MBi Social Care Limited

Downshaw Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Inadequate**
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 24 and 26 May 2016 and was unannounced.

Downshaw Lodge is a purpose built, two storey nursing home. The service provides support for up to 45 people who are living with dementia or have mental health needs. At the time of our inspection the service had three separate 'units'. Each unit was single sex due to the complex needs of the people who used the service. The provider recognised that this created some difficulties and that the women only unit was no longer appropriate for the needs of the people who lived there. Consequently, the number of women living at the service had reduced and the provider was looking to create a male only service.

This was the first inspection we have undertaken of Downshaw Lodge, since MBi Social Care took over the running of the service from Four Seasons (Evedale) Limited in early 2016. At the time of our inspection there were 32 people living at Downshaw Lodge. Our last inspection of Downshaw Lodge, when it was being run by Four Seasons was on 27 June 2014 when we found the service to be meeting all standards inspected.

At this inspection we found breaches of four of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to the safe management of medicines, training and supervision, safeguarding and governance. We are considering our options in relation to enforcement for some of these breaches of the regulations and will update the section at the back of this report once any action has been concluded.
We have made three recommendations. These relate to developing dementia friendly environments, ensuring systems support people's dietary and nutritional needs to be met, and ensuring continuity of activity provision.

At the time of our inspection there was a registered manager employed by the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager was off work at the time of the inspection and shortly after the inspection we received notice from the provider that they had been absent for 28 days. There were arrangements in place to cover the management of the service including a relief manager and support from quality development officer managers.

Downshaw Lodge provided support to people with a range of complex needs, including people who were living with dementia, people with physical support needs and people with mental health support needs. We received positive feedback from an external professional about the service's effective management of people's mental health and behaviours that challenge. However, we found there was limited training provided to staff in this area, and care plans were also limited in detail in relation to provision of support

with people's mental health.

The home advertised as providing support to people living with dementia. There were some limited adaptations to make the environment more accessible to people living with dementia and a refurbishment of the environment was being planned by the new provider. However, staff had received only basic dementia awareness training. We have made a recommendation that the service considers guidance in relation to developing dementia friendly environments as part of the planned refurbishment of the service.

Prior to the inspection we were made aware of concerns in relation to the safe management of medicines. We were aware the provider had taken steps to improve the way medicines were managed. However, we found some on-going issues. For example, we found records indicated one person had received their medicines later than required, and that the spacing between doses had been inadequate. If this medicine had been given at an inappropriate time there was a risk it could have had a negative impact on their wellbeing. Some records in relation to medicines also lacked clarity, and we could not be certain that one of the fridges being used to store some medicines had been maintained at an appropriate temperature to ensure medicines were kept in accordance with recommendations.

The provider was completing daily audits of medicines. However, these audits had not been entirely effective given the on-going issues we found. We received a notification from the provider shortly after our inspection that one person had run out of stock of one of their medicines and had gone without it for four days. This concern was shared with the safeguarding team by the provider.

The dependency of people living at the home was assessed. Despite this, managers told us there was no tool or other standard method to determine staffing requirements based on the combined needs of people living at the home. However, during our inspection we found the provider was staffing flexibly to meet people's changing needs. We saw there were sufficient staff to provide support to people when they required it.

Risks to people's health and well-being had been assessed and actions had been identified to reduce potential risks. This included involving health professionals such as GP's and dieticians where appropriate.

We saw actions had been taken to investigate safeguarding concerns when directed to do so by the local authority. In one instance we found measures had been introduced to reduce risks in relation to a safeguarding incident between two people living at the home. However, the practicalities of implementing these measures, which included keeping the individuals apart from each other, had not been fully considered.

The provider had submitted applications to the supervisory body to request authority to deprive people of their liberty where they lacked capacity and this was in their best interests. However, we found the provider had not considered all aspects of care delivery that might amount to restrictive practice. It was not always evidenced that potentially restrictive practices were undertaken in the person's best interests.

Staff had received training in physical intervention. We found there was a lack of detail in one person's care plan about when and how physical intervention should be used. We were told physical intervention had only been used on one occasion, which was in 2016. However, the provider was unable to locate any record in relation to this, which meant they couldn't demonstrate the intervention had been proportionate and in this person's best interests.

Staff we spoke with demonstrated that they knew the people they supported very well. There had been a high use of agency staff, although the provider had recently recruited more permanent staff and told us

there was only one vacancy at the time of our visit. People and relatives told us staff were kind and caring.

We found staff had not received regular supervision, and there were gaps in the provision of training, including training in safeguarding, infection control, falls prevention and training in nursing practices. The provider told us they had booked additional training prior to the end of our inspection. We saw these shortfalls had been identified prior to our inspection and were detailed in one of the service's action plans.

People told us they enjoyed the food provided, and we saw accurate records of food and fluid intake were kept. There were multiple records relating to people's dietary requirements that did not always match. We saw on one occasion a person had not received one of their build-up drinks as directed. This drink was provided to help ensure the person had a sufficient calorie intake as directed. Staff told us this was as the kitchen had been busy.

