Shaftesbury Care GRP Limited

Donwell House

Inspection report

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11 June 2018

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

Summary of findings

Overall summary

This inspection took place on 29 May 2018 and was unannounced. This meant the provider did not know we would be visiting. The home was aware we were returning on 31 May and 11 June 2018.

Donwell House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Donwell House provides care for up to 63 people some of whom have nursing needs and/or may be living with dementia. At the time of our inspection 44 people were living at the home. The home is made up of four units, two residential care units and two nursing units. The home had recently had a change in directorship.

A registered manager was in place. A registered manager is a person who has registered with the 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.

At the last inspection on 6 and 7 April 2017, the service was rated requires improvement. At this inspection we found the service remained rated as requires improvement.

The home did not always ensure that people had a safe environment. Items which posed a risk of harm to people were easily accessible.

Identified risks had not always been mitigated against. Medicines records we viewed were accurate and up to date. People received their medicines in their preferred way. PRN (as required medicines) protocols were not always in place or lacked detail. Protocols for the administration of covert medicines were not followed.

A robust recruitment and selection process in place. There were sufficient staff deployed in the home to meet the needs of people. The home had systems in place to ensure people were protected from abuse. Staff had completed a range of training and received regular supervisions.

Personal emergency evacuation plans (PEEP's) were in place to ensure people were able to evacuate the premises in an emergency.

Staff respected people's privacy and promoted their independence. People and their relatives were involved in decisions about their care and support. People's confidential and sensitive records were not always protected.

Menus were not always accessible to enable people to make an informed choice. People were supported to have a balanced diet. Kitchen staff catered for people's preferences.

Care plans contained limited information and did not always reflect people's needs and preferences. Some information was inaccurate.

We saw evidence in care plans of cooperation between care staff and healthcare professionals including occupational therapists and GPs. Follow up advice was not always sought in a timely manner.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

The home had activity staff on duty each day, including evenings and weekends, to support with activities. People were supported to supported to maintain links to their local community and to take part in various activities. Relatives and visitors were made welcome in the home.

People were provided with information on how to make a complaint. The registered manager promoted an open culture within the home.

Quality assurance systems were not always effective. However, the new director had a strong commitment to drive improvement within the home and had introduced new quality assurance processes.

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.

The home did not always ensure people had a safe environment.

Risks to people were not always assessed and mitigated against.

Staff were aware of what action to take if they suspected abuse was taking place.

Is the service effective?

Requires Improvement

The service was not always effective.

People had access to a range of healthcare professionals as appropriate. However, follow up action was not always made in a timely manner.

People were supported to eat and drink enough to maintain good health.

Staff had received appropriate training and support to enable them to fulfil their role.

Is the service caring?

Good

The service was caring

People and relatives told us staff were caring.

Information about the home and how it operated was readily available for people and visitors to the home.

People appeared happy and comfortable in the company of staff.

Is the service responsive?

Requires Improvement

The service was not always responsive

Documentation relating to the care of people using the service was not always accurate or up-to-date.

There was a complaints procedure in place. People's concerns and complaints were listened to and acted upon and feedback provided.

The service offered a good range of activities for people living at the service. This included activities inside and outside of the service.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was a registered manager in post.

A range of audit systems were in place. However, some audits were found to be ineffective.

There was a staff recognition in place to ensure that staff felt valued and recognised for their contribution.

Donwell House

Detailed findings

Background to this inspection

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

This inspection took place on 29 May 2018 and was unannounced. This meant the provider did not know we would be visiting. The provider was advised that we would return on 31 May and 11 June 2018.

On the first day the inspection team was made up of two adult social care inspectors, an expert by experience and a specialist advisor in nursing care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. An adult social care inspector completed the inspection on 31 May and 11 June 2018.

We reviewed other information we held about the service, including any statutory notifications we had received from the provider. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also contacted the local authority commissioners for the service, the local authority safeguarding, the clinical commissioning group (CCG) and the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send to us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who lived at Donwell House. As part of the inspection we conducted a Short Observation Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with seven people who lived at Donwell House, seven relatives, a director, the clinical director, the

registered manager, manager, deputy manager, two nurses, three senior care members, five care staff members, two activities co-ordinators, administrator and two kitchen staff.

We undertook general observations of how staff interacted with people as they went about their work. We looked around the home and visited people's bedrooms with their permission.

We examined five staff files relating to recruitment, supervision and training records and various records about how the service was managed. We looked at care records for five people who used the service.

