Shaftesbury Care GRP Limited

Donwell House

Inspection report

Wellgarth Road
District 2
Washington
Tyne and Wear
NE37 1EE

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07 April 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 6 April 2017 and was unannounced. A second day of inspection took place on 7 April 2017 and was announced.

Donwell House provides care for up to 63 people some of whom have nursing needs and/or may be living with dementia. There are two wings at Donwell House; one wing is made up of two residential care units. The other wing has two nursing units.

At the time of the inspection there were 46 people using the service, many of whom were living with a dementia. 28 people had been assessed as needing nursing care.

During an inspection in March 2016 we found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 specifically Regulations 7, 9, 12, 13, 14, 17 and 18. Donwell House was rated inadequate overall and placed into special measures.

We last inspected Donwell House on the 17 and 18 October 2016 and found the provider had breached a number of regulations we inspected against. Specifically we found evidence of continued breaches of regulations 9, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found the provider to be in breach of regulation 10. Donwell House was continued to be rated inadequate and remained in special measures

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

A registered manager was registered with the Care Quality Commission at the time of the inspection. They had been in post since 3 October 2016 and registered since 28 March 2017.

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.

During this inspection we found improvements had been made. This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

Governance and quality assurance systems had been introduced and had been effective in driving improvements. In order to ensure consistent good practice over time the systems and processes that had

been introduced needed to be embedded.

Risk assessments in relation to the premises did not include dates or signatures so we were unable to make a judgement as to the timeliness of these documents. Risk assessments in relation to people, such as mobility, skin integrity and choking were in place and identified control measures to minimise risk. One person who had a diagnosis of epilepsy did not have a protocol in place to guide staff as to the action to take should the person experience a seizure.

Care plans had improved since the last inspection, however we found one had not been updated following a change in need; another person's contained inconsistencies in relation to their nutritional needs and another person's lacked detail in relation to support with mobility.

Some mental capacity assessments were not decision specific and we did not see any capacity assessments or best interest decision in relation to the use of wheelchair lap belts. For other restrictions, such as bed rails, these were in place and detailed risk assessments had been completed to inform decision making. We have made a recommendation about the principles of the Mental Capacity Act 2005.

Staff training had improved however some staff were yet to attend training in moving and handling, safeguarding, mental capacity and deprivation of liberty safeguards and challenging behaviour.

Safeguarding concerns, accidents, incidents and complaints were all recorded and investigated. Action was taken to minimise the likelihood of reoccurrence and analyses were completed to identify trends and learn lessons.

People and their relatives told us they felt safe at Donwell House and were supported by staff who were caring, compassionate, respectful and able to meet their needs. Observations confirmed staff had warm, engaging relationships with people. People were supported appropriately and discreetly.

Activities were available seven days a week and people commented on the improvements that had been made. Of particular note was the joy and comfort people received from the pets as therapy dog (PAT dog) who worked alongside the nurse manager. People were often heard asking when the dog was coming to see them and they clearly enjoyed the opportunity of sharing time and affection with the dog.

The safety of premises, particularly in relation to fire safety, had improved. A new fire alarm system had been installed and staff told us about the system and the training they had received. A handyman, with a background in property maintenance, had been employed and was completing necessary health and safety checks.

The storage, recording and administration of medicines had improved. Care plans were in place and contained detail as to the importance of safe administration of medicines. Medicines profiles detailed person centred information such as how people liked to take their medicines.

New staff had been recruited safely, using appropriate vetting tools to ensure they met the requirements to support vulnerable adults. Staffing levels had been assessed using a dependency tool. It was noted the actual staffing levels exceeded the levels indicated on the dependency tool.

Inductions were in place and staff were positive that this gave them a good basis for supporting people in an appropriate way to ensure their needs were met. Staff told us they felt well supported and we saw that supervisions were held regularly in order to support staff. Annual appraisals were in the process of being

completed for relevant staff.

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

People's nutritional needs were assessed and referrals were made to dieticians and speech and language therapy as appropriate. Care plans were in place and nutritional monitoring occurred for people who were assessed as being at risk and needing additional support.

Referrals were made to external healthcare professionals and we saw involvement from community psychiatric nurses, district nurses, chiropody, dentists and GPs.

People and relatives told us they knew how to complain and said they were confident that action would be taken if they raised any concerns.

Everyone we spoke with, including people, relatives, staff and visiting professionals said improvements had been made to Donwell House.

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 safe.

Medicines were managed safely.

Safeguarding concerns were recorded, investigated and lessons learnt.

Premises safety and risk management had improved since the last inspection.

Systems and processes needed to be embedded to ensure consistent good practice over time.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Improvements had been made, but some training had not been attended by all staff, this included moving and handling, mental capacity and deprivation of liberty safeguards and safeguarding.

Deprivation of Liberty Safeguards (DoLS) were in place, however the principles of the Mental Capacity Act 2005 (MCA) were not consistently applied.

Staff felt supported and annual appraisals were due to be completed by the end of April 2017.

People were supported with their nutritional needs and appropriate referrals to health care professionals were made.

Is the service caring?

