Down House Limited

Down House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of Down House took place on the 16,17 and 18 January 2019 and was unannounced. We previously inspected and reported on Down House on the 18 and 19 January 2018 and rated the service as good in each key question and overall.

The inspection was a focused inspection. This inspection was completed to follow up on information of concern we had received. The team inspected the service against two of the five questions. The information we had received meant we looked at whether the service was safe and well-led. During the inspection, we did not find concerns to enquire further as to whether the service was effective, caring and responsive.

Down House is registered with us to accommodate up to 49 adults. Nursing care is provided. The service supports being living with dementia, a learning or physical disability, and or, people who may have a sensory impairment. When we inspected, on the first day, 24 people were living at the service. On the second day, two people returned from hospital increasing the number to 26.

A registered manager was employed to oversee the running of 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 had had a planned leave of absence from June 2018 and had returned on the 3 January 2019.

Prior to the inspection, we had been informed that there were concerns in respect of:

•People's medicine administration and management was not safe.
•Poor staff practice meaning they were not meeting people's individuals care needs.
•People living with diabetes were at risk of not having their needs met.
•People with or at risk of developing skin damage were not having their needs met.
•Meeting people's needs where they were at risk of choking and/or malnutrition was concerning.
•There was a high number of people were being nursed in bed with little social interaction.
•Poor record keeping in respect of people's medicine records and care plans
•Poor staffing levels.
•Poor manual handling practices in which people had been injured or were at risk of being injured.
•People were not having the assessed equipment available to meet their needs; records did not detail up to date manual handling needs.
•Equipment used by people was not always being safely maintained.

During our inspection we did find some concerns that reflected these issues. These related to, risks identified of people who had a diagnosis of diabetes, people who were at risk of their skin breaking down/had skin ulcers, people who had a history of seizures and who were at risk of choking.

In addition, poor record keeping by staff and lack of auditing of people's care records meant gaps and potential risks to people were not being identified and/or followed through on. People's medicines were administered safely but there were again concerns about some records not always being accurate and, following the providers medicines policy and national guidance.

We observed two incidences of poor manual handling practices, relating to the use of a hoist that caused us concerns. We requested the registered manager address this as a matter of urgency.

We were however satisfied that the equipment used to support people to mobilise and the mattresses people slept on were safe and had undergone qualified engineer checks within the previous six months.

Staffing levels were good during the inspection however, we received mixed feedback on this. We were also concerned that due to the layout of the building, staff were difficult to locate. This is something the local authority and we have spoken to the provider about on previous occasions.

In respect of people being cared for in their beds, we found that there were up to nine people using the lounge each day to sit and/or eat their meals. The rest, were in their rooms and/or beds; some people were very frail, but everyone who could communicate, told us this was their choice. The dining room was not used during this inspection. However, again the layout of the building made moving from the lounge to the dining room difficult as they are at polar ends of several long corridors.

We found breaches of regulations. You can see what action we told the provider to take at the back of the full version of the 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.

Some records relating to people's medicines were not always safe.
People at risk due to diabetes, skin fragility, choking and seizures were not all being assured safe care, at all times

People requiring being moved with a hoist were not all being assured safe care.

Records of people's care were not ensuring that essential details were recorded to demonstrate safe and continuity of care.

Staff continued to understand the responsibilities to identify and protect people from abuse.

Is the service well-led?

Requires Improvement

The service was not always well-led

The provider had not ensured good levels of leadership and governance had been maintained.

The provider was not demonstrating that they learnt from adverse events and practice then improved.

Records were not always an accurate account of people's care to help ensure they received safe care.

People, relatives and staff continued to describe the registered manager, provider and senior staff as being approachable.

Down House

Detailed findings

Background to this inspection

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

This was a focused inspection of Down House which took place on the 16,17 and 18 January 2019 and was unannounced. The inspection was completed due to information of concern having been received that questioned whether the service was safe and well-led.

The inspection was completed by one adult social care inspector, one pharmacist inspector, a specialist nurse advisor in the care of older people, as well as an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for older people who uses this type of care service.

Prior to the inspection, we reviewed all the information of concern we had received.

During the inspection, we read the care records of seven people living at the service and one who had recently passed away. We visited everyone during the inspection spoke with six people and four relatives. Two family members also completed questionnaires for us.

We spoke with the registered manager and provider. We chatted to staff but requested they complete a questionnaire which asked for their views related to the concerns we had received. We received 11 completed staff questionnaires.