Requires Improvement

Is the service safe?

Our findings

On our initial walk around the premises we found a number of hazards to people which posed a potential risk of physical injury or an infection control hazard. In one bathroom we found hoists, a razor without a cover and a large number of people's toiletries. In a second bathroom we found a foam insert for a cushion, nail brushes, a used continence pad and people's toiletries. We also saw a storage unit for dirty laundry positioned next to a trolley holding clean bed sheets. Some of the sheets were visibly stained. Within a shower room we found numerous pieces of shower equipment. Some items were positioned on the floor protruding upwards and were a clear hazard to people.

In the lounge area we found two metal wheelchair footplates. Staff we spoke with were unable to tell us who the footplates belonged to.

We discussed our findings with the registered manager. They were shocked and advised when they left on Friday the rooms were clear. They stated that all staff were aware of the risks people's toiletries posed to people living with dementia and the safe storage of such items.

We noted within incident records one person had been found with a top of a spray can in their mouth. An incident sheet had been completed on 17 March 2018 and stated that all spray cans had been removed from all bathrooms. Following the incident, the information had been cascaded to staff who worked on that particular unit. This meant the home had failed to effectively use important lessons learnt regarding maintaining people's safety across the home. The registered manager confirmed that staff were required to work on all units.

We accompanied the registered manager around the home and found a number of the issues were still present. The registered manager then directed staff to remove the items. We discussed the accountability of all staff with the identification of such risks and the lack of direct action to resolve the issues once identified. The registered manager advised they conducted a daily walk round but this was not recorded. On day two of the inspection the registered manager had designed a daily walk around document.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Systems were in place to ensure that medicines had been ordered, received, stored, administered and disposed of appropriately. Medicines were securely stored in a locked treatment room and were transported to people in a locked trolley when they were needed.

We found protocols for the administering of medicines covertly were not followed. Some lacked best interest assessments and others did not have a record of a discussion with the pharmacist to ensure the person could take the medicine safely in the method described.

PRN (as required medicines) protocols were not always in place or lacked detail. PRN protocols failed to

describe diversional techniques to be used prior to administration of anti-psychotic PRN medicines. Care records stated, 'anxiety, agitation, restlessness, distress'. This meant that there was limited written guidance for the use of PRN medicines and meant that staff may not have provided a consistent approach to the administration of this type of medicine.

The medicines administration records (MARs) contained recent photographs of people to reduce the risk of medicines being given to the wrong person, and all the records we checked clearly stated if the person had any allergies. This reduced the risk of someone receiving a medicine they were allergic to. However, we noted one person's allergies on their MAR was incorrect. The registered manager had to consult with the person's GP to obtain the correct and current information.

We observed people were given the support and time they needed when taking their medicines. People were offered a drink of water and staff checked that all medicines were taken. People's medicine support needs were recorded in their care records.

The provider had completed medication audits (one unit was audited per month), however these did not appear to be robust and they had not identified the issues we found. Where issues were identified there was an action plan in place to address the issues.

People and their relatives told us they felt there were enough staff deployed to meet their needs. We did not witness any people waiting for support from staff. The home used a dependency tool to calculate the number of care staff needed, taking in to account people's needs. The number of staff deployed exceeded the level determined by the dependency tool.

The home used the services of agency nurses. We asked an agency nurse how many people were on the unit they were responsible for. They were unable to tell us and started to knock on people's doors and count people. We discussed our observation with the registered manager. The registered manager advised all agency staff received an induction prior to commencing work and are fully involved in the handover process.

The home ensured systems were in place to make sure people were protected from abuse. Staff had completed safeguarding training. Safeguarding concerns were investigated and, when required, referrals were made to the local authority. These were collated and monitored for trends and any learning points cascaded to all staff during team meetings and supervisions.

Risks to people were not always identified. We found two people who were at risk of choking did not have risk assessments in place to help staff reduce this risk. The home had introduced a crash mat for a person and failed to put a risk assessment in place for the associated trip hazards created. The provider also had general risk assessments for the environment and premises in place ensuring people working and visiting were safe.

A business continuity plan was in place to ensure people would continue to receive care following an emergency. Personal emergency evacuation plans (PEEP) contained basic information about how best to support a person.. For example it reported, '[Person] gets very agitated becoming both physically and verbally aggressive.' It did not describe how to support the person for a safe evacuation.

