Stonehaven (Healthcare) Ltd

Donnington House

Inspection report

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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 was a comprehensive inspection took place on 18 and 19 September 2017. At the last comprehensive inspection, completed in June 2016, we rated the service as overall requires improvement. We issued two requirements in relation to regulation 9, person centred care and regulation 17 – good governance. The service sent us an action plan to show how they intended to meet these requirements but did not give specific timescales.

At this inspection, we found there had been some improvements in relation to planned activities for people, but this was not consistent. We found people were still spending large parts of the first day without any engagement. In relation to regulation 17 we found little had improved and this continued to be a breach. This was because audits and systems for checking the quality of care and support delivered had not identified the number of issues we found, such as care plans not updated or missing important details and records of medicine storage showing medicines were being kept in temperatures above the recommended temperature.

Prior to completing this inspection we received some information of concern from the local safeguarding team who had collated a number of safeguarding alerts and concerns. These centred on healthcare professionals raising concerns about the service not requesting emergency medical assistance in a timely way and poor communication. There was also an alert raised by a relative about lack of stimulation for people.

Donnington House is registered to provide personal and nursing care for up to 36 people. They provide care and support for frail older people and those people living with dementia, but do not provide nursing care. On the day of the inspection there were 18 people living at the home, including one person who was having a short break there.

There was a registered manager who has been in post for a number of years. They are also the registered manager for the providers other home situated next door. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were at risk of receiving inconsistent or inappropriate care. This was because not everyone had a care plan covering all aspects of their needs. This meant staff did not always have a guide about how best to plan and deliver people's care and support. For example in working with people living with dementia and associated agitation. Care plans were not person centred and did not always reflect people's needs, preferences, interests, hobbies or past lives. This meant staff would have limited knowledge about people and events that were important to them, and would limit what staff could talk to people about.

Healthcare needs were not always being well planned for. Care plans lacked detail about how staff should

respond to someone with epilepsy for example. One person's plan had not been updated in respect of their wound care and pressure sore, which had in fact healed but their plan did not reflect this.

One of the medicine trolleys was situated in a space which was too warm to be able to ensure that effectiveness of medicines would not be compromised. Despite the service regularly monitoring, the temperatures in the trolley being above the recommended temperature no action had been taken. We had identified a similar issue in the inspection completed in June 2016. Once we fed this back, the trolley was moved to a cooler area downstairs, next to another medicines trolley. However this also had high temperature reading in the warmer months.

Risks of scalds from hot water outlets had not been checked, to ensure hot water temperatures were maintained with recommended safe limits.
People, relatives and staff felt their views were not always listened to but did feel the registered manager was approachable. People could make their concerns and complaints known but this was not always fully documented to show how they had been resolved.

The registered manager had not kept CQC informed of all notifiable incidents.

People received their medicines safely and on time.

Staff had good training and support to help them to do their job safely and effectively.

Staff understood how to keep people protected and who to report any concerns to. Recruitment practice was robust and ensured only staff who were fit to work with vulnerable people were employed.

People's rights were protected because the service understood and applied the Mental Capacity Act 2005. They assessed people's capacity to make decisions. Where people lacked capacity, Applications to Deprivation of Liberty Safeguarding teams had been made. Where restrictions such as bed rails and pressure mats were being used to keep people safe, best interest decisions were recorded.

People, relatives and staff felt their views were not always listened to but did feel the registered manager was approachable. People could make their concerns and complaints known but this was not always fully documented to show how they had been resolved.

We found four breaches of Regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the back of this report.

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.

Environmental risks had not always been checked to ensure people's safety.

Although staffing levels were adequate, there had been occasions when due to sickness the service had been short staffed. Staff levels needed to be kept under review.

Hazards such as access to alcohol had not been kept secure.

Staff knew about their responsibilities to safeguard people and to report
suspected abuse.

Robust recruitment procedures were followed to ensure appropriate staff were recruited to work with vulnerable people.