We reviewed accident and incident reports on specific people and maintenance records. We also discussed with the provider about what governance arrangements had been put in place since the registered manager went on a planned leave of absence. We observed medicine administration, looked at 11 medicines administration records (MARs) and four care plans in respect of medicines.

Prior to the inspection we were in conversation with the local authority and attended multi agency safeguarding meetings. During the inspection, we spoke with four health and social care staff.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in January 2018 we rated this key question as good. Following this inspection, we have rated this section as requires improvement.

We reviewed the following issues to judge whether the service was safe.

•People's medicine administration and management was not safe.
•Poor staff practice meaning they were not meeting individual care needs.
•People living with diabetes were at risk of not having their needs met.
•People with or at risk of developing skin breakdown were not having their needs met
•Meeting people's needs where they were at risk of choking and/or malnutrition.
• A high number of people were being nursed in bed with little social interaction.
•Poor record keeping in respect of people's medicine records and care plans.
•Poor staffing levels.
•Poor manual handling practices in which people had been injured or were at risk of being injured.
•People were not having the assessed equipment available to meet needs; records did not detail people's up to date manual handling needs.
•Equipment used by people was not always being safely maintained.

Our findings in respect of these issues can be found below.

We could not be assured that people living with a diagnosis of diabetes were receiving safe care. NICE (National Institute for Clinical Excellence) guidelines and those of Diabetes UK state that diabetic care plans should be individual to the person. There was no evidence that these national guidelines were being used to inform the protocols at the home. People had risk assessment in place, however we that there were inconsistences in when people's blood sugars were to be taken and where these were being recorded. Not all staff knew where to locate this information and the results were not then being transferred to people's records to ensure continuity of care and oversight. We also found that people's records did not always detail when diabetic eye and foot checks were in place.

We were advised by a visiting health professional that there was a concern in respect of the availability of blood reading machines and their being checked for accuracy. The provider told us everyone had their own machines but the nurses told us this was not the case. We could not locate, and were not provided, when asked, with records that the machines were being kept, ensuring both accuracy and cleanliness. In response to our inspection findings, the registered manager set up a new system to record this.

We could not be assured that people at risk of skin breakdown were always receiving safe care. Some people had up to date, detailed wound care plans in place but others did not. Some people had records which detailed that their position had been changed at regular intervals and others did not. Care staff applied creams and other external preparations. However, records were not always completed to show when these were applied. There was also no evidence these records were then being overseen which would

identify any gaps. When we asked a nurse which people they were caring for and which the district nurses were looking after, we did not receive a clear response. We had to ask one person if they received support with their skin care as their care plan did not say so. The care plan told us they had ulcers on their lower leg but it was not until you got to the back of the care records that we saw three wound plans were not filled in fully. Despite this, the person confirmed the nurses were looking after their lower legs with regular dressings and that they were happy with the care they received.

We could not be assured that people at risk of choking were always receiving safe care. People had choking risk assessments in place. However, one person had been admitted to hospital having choked on food but they had not been re assessed following their return from hospital. This person had the mental capacity to choose food that they knew could place them at risk. We requested the registered manager review this with the person to ensure their current needs were being met. Since our inspection, this has taken place, with systems to monitor risks associated with choking being reviewed.

Two people required updated assessments to support them to eat safely. This had been observed by other professionals who had then reminded staff that referrals for assessment needed to happen but had still not been made. By the time of this inspection, one referral had been requested by the GP (but not passed through to the SALT; the speech and language team) and another had yet to be made. We spoke with the registered manager to ensure these referrals were chased and/or implemented. In the meantime, the kitchen staff prepared food as currently planned and ensured people had a range of choices.

One person at risk of choking was having their medicines crushed and given with their knowledge with food. However, staff had not identified that one medicine may not be safe to be given in this way. The patient information leaflet supplied with the medicine said it should be swallowed whole. When we brought this to the attention of the nurse in charge they told us they would contact the person's GP to seek advice and guidance

We also found products that were used to thicken people's drinks had been left in the lounge and in a person's room. Services have been previously informed nationally to ensure these products were not readily available due to the risk they pose to people who may consume them accidently and choke. When we spoke with the staff, they were unaware of the risks these products posed.