Monthly health and safety checks were conducted. Records relating to the maintenance and safety of the building were up to date and monitored. Accident and incidents were recorded, collated and analysed monthly. The registered manager advised that accidents and incidents were reviewed and any lessons

learnt were cascaded to all staff. We found on one occasion information gathered from an incident had not been given to staff throughout the whole home.

During the first two days of the inspection we witnessed three fire alarms all which were false alarms. Throughout the first alarm we observed people were left unattended, staff did not explain to people why they were leaving them. Once it was identified as a false alarm staff returned to their units. We did not observe staff reassuring people that everything was ok and doors were left closed following the activation of the alarm.

On the second day a person activated the fire alarm. On activation of the fire alarm the locked doors were released and once the fire alarm was deactivated the doors relocked. This allowed a person to gain access to a linked corridor and then the door locked, which resulted in the person being unable to return to their unit. Staff came to assist the person but did not know the access code for the door. The person had to wait for another staff member to arrive with the door code.

We discussed our observations and concerns about the impact on people with the registered manager. They stated that they thought staff were aware of all door codes. They reassured us that staff had completed fire safety training and were competent. Records confirmed staff had completed fire safety training and the home had conducted regular fire drills. We noted during the third fire alarm that staff ensured people were advised of the situation.

The provider had a robust recruitment and selection process in place. The provider ensured full employment checks were conducted prior to applicants starting work, these included obtaining references from previous employers and a Disclosure and Barring Service (DBS) check. The DBS checks help employers make safer recruitment decisions by preventing unsuitable people from working with vulnerable people. All nurses must be registered with the Nursing and Midwifery Council (NMC). The NMC is the regulator for all nurses and midwives in the UK. The registered manager advised us that all nurses NMC registrations were monitored and records confirmed this.

Requires Improvement

Is the service effective?

Our findings

People's needs were assessed before they came to live at Donwell House. This ensured that the home could meet their needs. The registered manager encouraged families and people important to the person to input as much as possible to enable them to capture in-depth knowledge about the person.

Staff were supported via regular supervision meetings and yearly appraisals. Supervision meetings are held bi-monthly to a minimum of six supervisions per year. Supervisions allow managers to discuss with staff how they are performing in their role and training needs which may have been identified. However, ad-hoc supervisions were arranged if necessary to allow any issues to be dealt with as soon as possible.

Staff completed a range of training, including subjects such as prevention of abuse, moving and handling, food hygiene, health and safety, fire safety and infection control. We noted some moving and handling and infection control training was needed for some staff, as these had recently lapsed. The registered manager advised training courses had been booked but had been cancelled by the provider. We saw they had secured the next available dates. The home had falls, dementia, infection control and end of life champions who had received additional training. There were a number of staff who work at the home who were unable to complete training via the usual method of delivery. The registered manager had arranged for alternative ways of learning to be made available to support these staff members to allow them to be competent and confident in their role.

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 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. For people who did not have capacity, mental capacity assessments and best interest decisions had been completed for each section of their care file. We noted some decision specific assessments for bed rails and floor sensors were in place. The registered manager had systems in place to monitor applications for DoLS to the local authority.

Staff we spoke with had an understanding of MCA and DoLS and why it was important to gain consent when providing care and support. Staff were clear about the need to seek consent.

Staff supported people to meet their nutritional needs. People told us they enjoyed the meals. One person told us, "It always lovely and hot." We observed lunchtime on two of the four units. Hot lockers were brought

to each unit and meals served to people in each dining room. Mealtimes were relaxed. People who required a little support received this in a pleasant manner. Staff members chatted to people and allowed people time to eat their meal comfortably. Staff were seen to ask people if they would like any more to eat or drink. One person told us "The chef here is very good. I have been here just over seven months and they bend over backwards to get something I like, even if it's just a sandwich. I can order special things like poached eggs and chips if I want."

The service offered a four-week rolling menu. We noticed that the menu which was on display was out-of-date. On one unit we noted the pictorial menu displayed Fridays choices when it was Tuesday. On the second of our inspection no images were displayed. This can lead to confusion for people living with dementia.

Kitchen staff were knowledgeable about people's dietary needs, likes and dislikes. One staff member described how they were mindful about the type of food which must be pureed as the texture and taste can be unpleasant. People were offered refreshments and snacks throughout the day.