Good

The service was caring.

Relationships with people were warm, caring and compassionate. We observed people, and their relatives, were treated with respect and dignity at all times.

People and relatives told us staff were caring, that they listened and tried to help.

End of life care was managed effectively and respectfully.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans had improved however we found some inconsistency in the accuracy and detail in relation to some people's needs.

People and relatives told us they knew how to complain. Complaints were recorded and investigated.

Activities were provided seven days a week.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

A range of quality assurance and governance systems were in place and had been effective in driving improvement. The timeliness of audits was being developed and agreed in order to ensure consistent good practice over time.

Staff and relatives told us the culture and management of Donwell House had improved.

Donwell House

Detailed findings

Background to this inspection

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

Day one of the inspection took place on 6 April 2017 and was unannounced. This meant the provider did not know we would be visiting. A second day of inspection took place on 7 April 2017 and was announced.

The inspection team was made up of one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about.

We contacted the local authority commissioners, the clinical commissioning group (CCG) and the safeguarding adults team to seek their views on the service and how it was run. We also contacted the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with seven people living at the service and five relatives. We also spoke with the registered manager, the clinical lead, the nurse manager, the deputy manager and the regional manager. We spoke with two senior care staff, three care workers, three nurses, one activities co-ordinator and one handyman. We also spoke with two visiting healthcare professionals.

We reviewed five people's care records and four staff files including recruitment, supervision and training information. We reviewed medicine records for six people, as well as records relating to the management of the service.

We looked around the building and spent time in the communal areas. 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.

Requires Improvement

Is the service safe?

Our findings

During our last inspection we found ongoing breaches of regulations 12, 17 and 18. Care and treatment was not provided in a safe way. The planning and delivery of care was not based on appropriate risk assessments. Risks to the health and safety of service users had not been assessed or mitigated.

There was a failure to ensure the premises and some equipment was safe to use for its intended purpose. Medicines were not managed in a proper and safe way. There had been a failure to maintain records in relation to safeguarding, complaints and accidents and incidents. There was no systematic approach to determining the number of staff needed and the range of skills required to meet people's needs and keep them safe. There was a reliance on agency nurses and agency care staff to cover significant staff vacancies.

During this inspection we found improvements had been made in all these areas.

All the people we spoke with said they felt safe living at Donwell House. One person said, "I'm well looked after, they are not cruel here like you hear about at some care homes." Another person said, "I feel very safe here, it's not where I want to be but everyone's very nice and things are better now." A third person confirmed they felt safe and that Donwell House had improved in recent months. A relative told us, "[Family member] is very frail, but they are well looked after, they are safe."

Safeguarding information was on display around the home. One activities co-ordinator said, "If I was concerned I would report it to [registered manager]. As I do activities I tend to blend in and I see a lot of interaction. Staff and others don't notice we are there so we see a lot, but if I heard or saw anything I would go straight to [registered manager]."

Safeguarding concerns were reported and recorded. Timely investigations took place and necessary action taken to minimise any future risk and to learn lessons. Accidents and incidents were also recorded, and trend analyses identified peak times for falls which were responded to by increased observations. Actions also included referrals to the falls team if people experienced two or more falls.

A new fire alarm system had been installed and staff confirmed fire drills happened on a regular basis. Duplicate fire zones had been replaced and there was clear signage around the building which corresponded to the building plan and fire panel. Care staff explained that the fire alarm now indicated which part of the building had activated the alarm so there was no longer any confusion about the zones. The training matrix showed that 51% of staff had attended fire training in the past six months. The registered manager said, "There's always someone on shift who is trained."

Staff understood the action to take in the event of a fire alarm sounding. One staff member said, "All the doors would close, we would ring 999. Make sure people are safe and move them to the next fire zone away from the fire. The assembly point is in the foyer and there are posters up for the zones that match the fire panel." A senior care worker said, "We have had briefings on how the alarm, fire system works. There's new training in place. It's very loud, the zones are clearly marked and the board is clearer as to where the fire is.

The panel says which zone and whether it's upstairs or down, left or right. That way we know how to evacuate."

Each person had a personal emergency evacuation plan that included detail on the support needed in the event of an evacuation. An evacuation register was in place however this was out of date. The deputy manager addressed this and immediately updated the information.

A handyman was employed who had previous experience in property management. They completed regular health and safety checks, including equipment, gas and electrical safety, fire maintenance, legionella checks and emergency lighting checks.

Building risk assessments were in place, however these were standard documents which had not been signed or dated so we were unable to assess the timeliness of the assessment.

We found the management of medicines had improved since the last inspection. One person said, "I get my tablets at the right time. They usually leave them and I take them." Care plans for the administration of medicines were in place but they did not include any detail on people's personal preferences about how they liked to take their medicines. Rather they contained all the detail about the importance of trained staff administering medicines, stock control and monitoring for side effects. Medicines profiles included the person's photograph and preferences for taking their medicines. Care plans included an indication of whether a medicine risk assessment was required.