People received their medicines on time and in a safe way.

Is the service effective?

Requires Improvement

The service was not always effective.

Healthcare needs were not always being well planned for.

People were cared for by staff had regular training and received support with practice through supervision and appraisals.

People's consent to care and treatment was sought. Staff used the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and understood how these applied to their practice.

People were supported to eat a well-balanced diet and they had access to health professionals to help sure they kept as healthy as possible.

Is the service caring?

Good

The service was caring.

People received care from staff who developed positive, caring and compassionate relationships with them.

Staff protected people's privacy and dignity and supported them sensitively with their personal care needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care and support was not always well planned or updated.

Activities were not always planned or tailored to individuals' needs and wishes.

People or their relatives concerns and complaints were dealt with but this was not always documented.

Is the service well-led?

Requires Improvement

The service was not always well led

Systems were in place to ensure the records; training, environment and equipment were all monitored on a regular basis, but these had not picked up on some key areas of improvements needed.

Staff morale appeared low and staff turnover was high.

Incidents which should have been reported to CQC had not always been notified.

Donnington 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 checked 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 18 and 19 September 2017. The first day was unannounced. The inspection team included an adult social care inspector, pharmacist inspector and an expert by experience. An expert by experience is someone who has had direct experience or their relative had used registered services such as care homes. The second day the inspection was announced and completed by one inspector.

We spent time observing how care and support was being delivered and talking with people and staff. We met with most of the people living at the home. We spent time in communal areas of the home to see how people interacted with each other and staff. This helped us make a judgment about the atmosphere and values of the home. We spoke with eight people to hear their views on their care. However, some other people were not able to comment specifically about their care experiences, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people living with dementia. We also spoke with three relatives who were visiting the service. Following the inspection we spoke with two further relatives.

We spoke with seven care staff, the registered manager, two deputy managers, one housekeeping staff, handyman and the cook.

We reviewed five people's care plans and daily records, medication administration records, three staff recruitment files as well as audits and records in relation to staff training and support, maintenance of the building and safety records.

We looked at all the information available to us prior to the inspection visits. These included notifications sent by the service, any safeguarding alerts and information sent to us from other sources such as healthcare professionals. A notification is information about important events which the service is required to tell us about by law. We also reviewed the service's Provider Information Return (PIR). This is a form that

asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Following the inspection we asked for feedback from three health care professionals to gain their views about the service. We received feedback from one healthcare professional and one social care professional

Requires Improvement

Is the service safe?

Our findings

People said they felt safe. Comments included "I feel 100% safe here and if I didn't I would raise it with the manager. She (name given) is as straight as an arrow."; "Yes I think I am safe here. I have been here a long time."; "I do feel safe here but I have only been here for a short while possibly 4 to 5 weeks. If something happened to me would I feel safe reporting it? I might let it go and see if happened again but would probably say something to others."; "I do feel safe and I am very happy here although another resident woke me up at 3am which was unsettling." When we fed this last comment back to the registered manager she said she was aware and had asked the person if they were happy to lock their bedroom door at night to prevent this occurring again.

At the previous inspection completed in June 2017 we found that medicines were being stored in temperatures which were too hot. Medicines need to be stored within manufacturers recommended limits so they are not damaged by heat. If they are stored at temperatures more than 25°C, it is too hot and could affect the safety and effectiveness of medicines. Although actions were taken to remove this risk, we found the issue during this inspection.

The temperature range in the medicines rooms and trollies were monitored and recorded daily. However the maximum temperature in the trollies was frequently higher than the maximum recommended for storing most medicines. In particular the upstairs trolley which was positioned in a south facing window, and near a radiator. In this trolley the maximum temperature was above the recommended 25 degrees C most days, and sometimes above 30 degrees C. This meant that we could not be sure that these medicines would be safe or effective for people, and were not stored in line with the home's medicines policy nor the medicines manufacturer's directions. When we pointed this out during the inspection, the trolley was moved to a cooler position in the home, although temperatures here were also recorded as being above 25 degrees on some occasions. Regular monthly medicines audits had been completed, which included a check that storage temperatures were recorded. The manager told us that she was aware that these storage temperatures had been too high, however the trolley had not been moved to a cooler location.