Care plans were complete and had been recently and regularly reviewed. We saw any changes to care plans were reflected in handover documents to help ensure all staff were aware. Information on preferences, social history and interests was recorded to varying degrees. The provider told us a new format for care plans was being introduced soon, which would help ensure such information was clearly captured. We have made a recommendation that the provider reviews systems in place to ensure people's dietary and nutritional requirements are met.

The activity co-ordinator was off work at the time our inspection, and we saw limited activities taking place. Activity resources were not readily available to staff and we saw the provision of activities were dependent on the activity co-ordinator. Records of activities previously held showed good consideration had been paid as to how to effectively engage the people living at the home in activities they enjoyed and found meaningful. We have made a recommendation that the provider makes arrangements to ensure activities are available in the absence of dedicated activity staff.

Staff told us they enjoyed their jobs and thought the staff team worked well together. The provider told us the results of a staff survey undertaken shortly after they had taken over indicated a problem with low morale. We saw an action plan was in place in relation to staff development.

The provider had already identified many of the issues we brought up during the inspection and we could see action plans were in place to address these shortfalls. The action plans were at various stages of their implementation and had clearly defined time-scales.

There was evidence that the service had consulted with people living at the home and relatives in relation to planned improvements to the service, including a planned refurbishment.

Systems were in place to monitor and improve the quality and safety of the service provided. We saw a number of these audits were overdue, and actions identified in one audit to improve the meal-time experience had not been effectively implemented. Daily medicines audits were being undertaken, but these had failed to recognise one person's medicines had run out or that temperature records for the medicines fridge were inadequate. Records of supervision and training had also not been kept up to date.

We noticed some malodours around the home, which a visitor also commented on. The provider told us floor coverings that may be contributing to the odours would be replaced as part of the refurbishment plans.

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.

Medicines were not always being managed safely. There was no procedure in place to ensure people requiring early morning medicines got them at the correct time. Records showed one person's medicines were not administered at an appropriate time, which increased the risk of them experiencing side effects from their health condition.

Risks to people's health and well-being were assessed and regularly reviewed.

There were sufficient staff on duty to provide people with the support they required in a timely way.

Is the service effective?

Inadequate

The service was not effective.

There was limited training in relation to dementia care or supporting people's mental health needs. There were gaps in the provision of training and supervision to staff.

The service was unable to locate a record in relation to a known incident where physical intervention was used. This meant the service was unable to demonstrate the intervention had been proportionate and in the individual's best interests.

Staff knowledge in relation to supporting people's health care needs, including diabetes was variable. Records showed people received adequate fluids and nutrition; however we found one person did not receive a build-up drink as directed.

Is the service caring?

Good

The service was caring.

Staff and people using the service reported staff were kind and caring. Staff demonstrated a good knowledge of people's preferences and interests.

We saw staff interaction with people was carried out in an unhurried, respectful and sensitive way. However, we did find that at times there were missed opportunities for interaction.

Checklists had been implemented to evidence when people had been offered and received support with personal care. There was limited guidance in care plans for staff to follow in the event someone repeatedly declined personal care support.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were complete and regularly reviewed. However, they lacked detail in areas such as how to effectively support people with their mental health needs.

We saw few activities taking place during the inspection. The activity co-ordinator was off work and staff had relied on this support for activities.

People told us they would be confident to raise a complaint if they felt this was necessary. We saw appropriate actions had been taken to investigate complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had recognised many of the shortcomings of the service and put in place actions plans prior to our visit. These were at various stages of their implementation.

Some audits were overdue and actions from audits had not always been effectively implemented. Records, including those of training and supervision had not always been kept up to date.

Daily audits of medicines had been conducted, but had not been sufficiently robust to identify some of the issues raised during the inspection, or to prevent a person going without their prescribed medicine shortly after the inspection.

Downshaw Lodge

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 24 and 26 May 2016. Our visit on 24 May 2016 was unannounced. The inspection team consisted of two adult social care inspectors and a specialist advisor who was a pharmacist.

Prior to the inspection we reviewed information we held about the service. This included statutory notifications that the provider is required to send us about safeguarding, serious injuries and other significant events. We also reviewed any feedback we had received about the service via phone calls, emails or the 'share your experience' form on CQC's website.

We sought feedback prior to the inspection from the local authority commissioning and safeguarding teams, the clinical commissioning group (CCG) and Healthwatch. Healthwatch is the national consumer champion in health and care.

Before inspections, we often ask the provider to complete a 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. We had not asked Downshaw Lodge to complete a PIR in advance of this inspection as the inspection date was moved forward due to concerns about the service. We took this into account when inspecting the service and making judgements in this report.

During the inspection we spoke with 17 staff members. This included: seven care assistants, two nurses, a cook, a domestic, the maintenance worker, a relief manager, two 'quality development officers' and a 'senior quality development officer'.

We spoke with two relatives who were visiting the home at the time of our inspection and five people who were living at the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of

observing care to help us understand the experience of people who could not talk with us.