People were supported to access external healthcare professionals to maintain and promote their health. Care plans contained information on the involvement of professionals such as GPs, district nurses, continence nurses, the falls team, dieticians, social workers, physiotherapists, the palliative care team and the old age psychiatry team. Care plans reflected people's needs and clearly showed where referrals to healthcare professionals had been made.

Follow up intervention of external health care professionals was not always requested in a timely manner. On the 28 April 2018 the district nurse service was contacted for advice for continence pads for a person due to their change in needs. The district nurse service advised that the type of pad required was not funded. The senior staff member advised they had made attempts to consult with the person's relative who had Lasting Power of Attorney (LPA) for finance. No record of this conversation was available. It was only after we raised the issue with the registered manager that the home made a further request for advice from the district nurse service.

The home had sought advice from the physiotherapist service in relation to a person's mobility. The physiotherapist had sent a 'chair exercise chart' to the home for staff to support the person. However, we saw no mention of this in the person's care file. When we spoke to a staff member they acknowledged this and told us that the person was not compliant with the exercise regime. We asked the registered manager if they had contacted the physiotherapist service to seek further support following the person's non-compliance with the current guidance. They advised they had not but would take action to address the matter.

Areas of the home had been decorated to support people living with dementia. One of the corridors in the Primrose Unit had been made dementia friendly and had been made to look like Donwell Village, which included a sign for a bus stop. Some people had photographs of themselves outside of their bedroom doors to support them with orientation, however not all rooms had this. Some communal bathroom and toilet doors had been painted in a bright contrasting colour to aid people with their orientation, other areas had not been decorated to this level.

Good

Is the service caring?

Our findings

The home had a warm homely atmosphere. During our inspection we observed many happy interactions between staff and people living at Donwell House. We have not been able to speak to all of the people using the service because some of the people had complex needs, which meant they were not able to tell us their experiences.

People and relatives we spoke with told us staff were kind and caring. One person said, "I couldn't do without them they are lovely." A relative said, "The staff are so caring."

We observed people and staff singing as they returned for lunch after sitting outside. One person commented, "We have been on holiday", as they danced down the corridor linking arms with a staff member. People were clearly happy and comfortable in the company of staff. One person told us, "They are kind to me." Another person said, "They are a great bunch."

Staff we spoke with had good knowledge of people's support needs, likes and dislikes and family structure. When possible staff took time to sit and chat to people. We observed staff were polite and respectful when addressing people. They encouraged people to complete individual tasks but were readily available if the person needed support. They offered support discreetly to people and only intervened when invited by the person.

People's dignity and privacy was respected. Staff were able to describe how they maintained people's dignity whilst supporting people with personal care. One staff member told us, "I shut the door, close curtains and chat as I help people. I ask what support they would like. Days can be different, we don't want to take their independence away." People had a choice of gender of their carer. Several people had expressed a preference for a female carer and this was recorded in their care plans. The registered manager told us this choice was always respected.

People and people important to them were involved in the development of care plans and were regularly consulted ensuring information was accurate and current. Relatives told us they were kept up to date on all matters.

People were supported to maintain relationships that were important to them. Visitors were made welcome throughout the day. Staff recognised the importance of relative's visits to the routine of people's days. One staff member reminded a person that their partner was due call and the person was clearly happy hearing this. When the relative arrived, they were offered a cup of tea and the staff member encouraged the person to recount the morning's activities. One relative told us, "We are always made welcome."

Information about the service was displayed in the entrance detailing staffing levels and clinical data including number of falls. The registered manager told us, "I want to be transparent, the information is there for all to see."

Information for local advocacy services was displayed in the entrance of the building. Records showed when required people were supported to gain access to an independent mental capacity advocate (IMCA).

People's confidential records were not always protected. On our initial walk around the home, we found people's confidential clinical monitoring information unattended in lounge areas.

We found senior's and nurse's offices, which contained people's care records, were left unlocked. This issue had been identified on the provider's May action plan which indicated to be actioned immediately. We noted on the second day of inspection key pads were being fitted to the doors.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed before they moved into the home to make sure staff were able to care for the person and equipment to support the person was available. Where a support need was identified, a care plan was developed setting out how it could be met.

We reviewed five people's care plans and those we looked at contained limited person-centred information on people's support needs. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person. Care plans were more task based, with less specific information to guide staff. For example, "I like a morning shower, my morning newspaper, my independence in various things like eating and drinking".