Not all parts of the home were being properly monitored to keep people safe. Checks of hot water outlets to ensure people were not at risk of scalding had not been completed in line with Health and Safety Executive guidance, as set out in 'Managing the risks from hot water and surfaces in health and social care 2016. The staff member, who had been tasked with this check, was checking the temperature of hot water at the pipe before the mixer valve. They said this was to ensure it was being stored at above 50 degrees C. This was a check to help prevent the risk of legionella. When we check one of the temperature of one of the bath hot water outlets, it was slightly above the recommended temperature which would prevent scalding. The staff member said they would adjust the valve to ensure water came out at below 42 degrees, but was unware they should have been keeping regular checks on this.

We received information from a family of a person who had wandered around the home one night and found a bottle of wine on the staff desk, and had started to drink this. This lack of ensuring potential hazards were not kept locked had placed them at potential risk

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was sufficient staff rotated for the number and needs of people, but staff sickness and staff leaving had left some gaps which meant that some shifts had been short staffed. The registered manager said their preferred staffing levels for the lower number of people currently living at the home was five care staff, including a deputy manager both morning and afternoon shifts and then two staff on duty at night. The three weeks previous staffing rotas and the two preceding weeks showed this was the staffing levels being aimed for. However, in previous weeks to the inspection taking place, they had sometimes only had three staff on duty. This was more difficult at weekends as there was no registered manager and not always a deputy manage to help support the care team, if they were short on care staff. The registered manager said they had been addressing this issue with the use of agency staff where there were known gaps and also through recruitment of new care staff. She said they had been successful in recruiting at least three or four new carers who were due to start shortly. She said this would ensure there were no gaps and agency would not be needed once new staff had received their induction and relevant training. We were assured staffing levels would be maintained at five care staff including a deputy manager. One relative said there had been some poor planning of rotas, so that on one occasion there was two agency staff working at night who may not have known people's needs. The provider had said the two agency workers involved had worked at the home on several occasions and were aware of people's needs.

People said there were times when they felt there was not enough staff on duty. Comments included, "They are at times when it is desperately short of staff. Right after meal times are the worst. I need two people to help me to the toilet but usually there are not two people available and I have to wait, at times a bit too long and end up having an accident. Why can't they employ kitchen staff rather than the carers doing dishes. They also have lots of agency staff coming in. At night now we have to lock our doors because a couple of ladies wander at night, it is a bit frightening to see one of them in your room when you wake up..." And "There are odd times when they are short of staff." Another person said "There are not enough staff to take one out and I am not doing anything much here."

Staff confirmed that in the recent past weeks they had been short staffed on some shifts, but staff had been flexible and stayed additional hours to help or came in for extra shifts where they were able. One staff member said, "I do not think people's needs were compromised, we made sure everyone got the care they needed but there was not always time to spend sitting with people or taking that extra time to give a person someone one to one quality time." One relative who contacted us following our inspection said, "Staff are always being asked to stay on to do extra shifts or hours and are not offered food or any thanks for helping with this. I feel their good will is being taken for granted and this may be why they are losing staff. We have been assured new staff are being employed but I worry about them having the right skills." The provider has assured us any staff working extra shifts are offered a meal.

People had been assessed for most risks and risk assessments helped to inform staff what to do to minimise any identified risks. For example, where someone had been assessed as being at risk of pressure damage, their risk assessment included ensuring the right equipment was in place and staff completed regular checks to help the person reposition. There had been a safeguarding concern raised by the community nurse team in the last 12 months. This was about the service being slow to ensure the right pressure reliving equipment was in place. One visiting healthcare professional said they felt this was resolved and people did have equipment they needed. One relative said they felt their family member may be a risk of not getting their inhaler in time when they became short of breath. There was no risk assessment for this, other than a risk assessment to show the person was not able to manage their own medicines independently. Their inhaler was kept in a locked medicines trolley so if they became short of breath the staff member would

need to go and access keys and get the medicines out and take it to the person. When we fed this back to the registered manager she said she would look into the person having their inhaler in a locked drawer in their room, for quicker access by staff when needed.