We carried out observations around the service and looked at areas of the home including the communal lounges, the kitchen, bathrooms and a small number of bedrooms. We reviewed records relating to the care people were receiving, including seven care files and 12 people's medication administration records (MARs). We checked other records related to the running of a care home, including records of servicing and maintenance, training records, policies and records of audits.

Requires Improvement

Is the service safe?

Our findings

Prior to the inspection we were made aware of concerns in relation to the safe management of medicines at Downshaw Lodge. This included incidents where it was it was alleged that people had not received their medicines as prescribed. These incidents were being investigated by appropriate authorities at the time of the inspection.

Through discussion with managers at Downshaw Lodge we understood changes had been made to improve how medicines were managed at the service. However, we found some continued issues in relation to the safe management of medicines. We saw medicines were kept safely in appropriate locked storage. However, we found staff had not recorded maximum and minimum temperatures for the medicines fridge on the ground floor. When we looked at the thermometer it indicated; "Max: 22; Min 6.7; In 10". This indicated the fridge temperatures had been outside of the recommended range of 2°C to 8°C. As no records of the maximum and minimum temperatures had been kept, we could not be certain the fridge had been maintained at an appropriate temperature. This meant there was a risk the efficacy of medicines requiring refrigeration could have been reduced. The provider told us they would arrange for a new fridge to be provided.

Records of medicines administered were being maintained. We saw records kept indicated what dosage of medicine was administered when variable dose medicines were provided, or if a person had refused their medicine. However, one person's medication administration record (MAR) showed they had refused their medicines one day. Following discussion, we established this person had not refused the medicines, but the home had not been able to administer the medicines due to this person choosing to sleep in late. Staff told us they had contacted the GP to seek advice in relation to this; however, no record of this could be located.

We found guidance in relation to the administration of 'when required' (PRN) medicines or covert medicines was limited in some cases. Protocols detailing when staff should administer PRN medicines were not always personalised. For example, some protocols didn't describe what signs people might show that could indicate they required pain relief. This could mean staff would not be aware of when people required when required medicines, particularly if they were unable to express this verbally.

Covert medicines are medicines that are given without the person's knowledge. Covert medicines should only be given when the person is deemed to lack capacity, and when providing covert medicines has been assessed as being the least restrictive option in that person's best interests. We reviewed records in relation to the administration of covert medicines for one person. There was no guidance specific to that individual for staff to follow about how their covert medicines should be administered. There was also no evidence a pharmacist had been consulted about any potential issues arising from administering medicines in food or drink. We looked at records in the medicines folder for a further two people administered medicines covertly and found a similar lack of guidance for staff as to how these medicines should be administered. This meant the home and staff administering the medicines could not be sure they were administering these medicines in a safe way.

We found evidence that medicines were not always administered at appropriate times. From discussion with nursing staff it was apparent there was no procedure in place to ensure medicines that were required to be administered early in the morning had been dispensed at an appropriate time. If these medicines were administered too late, this could affect how well they worked. One person's MAR we reviewed, indicated they had received their medicine late in the morning and there had not been the required gap between this dose and the subsequent dose. If these medicines had been administered at the times recorded on the MAR there would be a risk of a negative impact on the symptoms of this person's health condition. Following the inspection we asked the provider to look into this issue and make a referral to the local authority safeguarding team. They informed us there had been no ill effects to the individual, but that the safeguarding had been upheld.

Records were not always kept up to date in relation to the medicines people required. For example, one person's care plan stated a particular cream should be applied, but there was no record to show this had been done. The provider looked into this and told us this person was no-longer prescribed this cream, but the care plan had not yet been updated. This would increase the risk of the individual receiving inappropriate care as records were not clear and up to date.

Following the inspection we received a notification from the service that a person had run out of stock of one of their medicines and had not received that medicine for a four day period. Whilst it was reported that the person experienced no ill-effects, this indicated systems were still not sufficiently robust to ensure people received their medicines as required.

These issues in relation to the safe management of medicines were a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we noticed malodours present in areas of the home, including in the hallways and communal lounges. This was also noted by a relative we spoke with who told us they always found the malodour to be present. The provider told us they recognised this to be an issue. They told us this was something that would be addressed as part of the forthcoming refurbishment, which would involve replacing old floor coverings.

We found a bath in one of the bathrooms was unclean, and contained a substance that looked like mould. We informed one of the quality development officers who informed us this bathroom was not in regular use. We checked the bathroom later in the day and found it had been cleaned and there was no sign of the previously noticed staining. Other areas of the home we viewed were clean and tidy. We saw there were adequate supplies of personal protective equipment (PPE) such as gloves and aprons for staff to use. We visited the laundry and saw there were processes in place to ensure adequate separation of clean and soiled laundry.

Staff we spoke with felt in general there were sufficient staff to meet the needs of the people who used the service. One member of care staff told us, "We have a routine and we all get on as a team: If we are on with a senior they might ask us if we can do a specific task, but mostly we do what needs to be done." We saw staff were generally on hand to attend to people's needs. However, we noticed that there were three people who used the service who required close observation due to their behaviours, and another person who needed three people to assist with personal care. This meant that on occasion the unit would be short of staff. We were told staff would request support from a member of staff from another unit if required.

