsibilities had not received a full induction or additional training from the provider.
● Staff did not feel supported by the provider. Comments received from staff included, "They come here and just sit and do their own work. They don't go and speak to the staff or the residents or help us." And, "They did a lot of work on the action plan but then we haven't really seen them. They don't give us support to put things right or give advice. Nothing like that."
● The provider had a duty of candour policy in place. However, they had not ensured the management team were aware of their responsibilities in relation to this. Staff we spoke to were not aware of the need to review incidents in line with this policy. This process had not formed part of the providers review of accidents and incidents on the service action plan.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Feedback received about the quality of the service people received was not shared with people or their relatives. No meeting had been held with people or their relatives to ensure the concerns raised by the local authority were openly shared alongside reassurances around how they would be addressed. Quality surveys had been forwarded to people and their relatives in May 2022. At the time of our inspection the results had been forwarded to the service and were awaiting being analysed and acted upon.
● Staff meetings were not regularly held. Minutes were not written in a personalised way and there was little

input recorded from the staff in attendance. There was no evidence the provider had attended staff meetings at Dene Holm.

The failure to ensure robust quality assurance systems and ensure good governance was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff told us they felt valued by the management team within the home. One staff member told us, "(Management team) do all they can to support us. They make us feel valued and appreciated."
- Professionals visiting the service told us they were made to feel welcome and staff would be open and transparent when they requested information.