We checked the systems in place for managing medicines, and watched how they were administered to people. No-one looked after their own medicines at the time of this inspection, but there was a policy so that people would be able to do this if it had been assessed as safe for them. We spoke to staff who were involved in managing and administering medicines, and we watched some medicines being given to people at lunchtime. They were given using a safe method and we saw that people were asked about some medicines which had been prescribed to be given 'when required' such as pain relief. There were also written protocols in place to guide staff as to when it would be appropriate to give these 'when required' medicines. Staff who gave medicines had received training and checks to make sure they gave medicines safely. However there were no records of these checks being recorded. The manager told us that she would ensure these were recorded and updated annually in line with the home's medicines policy.

We checked 13 people's current MAR charts. Most charts were completed when medicines were given to people, and reasons were recorded if they had not been given for any reason. However we saw that one person was prescribed two critical medicines to be given every day. One dose of one of these medicines had been signed as given the previous day although the medicine had been left in the blister pack. This meant that this person had missed a dose of this medicine. The person's care plan stated that this was a time critical medicine and that doses must not be missed. Staff told us that they would draw up a contingency plan as part of the care plan for this person to make sure staff were clear as to what action needed to be taken if doses were missed or given late.

Separate records were kept of creams or other external items that were applied, and directions were available for care staff on how these should be applied for people. There were suitable arrangements for storing and recording medicines requiring extra security, and also for the return of unwanted medicines. Records were kept of all medicines received into the home and those that were sent for destruction, which meant that records could be audited to check medicines management in the home.

Staff understood the types of abuse that could occur and how to report concerns. Staff had received training in understanding abuse which was updated annually. The registered manager understood their responsibilities in working with the local safeguarding team when needed. [However there was one safeguarding issue where the registered manager failed to alert CQC or make a referral regarding a member of staff to the relevant authorities, who no longer worked at the home. This was so they could consider whether they were suitable to work with vulnerable people. The registered manager said she would do this retrospectively, but had assumed she couldn't take the issue further as the police said there was insufficient t evidence to proceed with a criminal case. The safeguarding team had received a number of alerts and concerns for this service over the last 12 months. Not all of these were substantiated but there were themes of around poor communication and lack of staff understanding in seeking medical help in a timely way.

Safe recruitment practices helped to protect people. Staff recruitment files showed checks were completed in line with regulations to ensure new staff were of good character and suitable to work with vulnerable adults. New staff were required to complete an application form. We were assured that any gaps in employment histories were followed up during the interview process. No new staff were offered employment before all their checks and satisfactory references were received.

Emergencies were planned for. For example, each person an emergency evacuation plan and regular fire safety checks were being done, including testing of alarm bells. Fire equipment such as extinguishers had

been serviced and maintained on an annual basis.

The home's communal areas were clean and mostly free from odour. There were some areas in the downstairs corridors where there was a strong smell. The registered manager said they were aware of this. Staff were completing regular deep cleaning of carpets in that area. The housekeeping team ensured the environment was clean and risk of cross infection was minimised by the use of good infection control procedures. There were cleaning schedules to show what was completed each day and week. There were ample supplies of protective equipment such as disposable aprons and gloves. Staff described how they used this equipment appropriately, for example, when delivering personal care.

One relative said they often found staff serving food without protective clothing and gloves being used. They had fed this back to the management team who said they would address this. Two relatives shared their experience of a family member having moved into the service and them having to clean the bedroom and specifically the drawers. We had received this information since completing the inspection, but have fed this back to the registered manager.

Requires Improvement

Is the service effective?