At the time of our inspection there were 32 people living at the home. The provider told us they had maintained staffing levels since they had taken over the home when there were around 42 people living at

Downshaw Lodge. We saw people's dependency had been assessed. However, the managers we spoke with told us there was no dependency tool or other way of reviewing the combined dependency of people supported by the service to help determine staffing requirements.
We reviewed rotas, which indicated staffing levels on previous weeks had been similar to those at the time of our inspection.

On the second day of our inspection we saw the provider had implemented one to one support for one individual due to a change in their support needs. This member of staff was provided in addition to the usual number of staff on duty. This demonstrated the provider was staffing in a way that was flexible and responsive to people's changing needs.

Staff we spoke with had an understanding of their role in protecting people. Staff were able to explain the signs they would look for that could indicate someone was being abused or neglected. They told us they would feel comfortable raising any concerns they might have with a manager, and were confident the manager would take appropriate actions.

We reviewed the safeguarding file and saw that this had not been kept up to date. The quality development officer informed us that they had inherited this file from the previous provider, and were no longer using it. Instead, all information regarding safeguarding concerns was logged on the service's electronic system. We were told that this would provide information about any allegations, and the outcome of any investigation. We discussed recent safeguarding concerns raised at the service with the managers.

In some instances the provider had been asked to undertake an investigation having reported the concern to the local authority safeguarding team. We looked at records of some of the investigations and could see actions had been identified where required to help ensure people were kept safe. However, we saw that the practicalities of minimising risk were not always fully thought out. For example, there had been an allegation of abuse between two people living at the home. The provider had identified measures including 15 minute observations for both people, providing bedrooms in different areas of the home and ensuring the two people ate their meals apart from each other. We spoke with one care worker about how this worked and they informed us that it meant keeping a close eye on both people. However, they told us this could sometimes be difficult to manage. We discussed this with the provider who agreed they would seek further advice on the appropriate handling of this matter from the safeguarding team.

We saw risk assessments had been completed that considered potential risks to people's health and wellbeing. These included risks such as choking, smoking, malnutrition, risks to skin integrity, falls, mobility and bathing. Risk assessments had been regularly reviewed and where risks had been identified care plans were in place that detailed steps required to help ensure these risks were appropriately managed and reduced where possible.

We reviewed recruitment practises at the home to see if safe procedures were being followed. There was a recruitment tracker in place that showed when required documents such as criminal records checks, references and signed contracts had been received from applicants. We reviewed records of recruitment in staff personnel files. These showed adequate steps had been taken to help ensure staff were of suitable character before they commenced work at the home. There were records of interviews in staff files, which showed staff members' suitability for the role had been considered. We saw at least two references had been sought for each staff member, and there was a completed application form, full employment history, proof of identity and a disclosure and barring service (DBS) check in each file. A DBS check shows whether the applicant has any known convictions or is barred from working with vulnerable people, and helps employers make safer recruitment decisions.

We reviewed records relating to the maintenance and safety of the environment. Required tests of electrical and gas systems were up to date and any required remedial works had been completed. Equipment such as hoists had been recently serviced and systems were in place to ensure water systems were correctly maintained to reduce risks of legionella.

Regular checks were recorded in relation to the safety of the environment, including checks of bed rails, window restrictors and the fire alarm system. A comprehensive risk assessment of the environment and fire safety had been carried out by an external contractor, and there was an up to date emergency contingency plan in place. We saw personal emergency evacuation plans (PEEPS) were in place, which would help inform staff and the fire service what support people required to evacuate from the home in the event of an emergency. The PEEPS had been recently reviewed, although it was acknowledged that the list needed to be updated to reflect recent changes in the home's occupancy.

Inadequate

Is the service effective?

Our findings

We saw that relevant health professionals were involved in people's care to help them maintain good health. We looked at the communications diary and records in care files, which reported frequent health visitors such as opticians, dentists and chiropodist. Care staff we spoke with were aware of people's healthcare support needs as detailed in their care plans. During our inspection one person who used the service was escorted by a member of staff for a hospital appointment. Where General Practitioners (GPs) had visited the notes of the visit were recorded in case files, and instructions passed on to staff through the communication book and handover notes. We spoke with a district nurse visiting the home who told us they had found staff approachable, and said they had got all the information they required about the person.

Prior to our inspection we were made aware of concerns in relation to effective management of diabetes at the home. We saw the provider had produced an internal action plan to inform how they intended to improve care provision in this area. We saw evidence the actions identified for immediate implementation, such as discussing any concerns in relation to diabetes in handovers, had been put in place. The provider told us other actions such as issuing guidance on diabetes care had also been put in place, though the training matrix did not evidence that any training in relation to diabetes had yet been completed.

Care plans we viewed contained guidance for staff that would help ensure people's diabetes was being effectively managed. For example, one person's care plan contained details about when to monitor blood sugar levels, guidance on diet and foot care, and observations that should be carried out. We saw evidence of monitoring of blood sugar level, diet and fluid intake taking place for people that required this due to their health.