We found the service had recently admitted a person who was at risk of seizures. However, staff had not been trained beforehand to support the specific needs of this person. Emergency medicines that might be needed for this person had not been supplied when the person had been discharged from hospital. The medicines had been requested following a GP visit that took place during the inspection.

The service had equipment to support people in the event of needing their airways cleared. In line with good practice, these suction machines should be kept ready to use quickly. Despite repeated requests, we were not provided with how the service was ensuring this was taking place. The registered manager advised the machine was checked daily and that records were kept.

We could not be assured that people requiring support to move, especially with a hoist, were always receiving safe care. Staff had received up to date training or were planned in to receive this where it was requiring renewing. We observed two incidents of people being moved with a hoist. One person had bare legs and the sling could be seen digging into their legs and they were not placed sufficiently back into the wheelchair seat to ensure they would not then fall. The wheelchair also did not look sufficiently wide enough to fit the person. We requested the registered manager immediately ensured this person was safe before being moved again. Another person became very agitated when being moved by the hoist and we

observed that staff did not speak with and reassure them. The person then grabbed the sling which could put them and staff at risk of injury. We spoke with the registered manager and requested they ensured staff understood the importance of reassuring people to keep everyone safe.

People had the assessed equipment available to meet their needs. However, there were no effective systems and processes in place to ensure slings were available in sufficient numbers and that people's moving and handling care plans were accurate.

Records of people's care did not ensure essential details were recorded to demonstrate safe and continuity of care. For example, inconsistency in ensuring risk assessments and care plans were up to date. Records were not always readily available to care staff, records were not completed so they were factual or contained the full facts. Loose papers recording people's care needs were not secured to prevent loss. We also found incidences where records of care were being completed on separate pieces of paper and so recordings were not in date order. Fluid and nutritional intake by people was recorded inconsistently. Some records did not have the person's name on them or accurate dates.

The inspection team found following people's care needs through was difficult as the records were not always complete. For example, when following a person's care records where they were prone to constipation, and found on three admittances to hospital to need medical intervention, we found the recording required improvement. Their care plan, risk assessments, medicine administration records and record of their daily care had gaps in them. Facts were not recorded that would tell us the service was meeting this need fully. Staff were not using the provider's preferred Bristol Stool Chart and, there was no record of communication between staff to show when/if concerns had been raised. Their laxative medicine was being administered 'as required' despite being prescribed to take regularly. This had been despite a concern about the administration of the laxative being raised by the hospital in September 2018. Guidance was available to help staff decide when it might be appropriate to administer a when required medicine and to record the outcome, but this was not in place for all who had required medicines.

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

Many of the incidents we identified had been advised by the local authority to the provider and registered manager, and actions were already being taken by the registered manager to ensure the safety of people's care improved. The registered manager had also completed some quality and safety morning audits and had created an action plan. New electronic care records were in the process of being developed with a launch date by the beginning of March 2019. The registered manager was already developing a moving and handling workshop for staff to improve their understanding and implementation of their training. At the time of our inspection, immediate action took place to address the moving and handling issues we found.

During our inspection, we spoke to staff involved in the governance and administration of medicines. The observation we completed demonstrated this was achieved safely. Medicines were ordered, stored and disposed of safely. Nurses signed MARs when people had medicines administered or recorded a code if a medicine was not given. The support that people needed to take their medicines safely was recorded in their care plans. The medicines policy had recently been reviewed and updated. The registered manager had audited medicines processes and had identified areas where improvements were needed. An action plan was in place to improve these areas.

Staffing levels were good during the inspection however, we received mixed feedback on this. We did not hear call bells ringing for long periods of time. People presented as having had showers, baths and we

observed staff sitting and talking with people in their rooms. We remained concerned that due to the layout of the building, staff were difficult to locate. This is something the local authority and we have spoken to the provider on previous occasions.

One family member said, "No, I don't think that there is enough staff" and another, "Staffing at Down House seems reasonable." One person said, "Yes I do feel safe here, but sometimes there's not enough staff".

The majority of staff reported there were enough staff that worked well together. Most felt they had time to give quality care. A staff member said, "Definitely enough staff; just one or two staff have poor sickness levels" however, another staff member said, "No, there are not always enough staff. It means then that only basic care needs are met and staff do not then get quality time with the residents". One staff member told us that the afternoons had recently been staffed by one nurse and two care staff which can mean they could not spend quality time with people.

People continued to be looked after by staff that understood how to keep them safe from abuse. Staff received ongoing training and explained how they would ensure they reported any concerns to the senior staff, registered manager and provider. All felt any concerns would be listened to.