Our findings

Prior to completing this inspection we received some information of concern from the local safeguarding team who had collated a number of safeguarding alerts and concerns. These centred on healthcare professionals raising concerns about the service not requesting emergency medical assistance in a timely way and poor communication.

People's healthcare needs were not always being well planned for. Care plans lacked detail about how staff should respond to someone with epilepsy for example. One person's plan had not been updated in respect of their wound care and pressure sore, which had in fact healed but their care plan did not reflect this. There had been some concerns raised by the emergency ambulance service about failure to ensure emergency medical assistance was requested in a timely way. There had been two occasions where people had been unresponsive but care staff had not called for emergency medical support straight away. These concerns were in the process of being reviewed by the local safeguarding team. The lack of clear detail in care plans for directing staff to understand and be effective in dealing with people's medical needs meant people were at potential risk.

During the first day of the inspection we found equipment being stored in the downstairs toilet which meant it was difficult for people with mobility issues to access the sink to wash their hands. We fed this back to the registered manager but the equipment was not moved until late in the afternoon. One relative spoke about the storage of equipment being a hazard to people. This was because it was being stored in bathrooms which made access difficult.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were positive about the skills and effectiveness of the staff team. One person said "The staff are very well trained including those from the agency. They are very caring even when rushed off their feet." Another said "Staff are very good. On the odd occasion you get a carer who is a bit off but usually they are very good. They always ask me if I want any help there are times when I am glad of a bit more help and they are happy to help me." Two relatives felt the staffing deployment meant there was not always staff available with the right skills to meet people's needs. For example, one relative said they had noted the person had been got up by an agency care worker who although helpful, did not appear to understand what was needed. We were assured by the registered manager that where possible, they ensured there was good skill mix to meet people's needs. She said there was always a senior on duty who had experience and skills to guide newer members of staff.

Staff said they had opportunities to develop and enhance their skills with regular training. This was both via eLearning and some face to face sessions. Training included areas of health and safety such as infection control, fire safety, first aid and understanding safeguarding and mental capacity. Staff were also supported to complete diplomas in care as well as more specialist training such as working with people with dementia. Staff who were new were expected to complete an induction process which included three shadow shifts

with more experienced staff. Staff new to care were expected to complete a nationally recognised induction called the Care Certificate. This helped to ensure new staff understood the key elements of delivering safe, effective and compassionate care. There were no records available of staff who had completed this certificate, but we were assured this was on ongoing process for new staff. One relative had raised concerns about the number of new staff starting at the service. Also the need to ensure they had good induction processes in place and were given clear information to meet people's individual's needs.

Staff felt they were supported to develop their skills and talk about their training needs via one to one supervisions sessions with a member of the management team. Records showed these occurred on a regular basis and included staff appraisals once a year.

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions of authorisations to deprive a person of their liberty were being met. Two people had such safeguards in place. Most people had applications pending. Some staff were not aware who may be subject to such safeguards, but did understand the principles of why they were needed to protect people's rights.

We observed staff offering people choices and gaining consent before care and support was delivered. For example, offering choice of drinks and asking people where they wanted to sit. When assisting people with personal care, staff made sure the person was ready to get up and move to the bathroom.

People benefitted from being offered variety of meals to suit their tastes and promote their health and well-being. There was a choice of at least two options for lunch and people chose this the day before. We observed one person saying they had not ordered what had been served. The care staff went back to the kitchen and brought them the second option. Drinks and biscuits were offered between meals. People said they enjoyed the food. Comments included "We eat at set times usually at 12.30 and 5pm. We have a choice and the food here is very nice. It varies where I eat my lunch, sometimes I eat in the lounge or in the dining room. I don't have meals in my bedroom. We also have snacks and drinks mid-morning and mid-afternoon."; "The meals are very good. I can't remember if we are given a choice but I think there is a good variety of meals on offer. I assume I could get a drink or a snack if I ask but I never ask. They do give my visitors coffee and biscuits when they come."; "The meals here are good, they have a good cook."