We discussed diabetes care with care staff, who demonstrated a sufficient basic understanding of the support people required around diet and signs of high and low blood sugar for example. We saw supervision records that showed actions had been taken in attempt to improve nursing staff competence in provision of diabetes care. However, we found knowledge in this area was still limited. On one occasion we saw nursing staff did not take the most effective actions to support a person who had a low blood sugar reading. The nurse measured the person's blood sugar level and found it was low. They took appropriate action by providing a glucose drink, however they did not direct care staff to ensure this person had their breakfast in a timely manner. This would have been an appropriate step to help ensure their blood sugar was maintained at a safe level. The provider had recently employed a new clinical lead for the home with expertise in diabetes. They were going through their induction at the time of the inspection.

Downshaw Lodge was providing support to people with complex needs, including mental health needs and people who had behaviours that could challenge services. We spoke with a community psychiatric nurse (CPN) who had worked with the home for a number of years. They told us the staff should be commended for consistently managing a high level of challenging behaviour effectively. They also told us the home's management of mental health had progressed and that there were few hospital admissions in relation to mental health needs from the home.

In spite of this positive feedback, we found there had been no training provided to staff in relation to managing the mental health needs of people living at the home. The CPN and managers we spoke with told us they were intending to work together, with the CPN providing support around specific individual's mental health needs.

We looked at records of training and saw training had been provided in areas including moving and handling, basic life support, and fire safety. However, there were gaps in training in other areas. For example, out of the 40 staff listed on the training matrix, nine (23%) had not completed safeguarding training, 12 (30%) had not completed infection control training, 14 (35%) had not completed mental capacity act and deprivation of liberty safeguards training, and no staff were listed as having received training in falls prevention. The provider told us only basic dementia awareness training had been provided, despite the home advertising as specialising in this area.

There were also gaps in the provision of training in clinical procedures to nursing staff. Only one member of nursing staff working at the home at that time was indicated as having received training in tissue viability, and only one nurse was indicated as having received training in catheter care. It was acknowledged that some of the nursing staff had only been recently recruited. However, the provider was not able to explain how they ensured nursing staff were competent in these areas.

Three care staff we spoke with told us they had not received a recent supervision. Two of these staff had not received supervision since commencing work at the home, with both having been in post for over six months. We saw records of a limited number of group and individual supervisions having taken place, though these seemed primarily to discuss specific concerns with staff members. The supervision matrix we received indicated that 14 out of 23 staff had received a supervision in 2016. However, the matrix did not appear to list all staff.

The gaps in supervision and training of staff would mean the provider could not be certain that staff were adequately supported and skilled to provide effective support to people living at the home. The issues in relation to the competence, training and supervision of staff were a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The décor around the home appeared tired; the paintwork was scuffed and the flooring in some areas was damaged or required replacement due to contributing to the malodour around the home. The walls and communal areas upstairs were bare. There were holes on the walls where pictures used to hang. Staff told us the pictures had been taken down by one of the people living at the home. One of the managers we spoke with told us they were considering alternative options such as paintings or murals on the walls for this area.

We found there were some basic adaptations to make the environment at Downshaw Lodge more accessible to people living with dementia. There were pictorial signs for rooms such as the toilets and the dining rooms, and there was limited use of colour schemes that would help people living with dementia orientate around the home and recognise where bathrooms and toilets were. There were no photos or other distinctive indicators in place that would help people recognise their bedrooms.

We discussed the environment with managers at the service who informed us an extensive refurbishment was being planned in consultation with people living at the home and their relatives. We saw evidence that relatives had been contacted about the planned changes and this had also been discussed at a relative and residents meeting.

We recommend the service reviews current guidance in relation to dementia friendly environments and incorporates dementia friendly adaptations as part of the refurbishment. This should be done in consultation with people using the service.

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 service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw care files considered individual's capacity to provide consent and participate in decision making. Staff were able to explain how they would seek consent from people, including people who may have limited verbal communication.

The provider told us DoLS applications had been submitted for all people living at the home. However, whilst the service recognised that ongoing supervision and potential actions such as preventing a person from leaving may be a deprivation of their liberty, we did not see any evidence that the service had considered other ways they might be depriving people of their liberties. For example, through the rationing cigarettes, encouraging people to go to bed by turning the TV off, or deliberately keeping people apart to ensure that they remained safe. Whilst decisions had been taken in consideration of the well-being and protection of the people who used the service, there was no evidence that a best interest process had been followed. This would have meant ensuring discussions were held with relevant persons to ensure any decisions were the least restrictive option and in that person's best interests.

Two care staff we spoke with were unable to explain what DoLS were, and were unaware of anyone they cared for that had an authorised DoLS in place. It is important for care staff to be aware of such information so they can be certain that any restrictive practice that may be required has been legally authorised. The provider confirmed they had booked additional training in MCA and DoLS prior to the end of the inspection.

One person's care file we looked at indicated that physical restraint may be required when providing personal care. Staff had received training in physical intervention that was specific to this individual, and they told us they would only use restraint as a last resort. However, there was a lack of detail in the care plan in relation to when, or how physical intervention would be used, or the steps staff should take to ensure any intervention was the least restrictive option. Staff told us physical intervention had only been used on one occasion. The provider was unable to locate any record in relation to this incident. This meant the provider could not demonstrate that the use of restraint in this case was necessary or proportionate, or that any analysis or learning had taken place in relation to the incident.