Two care records contained consent forms which had been signed by their relative as people were unable to sign themselves, however their relatives were not the legally authorised representatives to sign on their behalf. Best interest meetings had not taken place with people, staff and other professionals involved in their care. For one person their consent to share confidential information form had not been signed. A member of staff told us that where people were unable to sign themselves, they invited relatives to an 'inclusion meeting' to discuss/sign people's care plans.

Where appropriate, care records included Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms which means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). These were up to date, the correct form had been used and included an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals completing the form.

End of life care plans were in place for people, with terminal and life limiting illnesses which meant information was available to inform staff of the person's wishes at this important time and to ensure their final wishes were respected

One care plan reviewed included an Emergency Health Care Passport (EHCP). This document contained important information regarding a person should they need to be admitted to hospital from the home. It included information which was specific to that person such as their: medication; medical condition; eating and drinking; moving around and how that person would like to be communicated with.

People's needs and plans of care were reviewed once a month, however we did not see that they resulted in changes to reflect people's current support needs and preferences and mainly stated 'no change'. One care plan that was reviewed on 19 April 2018 contained incorrect information regarding this person's ability to eat and swallow. An update had been received from the Speech and Language Therapist team (SALT) following a reassessment of this person's needs on 21 March 2018. The SALT team provides treatment, support and care for children and adults who have difficulties with communication, or with eating, drinking and swallowing. This person's EHCP had not been updated to reflect this change in their needs. No amendment had been made to reflect this change until 19 May 2018 and a choking risk assessment had not

been completed until 31 May 2018. This was brought to the attention of the manager who took immediate action to amend this person's EHCP. Additionally, and as a matter of urgency, the daily menu sheets for this person were reviewed from the time of reassessment and these were found to contain the correct dietary information.

People living in the home were at varying risk of pressure ulceration. Assessments had been carried out to identify which people were at risk of developing pressure ulcers and preventative pressure relieving measures were in place for those people who required them. People had care plans to inform staff of the intervention they required to ensure healthy skin, however one person's care plan was limited in content and stated "ensure pressure mattress is working at correct setting".

Staff had access to a handover document however this was limited in content. We noted people were reported in a negative manner. For example 'vocal overnight.' We discussed our findings with the registered manager who acknowledged that further work was required in the recording in daily notes.

Staff monitored people's food and fluid intake to minimise the risk of malnutrition or dehydration. The food charts recorded the food a person was taking each day and included portion sizes. Fluid intake charts recorded the fluid a person was taking each day, however fluid intake goals and totals were not recorded. Charts were completed, however they did not appear to have been analysed, which meant staff may not have been effectively monitoring people's intake and taking action when required.

We observed one person had a crash mat next to their bed. We noted the bed was a normal single bed with six legs with gaps which were a potential entrapment hazard. We reviewed the person's care records and found no records as to why and when the crash mat was introduced and which external professional had advised the use. There was no risk assessment in place to reduce risk of falls to the person due to the crash mat. The registered manager reviewed the person's care records and could not establish why the equipment was in place. They contacted external healthcare professionals involved with the person's care and they were advised that guidance on the use of such equipment had not been given.

Activities are big part of life at Donwell House. Activities staff were very much involved with the planning and organisation of events. The registered manager has sought ideas from the activities person via a questionnaire in terms of what they thought would make a good activities co-ordinator. When we spoke to one member of staff it was very clear that they had felt empowered to be the best they could be in their role and they told us, "I think of it as, if my family member lived here what would I want, and I would want them to be active and doing the things we do at Donwell."

The service has a good range of activities with lots going on for people to engage with and enjoy. During the first day of the inspection, we saw that people were going out in the minibus for a day out to the coast. We spoke with one of the activity co-ordinators on duty who informed us that the care home had activity staff on duty each day, including evenings and weekends, to support with activities. The registered manager told us "This is a new chapter in people's life. We hold cheese and wine parties for (people), the ladies have wine and the men have lager."

Activities were arranged for both group activities and for those people with a special interest. For example, some gentlemen who lived at the service liked to visit the local pub to play dominoes and cards and to have a drink of shandy. For the ladies living at the service, the manager arranged for a mobile clothes shop to visit to allow people to look through racks of clothes before choosing and purchasing items of clothing. One person living at the service liked to go for fish and chips to Tynemouth. Another person living at the service used to be in the Navy and the activity co-ordinator arranged for a day out to visit Hartlepool marina to

allow this person to reminisce. At Christmas people living at the service made a CD which was sold to raise funds to allow for more activities.