One person felt the meal times were not flexible enough. They said "There is no flexibility for meal times even though they say there is. It is meals rule.com. The meals are very good and there is always a choice." One relative said they had asked the provider to ensure there were enough water jugs so that these were available in people's rooms. There were no snacks available for people to help themselves to; these only seemed to be available at set intervals during drinks rounds. When we fed this back to the registered manager, she said they could make wrapped items and fruit available for people. They also said that meals could be kept warm for people or reheated if they chose not to eat at the set mealtime. They also said staff had access to simple snacks such as toast and sandwiches if people were hungry outside of mealtimes.

The cook said they were able to cater for any specialist diets and had a list of people's likes and dislikes. This

was in order to ensure menus and meals were tailored to meet people's needs and preferences. People who were at risk of losing weight were monitored and where there was a decrease in weight which may affect their well-being, GP referrals were made to consider food supplements. One relative said they had asked the GP to consider another option for food supplements. The person had been prescribed milk shakes which they had been enjoying, but they had run out. They had reminded the service to reorder these and make up with extra fat milk, which had worked well for their relative.

Good

Is the service caring?

Our findings

People said staff were caring. Comments included "The majority of staff are very caring. The younger ones are far happier than some others. Some carers are a bit grumpy and don't smile. We need happy carers not miserable ones. They always knock on the bedroom door before coming in and when I am on the toilet they leave me until I am ready and I call them. They also protect my dignity with a towel when washing me." Another person said "Not all the carers knock on the door before they come in and the majority are good mannered but you get the odd one who isn't." Relatives described staff as kind and caring for the most part. One relative had lots of praise for particular staff whom they said "showed a great deal of kindness and understanding."

People's dignity and privacy was respected. Staff were able to give examples of how they worked to ensure people dignity was being upheld. For example ensuring people were assisted to change if they were incontinent, and offering support to people discreetly when it was clear they may need to use the bathroom. One person raised the issue that they felt their dignity was sometimes compromised by the fact they were asked to wait for staff if it was a busy period. They did not feel staff were at fault, but that more staff was needed to ensure people's dignity could be respected in a timely way.

Staff described people in way which showed they respected them as individuals. They were able to also describe ways in which they worked with people to ensure their needs, wishes and privacy were respected. For example, always providing personal care in private and keeping people's body parts covered. Staff promoted people's choice in everyday decisions such as what they wished to wear, what drinks and snacks they would like.

Staff interacted with people in a friendly and caring way. One care staff came on duty and was observed speaking with people and giving them a hug, asking how their day had gone. Another staff member was observed supporting a person to eat their meal in a caring way, making sure they had eye contact and talking with them throughout the process.

People were able to have visitors at any time. People's comments included; "They are very good here they welcome visitors, even my grandchildren can come in and my dogs. They are very good about that;" "My family do visit, my son comes in two to three times a week. They also let my four year old great grandson in to see me. On my 90th birthday we had a party here and all my family came;" "My sister and brother in law are made to feel very welcome here." Relatives confirmed they were made welcome. One said "We are made to feel very welcome here and always given tea and biscuits. They talk to us about our relatives needs and vice versa…"

People were supported to personalise their rooms with photos, pictures and knick knaks. There was signage up to support someone to know where their room was as they were new, and was finding it difficult to find their way around.

The service had received many thank you and compliment cards. Comments included, "I would like to thank

you for all the care during the time she was with you. I would especially like to thank all the carers who were with her during her final weeks when they made her very comfortable and made her passing easier for her, and to a degree for us…you have our deepest gratitude." Another said, "To all the fabulous staff at Donnington. Thank you for taking such wonderful care of (name of person), she was so happy staying with you and the care that's she received was faultless. You all showed such kindness and warmth, it was humbling to watch."

Requires Improvement

Is the service responsive?