These issues were a breach of Regulation 13 (1) (2) (4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The service had put an action plan in place in relation to weight loss, following concerns previously identified in this area. This detailed actions in relation to the regular monitoring of the meal-time experience, actions in relation to revising menus and bringing in additional staff support to the kitchen. We

found weekly weights monitoring meetings that had been in place had not taken place recently. However, we saw evidence that fluid and dietary intake was recorded after meals and weights were recorded on a monthly basis or more frequently if required. Where there had been unplanned weight loss this had been acknowledged, care plans had been revised and referrals made to specialists such as dieticians and speech and language therapists (SALTS) where required. This would help ensure people's support needs in relation to eating and drinking were adequately assessed.

People we spoke with told us they liked the food provided. We heard one person tell staff their meal was 'delicious' and another person told us the food was 'excellent'. People told us they received a sufficient amount to eat and drink, were given a choice of two meals and could request an alternative meal if they did not like the choices provided. We saw people received the support they required to eat and drink over meal times. Staff sat to the side of people requiring assistance with their meals and support was provided in an unhurried manner. Tables were set with a table-cloth and cutlery, but no condiments were provided. This had been identified as an action from a previous meal time experience audit.

Staff we spoke with were aware of people's dietary requirements as detailed in their care plans. However, we saw systems to ensure that the right meals were offered were unclear: a whiteboard in the kitchen area detailed each person who used the service and any special instruction about their diet, for example, if they required a low sugar diet, or pureed food. A folder then detailed further dietary requirements such as the consistency of any pureed foods, and a further folder included any clinical recommendations made by the SALT or dietician. The information in the three different places did not always match.

Whilst records in many instances indicated people received the dietary support they required, we found one instance during the inspection where a person did not receive support in accordance with their dietary guidelines. This person had been recommended to have a build-up drink between meals. This is a drink that provides a high number of calories, and would help ensure this person's intake was sufficient. When we asked staff about this on the first day of our inspection, we were told that the kitchen staff had overlooked this on that morning as they had been 'too busy'. We did not see any evidence that this had had a detrimental impact on the individual or that there had been other instances of the build-up drink being omitted.

We recommend that the provider reviews processes and procedures in place in relation to the provision and recording of needs in relation to nutritional support.

Good

Is the service caring?

Our findings

Relatives we spoke with told us staff had a caring approach. One relative told us; "I have no complaints about the care. That is good. They are on the ball and caring." Another relative said; "[My relative] likes it here. Staff are good with him and always kind. I have no problem with the care, the staff are all really nice and they make sure his needs are met".

On the second day of our inspection half of the six staff working on the first floor of the home were agency staff. Rotas and staff confirmed there was frequent use of agency staff at the home. One relative told us there appeared to be regular use of agency staff and said when they called the home agency staff would often ask them to call back at another time, which hindered effective communication. The provider had recently recruited new staff and they told us there was now only one vacancy for a member of nursing staff. The provider said they expected not to require the use of agency staff by June 2016. They also told us they 'block booked' agency staff whenever possible to improve the continuity of the service provided to people. The agency staff we spoke with confirmed they had worked at the service on previous occasions.

From discussions with regular care staff, it was clear they knew the people living at Downshaw Lodge very well. Staff were able to tell us about people's interests, preferences and the most effective way to support them. One person we spoke with said; "I get on with the staff. They know you by name." A visiting professional we spoke with told us; "Care staff know the gentleman inside out and upside down," and talked about there being a core team of dedicated staff within the home. One member of staff told us that they liked working with the client group as, "they have interesting stories, and you can learn so much about them and their life."

We saw care staff interacted with people in a kind and sensitive manner. For example, we observed staff greeting people warmly in the mornings when they came to the dining room for breakfast. Whilst the interactions we observed were good, we found the frequency of interaction between staff and people living at the home to be variable. On the first floor of the home we observed staff chatting with people, and starting and encouraging discussions about shared interests such as football. However, on the ground floor there were occasions when there were missed opportunities for interaction. For instance we observed staff stood by, or just outside the main lounge area not engaged in other tasks and not interacting with people.

People and relatives we spoke with told us staff were respectful of their privacy and dignity. One relative told us; "They always seem very caring. They always knock on the door and are respectful." Prior to the inspection we had been made aware that concerns had been raised with the home in relation to the support some people received in relation to aspects of personal care such as washing and shaving. In response to these concerns the provider had introduced a checklist to track the provision of personal care support to people. We reviewed these documents, which indicated support with personal care was offered on a regular basis. We noted that some people's records indicated support with personal care was regularly declined.

We reviewed the care plan for one person who had frequently declined support with personal care. There was no information in the care plan to guide staff about the actions or support they should offer to this

person if they consistently declined support with personal care. However, we observed staff providing effective and sensitive support in relation to personal care. We overheard a care worker asking a person if they were ready for a wash and shave. When they did not agree, the carer offered to come back in a short while to assist him. When they returned around five minutes later this person agreed to accompany the care worker to attend to personal hygiene.