A relative said, "I cannot complain about the care, I know they (staff) have their emergencies and my wife may have to wait but I've got no complaints, they're always respectful, helpful, and they give her a kiss at night".

We were satisfied that the equipment used to support people to move and the mattresses people slept on were safe and had undergone qualified engineer checks within the previous six months.

In respect of people being cared for in their beds, we found that there were up to nine people using the lounge each day to sit and/or eat their meals. The rest, were in their rooms and/or beds; everyone who could communicated told us this was their choice or they were very frail. The dining room was not used during this inspection. However, again the layout of the building makes moving from the lounge to the dining room difficult as they are at polar ends of several long corridors. There was a very active co-ordinator of activities who spent time with people; everyone was very positive about this member of staff and enjoyed spending time with them.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection, we rated this key question as good. On this inspection we have given the rating of requires improvement.

The last inspection in January 2018, the rating of good had been after many years of non-compliance for this service. However, the provider had not demonstrated during this inspection that they have been able to maintain a safe service.

The service employed a registered manager. They had gone on a planned leave of absence from June 2018 to January 2019. 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.

Prior to the registered manager going on their planned absence, CQC and the local authority communicated with the provider to seek reassurance. This was due to the service's recent ability to secure full compliance. We received an action plan that detailed how this would be assured.

The provider had employed key staff in senior positions to manage the service during the absence of the registered manager and, audits of care at the service continued to be completed. However, the provider failed to have a system that provided them with assurances and oversight that the service was being run safely and appropriately. There was an assumption on behalf of the provider in respect of the skills of those they had put in charge at the service, but no evidence could be produced during the inspection that these staff had been inducted into their roles fully.

Staff did not follow their provider's policies on dealing with significant events, where a person had been injured to ensure this had been fully investigated. It was not reported to the provider and the accident book had been completed with omissions of significant facts. This also meant the provider could not fulfil their responsibilities of the Duty of Candour (DoC). The DoC is the responsibility placed on all registered persons when something goes wrong to be open, transparent and apologise when something goes wrong.

We found the systems operating in the service had not ensured they had learnt from recent events such as accidents and adverse events. This meant, they could not always demonstrate they had evaluated their practice with the aim of improving. We found there was a lack of enquiry by senior staff and the provider in identifying when further investigation was needed. As well as the example above, we found other circumstances where adverse events were known to have taken place. The details of these events are covered in the safe section and involve an incident of choking and referrals not always being made to external agencies for advice and guidance relating to people's health care needs.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

The registered manager returned to their post on the 3 January 2019 and had already identified issues that needed to be addressed. They had commenced an action plan and had started the process of addressing what they had identified with staff. They were disappointed in the findings of the inspection and the concerns that had arisen during their absence. However, they expressed a commitment to addressing the issues straight way. Immediately following the inspection, we spoke with the registered manager about reviewing the adverse events we had identified. They responded positively and acted to investigate and report back what they found.

The provider expressed their part in why the service was no longer safe and again, a commitment to working with the authorities to put things right. They told us they were in the process of moving over to an electronic system for all records. They showed the inspection team how this would work and was due on line by March 2019. This would mean all care records; monitoring forms and policies would be available to staff to complete. Senior staff, including the registered manager, would be alerted to any late entries for people so could follow up immediately. Staff would also have up to date guidance on key care areas that they could refer to for advice. Staff training had been planned in and there was close communication with the system developers taking place to ensure the system was fit for purpose.

People, family and staff continued to report that they felt the registered manager was approachable. One member of staff said, "[The registered manager] is very approachable and easy to talk to; she is a very good listener" and another, "They are there every time I need support and advice."

A family member said, "I am very satisfied with the care that my relative received at Down House" adding they felt comfortable approaching the registered manager and provider if needed.

Meetings continued to be held with people living at the service and the views of people living their sought. These were used to inform practice and the service however, the registered manager had identified the need to update themselves in respect of this. They were arranging a meeting in the near future.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1)(2)(a)((b)(e)(f) People were not ensured safe care and treatment in that, all risks were identified, up dated and, everything possible was done to mitigate these. The equipment was not being assured as being safe or available in sufficient number.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1)(2)(a)(b)(c)(f) Systems and processes were not operating effectively to ensure risks to people were identified by the provider's quality assurance process.