Our findings

At the last comprehensive inspection, completed in June 2016 we found a breach in regulation 9- person centred care. This was because there were not enough planned activities and opportunities for people to have meaningful engagement. We issued a requirement and the provider and registered manager sent us an action plan showing how they intended to improve in this area. This included the employment of an activities person.

Although there were some improvements this was not consistent and we found people were still spending large parts of the first day without any meaningful activity or engagement. The activities person worked three days per week across two services. There was a planned set of activities for each day, but on days the activities person was not available, the care staff were tasked with ensuring the activities went ahead. Staff said this was difficult to achieve when they were short staffed. This was because they had to ensure people's basic care needs were being met. This included getting people up, washed and dressed. One staff member said that if they were down by one staff member on the morning shift they often hadn't finished getting people up and ready until almost lunchtime. Another staff member said it was easier to plan for activities for the afternoon, but often people were resting and less inclined to be engaged.

People did not feel there was enough stimulation, activities or opportunities to go out. People's comments include; "There are not enough activities. They never take us out. We have one music evening, bingo which I can't stand and some ladies occasionally do some knitting. There is nothing for men like me;" "We have entertainment on a Tuesday evening, music, singing and dancing; Bingo is every other Tuesday afternoon and some do knitting. I have been on rare occasions taken out in a wheelchair for a coffee or down to the sea but it is only on a nice day. I can't really grumble;"

Others commented; "Entertainment and getting together is poor. I spend an awful lot of time on my own. I am still able to do my crossword puzzles and thing like that. I have stopped watching TV and can't remember how to operate it. I miss going out and not having anything much to do. I am lucky I have a good view from my bedroom window and I have my china cats on display in my room;" "I enjoy singing on a Tuesday and I like going out into the garden. I like swimming, I use to surf but they don't take me swimming. I would also like to go out and buy some new clothes, for example, but the carers don't take us out much. I have been able to put my own things in my room but I hate those alarm mats as they keep going off and waking me up. I have a wonderful room and can do my own thing to it;" and "I just sit here on my own. Don't do anything."

One relative said "There is a noticeable lack of activities here as well as social interaction We were introduced to a man who is supposed to do activities with residents. He did offer to take our relative out but it hasn't happened, not sure if our relative knows him well enough. The only activity we have witnessed is the occasional visit made by a man with his 'Pat' dog. This area does need improving as we are considering whether this is the right place for our relative."

The deputy manager said they were beginning to forge links with the local church group to come and do a

knitter/natter session and they also had paid entertainers coming in on a regular basis. The provider information return also details 'weekly hairdressing sessions to promote social interaction, regular visits by the therapy dog and community events.'

The service was not always responsive to people's needs. This was because people's care and support was not always well planned. For example one person had no detail about what their social needs were or past life. The document or part of the care plan used to help staff understand this aspect was called 'All about me'. This was blank for one person's plan we reviewed. Another person old us they would like to attend church more often, that being a catholic was important to them. The section of their care plan about religion or beliefs said "does not attend church." Another person had no care plan to show how staff should work in a consistent way with someone living with dementia who frequently became disoriented to time and place. We observed this person becoming distressed on at least five occasions during the first day of inspection. Care staff were kind but offered different explanations as to why they was living at Donnington house and could not leave. This meant there was no consistent approach in supporting this person.

People did not always feel they were included in the development or review of their care plans. There was no evidence to show how staff were sharing this information. One person said "I have not been fully involved in my care plan and at times I feel excluded. They don't discuss my care with me. They forget I am the one being cared for. I have asked them to let me read what they put in my file but they won't show me and I want to see it and sign it off but they don't let me. They don't listen to me. They think because I am disabled I am thick in the head. I am completely excluded when it comes to care planning."

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person felt they had been involved in their care plan and said "They do discuss my care plan with me sometimes. If I want anything changed they talk to me about it. I mainly get what I need. They do listen to me, are very caring and currently very gentle and careful with my sore eyes. They will do anything I want and are very friendly and helpful."