The provider told us no-one living at the home was receiving end of life care at the time of our visit. We asked if there was a specific approach or model of end of life care that the home would provide should anyone be approaching the end of their life. The provider told us other homes in the group followed the 'Six Steps' end of life programme, but that there had been no specific end of life training at Downshaw Lodge. Training records confirmed no specific end of life training had been provided, although we saw evidence that training in this area had been booked.

The provider had policies in relation to equality and diversity, which included specific guidance on considerations care staff may need to be aware of in relation to care provision to people with different religious beliefs or cultural backgrounds. Training records showed the majority of staff had undertaken training in equality and diversity.

Requires Improvement

Is the service responsive?

Our findings

Care plans we looked at had been reviewed consistently on a monthly basis. Changes to care plans were documented, with the reason for the amendment being recorded. We saw that these changes were also reported at the handover meetings and marked on handover notes so all staff were aware of the changes. Reviews of care highlighted trends and changes, for example, we saw in one care file that the person's weight had dropped steadily over the preceding months, so a corresponding care plan (first line nutrition plan) was put in place.

People's preferences in relation to their care, support with personal care and food preferences had been recorded. We saw there was inconsistent use of person-centred planning tools that provided information about people's social histories, former interests and significant events. The provider told us a new format of care plan had just been approved, which should help ensure such information was recorded routinely.

We found information provided in care plans in relation to the support individual's required in relation to their mental health was often limited. For example, there was limited information on signs of triggers to behaviour that challenges or that might indicate a decline in mental health. We spoke with a community psychiatric nurse (CPN) who had worked with the home for several years. They agreed that care planning in relation to mental health was limited; although they also noted that staff had been effective at managing people's mental health needs despite this limitation.

We found records of care provided were regularly maintained. For example, we saw records of pressure relief were regularly updated. These records indicated people received support with pressure relief to reduce the risk of developing pressure sores as frequently as their care plans directed. Other records, including records of close observations, food and fluid intake and behavioural monitoring charts were also regularly updated during the inspection.

We saw little meaningful activity taking place during our inspection. The TVs were on in the lounge and we saw some people sat reading newspapers. At one point staff started a game of 'I-spy', though there was little involvement in this and it is questionable whether this was an activity that would have been of interest to the people living at the home.

The home employed an activities co-ordinator who was not in work at the time of our inspection. There was an activity schedule on display, which was out of date and displayed a schedule for April 2016. This had been updated by the second day of our inspection. We saw activity resources, including the activities file were kept in a locked bedroom. This would have presented an additional barrier to care staff arranging activities.

We looked at the records of activities and saw that for most people, a record of their interests and ideas for activities had been recorded. A good level of detail, providing person centred insights into activities people enjoyed had been recorded in some instances. For example, it was recorded that one person had enjoyed a game of dominoes and they had told the staff member they used to play dominoes at the pub. For another

person it was recorded that the activity co-ordinator had got a book that was of interest to that person and looked at pictures in it and discussed this person's former work history with them. We could see that creative ideas for activities that would engage people living at the home had been considered and in some instances carried out. However, the provision of activities had been reliant on the activity co-coordinator and as such had dropped off in their absence. We also saw some people had not had their preferences recorded and had no recorded activities in their section of the file.

We recommend the provider makes arrangements for the continued provision of activities in the event that dedicated activity staff are not able to provide this support.

On our arrival at the home at approximately 8am, we noted there were a large number of people already out of bed and eating breakfast. We queried this with a member of staff who told us people were up through choice and that there were no set times by which they had to assist people out of bed. Staff told us there would be no problem if someone wanted to have a lie-in and we saw this was the case with other people at the home.

We saw there was an up to date complaints policy that contained details of organisations external to the provider that someone could contact if they were not satisfied with the handling of their complaint. People we spoke with told us they would feel confident to raise a complaint should they feel this was necessary. We looked at the providers record of complaints and saw complaints had been investigated, and actions taken to resolve complaints.

There was a schedule of residents and relatives meetings displayed at the entrance to the home. We looked at minutes from a recent meeting and saw that the refurbishment of the home had been discussed and people were asked for their colour preferences. Other topics of discussion had included activities and dining ideas. The provider told us they had sent questionnaires to relatives to gain their views about the service, but that they had not had any returned at the time of our inspection.

Requires Improvement

Is the service well-led?

Our findings

The home employed a registered manager as is required as a condition of the service's registration. The registered manager was off work at the time of our inspection and we received a notification informing us the registered manager had been absent for 28 days shortly after our inspection. There were arrangements in place to ensure adequate support was in place to cover the registered manager's absence. This included a relief manager and a quality development officer who were both based at the home on a full-time basis. There were also regular visits from the director of operations. The relief manager was supported by a deputy, and the service had recently appointed a clinical lead who was going through their induction at the time of the inspection.