We asked about activities for people who were living with dementia and the activity co-ordinator informed us that all people living at the service were engaged in some form of activity on a daily basis (if they chose to do so). This meant that people did not become isolated. For those people with dementia their activities could be via one to one engagement and would include hand massages and sensory activities. One member of staff told us that on a night-time, people came into the conservatory to relax with sensory mood lighting, music, cushions and fiddle muffs. There was also a wishing well in the conservatory and one staff member informed us that people enjoy throwing a coin into the well and making a wish.

The service also had a separate building which was adjacent to the main building. This building was used for social events for people living at Donwell House, including dancing and a hairdressing service.

The home had a pet cockatoo named Spike which people enjoyed interacting with. Staff told us that Spike had belonged to one of the people living at Donwell House. One person also had their own budgie which staff supported the person to care for.

Donwell House had two outside spaces for people to use for their leisure. However, both areas were noted to be unkempt. One area had an old ice cream box lying on a garden chair which contained mouldy ice cream, a cup which held old orange juice and a crayon. We brought it to the attention of staff who removed the items from the garden. We noted this area was not directly accessible to people unless they were supported,

The service had a complaints and concerns policy in place. The complaints policy and analysis was displayed in the main foyer of the service. This showed how many complaints have been received during the previous month. People were asked to sign the complaints sheet to confirm if they were happy with any explanation or apology provided. The registered manager analysed complaints and outcomes were shared with staff via one to one supervision, group supervision sessions or through the disciplinary process. This allowed any lessons learnt to be shared with staff, along with reviews of care needs and any training issues which may had been highlighted as part of the complaint.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with told us the home was well run. One person said, "Things work well." Another person told us, "All the staff do a good job." A visiting healthcare professional told us that they had seen improvements in the home over the recent months and said the registered manager and staff had worked hard to make improvements to the home.

The service had recently undergone a change of directorship. The newly appointed director of the service was in attendance for part of the inspection. They were very supportive of the registered manager.

The home continued to carry out regular checks and audits on the quality of the service such as infection control, medicines, dining experience and care records. We questioned the effectiveness of the audits as they did not always identify the issues we found during our inspection.

A new fortnightly auditing visit had just been introduced. The first had taken place three days prior to our inspection. It had highlighted a number of the concerns we had raised with the registered manager and had clear actions for completion within a set time. The director told us they were aware that further improvements were required to the service including the environment, decoration and care planning and were keen to see the impact of any improvements made.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. The registered manager clearly understood their responsibilities as a registered manager and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.

The registered manager had a transparent and open-door policy approach and staff were encouraged to raise any concerns they may have, or share ideas for improvements. Lessons learnt were taken on board and shared with staff via supervision meetings or staff meetings to encourage and improve the service. Staff we spoke with told us the registered manager was approachable and they felt they were listened to.

Staff meetings were held every two to three months. The registered manager had adopted a system were staff who were absent from the meeting were asked to read and sign meeting minutes on their return. Relatives meetings were held quarterly and people were invited to attend to discuss any issues or to suggest ways to improvement to the service.

The registered manager to us that they were very proud of staff who worked at Donwell House. A staff reward scheme was now in place. This scheme allowed both staff and relatives to nominate staff who they thought had done well in terms of how they had supported people living at Donwell House. The deputy manager told us that one staff member couldn't believe that they had been nominated as they had worked at Donwell House for a number of years and hadn't received anything like that before.

We spoke to one nurse who told us that they were very involved in promoting Donwell House. "Morale is a lot better. We have weeded out the staff that didn't want to be here. Staff on my unit are confident and motivated. We have ongoing training for staff and I like to be a mentor for my staff. For example, if a person is upset, I use my experience to diffuse the situation and staff can learn by watching. I receive 99% good comments from relatives. This is the first time I have been happy coming to work as a nurse".

They also told us that they were encouraged to share ideas with the registered manager and deputy manager due to their nursing background, along with being a mentor for staff on their team.

The service used different formats to communicate with people living at Donwell House and their relatives. Notice boards in the foyer displayed information regarding forthcoming activities, invites to relative meetings and information regarding safeguarding information. The service produced a monthly newsletter that was available for all. This also available in large print and braille if requested. The service also has Facebook and Twitter page which was managed by the registered manager.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The home did not ensure people had a safe environment and all reasonable risks were mitigated against.