People's views were sought in a variety of ways, including having regular 'residents and relatives meetings'. People said they attended these and talked about aspects of the service. People felt their views were listened to. One person said "I have never had to complain but if I wasn't happy I would talk it over with the carers or the manager. The manager I am sure would do her best to resolve things. I find her easy to talk to." Another said "I would have to find someone to help me but I am sure my relatives would help me make a complaint."

The service had a complaints process with written details of who people could make their concerns and complaints known to. The provider information return stated there had been one complaint in the last 12 months. Two relatives said they had raised several concerns and complaints known to the registered manager and provider, but some of this detail had not been documented within the complaints folder.

We recommend all concerns and complaints are documented and any actions taken recorded as evidence of how the service are responding to people and relatives views and concerns.

Requires Improvement

Is the service well-led?

Our findings

When we last inspected in June 2016, we found a breach of regulation 17- good governance. This was because people were placed at risk. This was because the provider had failed to act on findings of audits of high room temperature storage of medicines, care plans not being updated and worn furniture not being removed. The registered manager sent us an action plan detailing how they intended to meet this regulation. However on this inspection we found effective actions had still not been taken in response to findings of audits.

Despite completing daily checks on temperatures no action was taken to mitigate the risk of high temperatures recorded in medicines trolleys. The deputy manager said they had been auditing the checks on the room where medicines were stored but these had not included the temperatures being recorded in medicines trolleys, which were stored in two different areas of the home.

The registered manager said she and the provider's quality assurance manager checked on environmental audits. They had failed to identify the checks and audits on water outlets were being completed wrongly. This meant they could not be assured that risks of people being scalded from hot water had been fully checked and mitigated.

Internal audits had also failed to pick up on the fact care plans were not up to date. We asked to see any audits in relation to checking care plan information was up to date. We were shown an audit which stated on 27 July 2017 on rooms 1-5 care showed care plans were checked and it had signed stated "all in order." On 4 August 2017 room 6-14 care plans were checked it had been signed to say "all in order." On 11 August 2017 room 6-14 and rooms 15-22 care plans were checked and similarly signed to say "all in order." However, we found four care files which had not been updated and did not include all the details needed to ensure people received the right care and support. This showed audits on care plans were not effective as they had failed to highlight areas where plans had missing information.

This is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager understood their role and responsibilities and had ensured CQC were kept informed of most accident and incidents. However, when we reviewed a list of reasons why staff had left, we saw one had left due to a theft. The registered manager said the police had been contacted but they lacked sufficient evidence to proceed with a criminal case. The registered manager said they were dismissed, but this was not reported to CQC or to the vetting and barring service.

This is a breach of regulation 18 of the Health and Social Care Act 2009 Registration Regulations 2009.

Some staff felt their views and opinions were listened to and they felt valued for the work they did. Other staff felt less positive and said staff morale had been low and staff had been leaving. The deputy manager showed us a list of staff who had left in the last 18 months, which was approximately 15 and their stated

reasons why. Some had moved out of the area but some had gone for more pay or other types of work. One relative raised the issue that staff were not rewarded for their efforts to help out when short staffed. They said they were not offered a meal if they worked a long shift. Staff said staff morale was low due to staff leaving, low pay and continual requests to complete extra shifts.

The provider information return had identified areas for improvement for staff morale and better team working. This included introducing champions in key areas of care. It also included the use of mystery shoppers employed by the provider. If the service got good feedback, the whole staff team got a small financial bonus. They also identified that regular team meetings helped to foster better communication and good working relationships between staff.

The registered manager was covering two services which had impacted on their time. They had appointed a further deputy manager to help with some of the management tasks but due to being short staffed this person was frequently supporting care staff with day to day caring tasks.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager failed to ensure all notifiable incidents were reported to CQC

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not receiving person centred care because care plans lacked detail and guidance for staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk of not receiving safe care because not all risks had been fully assessed and where possible mitigated.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems had failed to ensure people's safety

The enforcement action we took:

We have issued a warning notice in respect of regulation 17