The current provider, MBi Social Care, took over the running of Downshaw Lodge at the beginning of 2016. The provider had recognised a number of shortcomings, as well as being made aware of concerns by the local CCG as a result of their visits. In response to this, the provider had put action plans in place in relation to areas including management of weights, activities, diabetes, medicines, the environment and staff development. We reviewed these plans, which had clearly identified actions and time-scales recorded.

The action plans were at various stages of their implementation and we saw many of the issues we had identified had also been recognised in these documents. For example, we saw it was identified that staff supervision needed to be re-started and that there would be a review of training. The date for completion of these actions was identified as 30 July 2016. We the majority of actions identified in the plans for implementation had been actioned by the identified date.

We saw that regular weekly checks were undertaken and recorded, for example, a '24 hour handover file' showed the manager had reviewed clinical observation charts, accident and injury notes, and weekly food checks. Checks also included a daily register, including any hospital admissions, GP and Health visits undertaken during the week, any changes in medication including short courses of antibiotics and any pressure damage noted. Copies of handover notes were kept in this file for one month before being archived.

Systems were in place to audit aspects of the service including infection control, meal-time experience, falls, weights, care plans and pressure care. We saw many of these audits to ensure and improve the quality and safety of the service had not been completed in April. Weekly weight monitoring meetings had stopped taking place and the training and supervision matrices were not up to date. We saw actions identified in a meal-time audit carried out in March 2016 had not been effectively completed. This audit highlighted that tables were not set with condiments for example and we saw this was still the case. It also highlighted that people's feedback on the meals provided was not being recorded and sent to the kitchen. We found this was still the case at the time of the inspection.

Due to concerns raised with the home in relation to the management of medicines, the home was required to complete daily audits of medicines and send these to the CCG. We found weekly, monthly and quarterly medicines audits had not been completed to schedule, which the provider told us was due to these audits

replicating the findings of the daily audits. However, despite these daily audits, we still found issues in relation to the safe management of medicines as highlighted in the safe section of this report. We received a notification shortly after our inspection informing us one person had run out of a medicine and had not had their medicine administered as prescribed for a period of four days. This showed these audits were not effective.

These issues in relation to systems in place to ensure the effective monitoring and improvement of the quality and safety of the service were a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the people we spoke with who were able to give us their opinion told us they were happy living at the home and satisfied with the service provided. The majority of staff told us they felt well supported, and found the management team to be fair and approachable. One member of staff said; "I think the new managers are brilliant. You can go in to any one of them and they'll listen to what you've got to say. They are really good, it's so much better now". The one staff member we spoke with who told us they felt less supported told us they found that the pressure on staff had increased since the new provider had taken over.

We saw dates were scheduled for regular team meetings. We viewed minutes from the last team meeting in April 2016. Topics discussed included the development of the service, completion of records and findings of a recent staff survey. We saw positive feedback had also been given to the staff team. The provider told us they felt the staff team were committed, although the findings of a recent staff survey had indicated low morale. One of the action plans in place was to address the findings of this survey.

Staff we spoke with told us they were happy in their jobs. They told us they felt the staff team worked well together. One staff member said; "I love coming to work. We all pull together and work as a team." Agency staff and recently recruited permanent staff told us they felt they had received sufficient support to undertake their role effectively. They told us there was always a staff member they could approach for advice if required.

We spoke to the director of operations who told us that they were looking to improve the delivery of services and believed that working for a smaller organisation like MBi Healthcare increased the flexibility and meant greater accountability and a quicker response to people who used the service. For example, by allowing people who used to service to choose soft furnishings for their rooms. The quality development officer explained that the change of ownership had led to a shift in culture and that they were attempting to promote a person centred philosophy of care. They told us this had led to a number of the established staff leaving, but had provided an opportunity to recruit new staff that would be more likely to understand the culture.

The quality development officers told us they felt staff had worked very hard and had made good progress with developing the service. We found managers at the service were responsive to feedback we gave and started identifying actions they could take to make improvements, such as arranging training the mental capacity act and discussing weights as part of the regular 'flash meetings' held between heads of department. We saw the provider produced a magazine, which contained updates about services in it. We saw a section on Downshaw Lodge, which included a statement from the managing director that acknowledged previous standards and practices at the home had been 'wanting' and recognising progress, was now being made. We also saw an email from the managing director to staff at the service, which highlighted the importance of being honest, responsive and responsible. This indicated the provider was committed to working in a transparent way and improving the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not taken adequate steps to ensure decisions were made in people's best interests where they lacked capacity. The provider could not provide evidence that acts intended to restrain an individual were necessary and proportionate. Regulation 13(2)(4)

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Medicines were not being managed safely. Regulation 12(2)

The enforcement action we took:

We issued a warning notice. The provider is required to make improvements to meet the requirements of the regulation by 27 July 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems in place were not adequately robust to ensure the effective monitoring and improvement of the quality and safety of the service.

The enforcement action we took:

We issued a warning notice. The provider is required to make improvements to meet the requirements of the regulation by 27 July 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	Staff were not provided with adequate training and supervision.

The enforcement action we took:

We issued a warning notice. The provider is required to make improvements to meet the requirements of the regulation by 27 July 2016.