Some people who used the service needed to be given their medicines in a disguised form (known as covertly). A nurse said, "For covert medicines we have a mental capacity assessment, a GP letter, and a determination of people's best interest. It's all done under the Mental Capacity Act." We saw appropriate records were kept for the administration of covert medicines. Detailed protocols were in place if people had been prescribed as and when required medicines. These included information on what the medicine was for, if anything should be tried before administration, and detail of the dosage and frequency of administration.

Medicine administration records (MARs) where completed appropriately and a coding system was used for as and when required medicines or if someone refused medicines. Notes were recorded to explain the reason for the coding. We did not see any gaps on MARs and we observed two medicine rounds which were managed appropriately with respect shown for the people needing medicines.

Medicines were stored safely and appropriately. Temperature checks of the treatment room and medicine fridge were completed and were within the recommended range for safe storage.
Medicines that are liable to misuse, called controlled drugs were stored securely and daily checks completed. Homely medicines had been removed from the treatment room and we were told that they were no longer used.

All the staff who were responsible for the administration of medicines had attended training and had an annual medicine competency assessment.

Risk assessments were completed in relation to nutrition, choking, diabetes, falls and mobility and skin integrity. The assessments identified the risk and the action that should be taken to minimise and manage the risk. If people had been assessed as having additional risks, such as, displaying behaviour which may challenge these were also assessed. Actions such as referring to other professionals, increased observation, use of diversionary techniques as well as the use of medicines for some people, if necessary, were all

recorded. We saw one person had a care plan which referenced them having epilepsy. It stated the seizures were of unknown cause and referenced the emergency health care plan but there was no risk assessment or epilepsy protocol in place. This meant staff may not have had access to the information they needed to support the person appropriately.

The clinical lead said, "Senior staff are involved in risk assessments, care staff have added information in and are starting to complete some assessments, they are being proactive."

People and their relatives confirmed there were enough staff on duty to meet their needs. One person said, "If you press the bell (nurse call) they always come quickly and ask what you need. If it's urgent they will help you straight away but if you can wait they say they will come back after they've finished doing what they were doing." One nurse said, "Yes there's enough staff. We can concentrate on the person as it's a small unit which improves people's lives. It is fabulous." The clinical lead and senior care staff also confirmed there were enough staff to meet people's needs.

A dependency tool was used to calculate the number of care staff needed. We noted the actual staffing levels exceeded this calculation. There was one nurse in each of the nursing units during the day and one nurse overnight. In addition the deputy manager and nurse manager were supernumerary to the rota and the two clinical leads worked a combination of care and supernumerary hours. The residential units were led on a day to day basis by senior care staff.

A visiting professional said, "I think the staff structure is really good. There is always someone senior on the floor. Everything is different; it's much improved."

Staff had been recruited since the last inspection and we found appropriate checks had been completed before they commenced in post. The process included an application and interview, followed by the receipt of satisfactory references and an enhanced disclosure and barring service check (DBS). DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

During the last inspection one bathroom was not available for people as the bath was out of order. This remained the case at this inspection. A senior care worker said, "The bath is still out of order but it's being discussed with the owner today." People had access to a shower room and were supported to use the bath in another unit if that was their preference.

Requires Improvement

Is the service effective?

Our findings

During our last inspection we found ongoing breaches of regulations12 and 18. The provider had failed to ensure staff received appropriate support, training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. The provider had failed to ensure decisions around people's care and treatment met with the requirements of the Mental Capacity Act Code of Practice.

During this inspection we found improvements had been made.

A training matrix showed some improvements had been made to training however ongoing staff development was required. For example, some staff still needed to attend moving and handling training, safeguarding vulnerable adults, mental capacity and Deprivation of Liberty Safeguards (DoLS) and challenging behaviour training.

Staff told us about improvements to training. One staff member said, "We have lots of training and refresher training and are encouraged to develop. I'm going to start a dementia course." A nurse said, "There's lots of training, it's all hands on and face to face; moving and handling, fire training, health and safety, all the mandatory training. It's all professionally done, well attended, it's good training. Staff have signed up to dementia training so they will understand people's behaviour."

The clinical lead discussed nurse competencies with us. They said, "The training is good, we have done death verification, PEG feeding, sub cutaneous fluids, catheterisation, nutrition, pressure care. All the nursing staff also do all the care staff competencies."

The deputy manager also described improvements to us. They said, "The senior care staff and the nurses have enrolled on a 14 week course in care planning for support to do it correctly. Staff are working on allocated units to ensure consistency. All the staff working on the EMI units are on an eight week dementia course so they have appropriate training for people." EMI is a traditional term meaning Elderly Mentally Inform, more recently referenced as people living with a dementia.

A senior care worker said, "There's a lot going on at the minute, its constant, I've signed up for a care planning course and some of the seniors are doing a year long clinical course – a diploma."

A relative said, "The staff seem trained and competent."

Staff who had recently been appointed in post said they had received an induction. One staff member said, "Induction was great. It was amazing from day one. We did a week's course which included moving and handling, first aid, health and safely, safeguarding. I went through the care plans and discussed Deprivation of Liberty Safeguards (DoLS) and capacity to consent. I'm also starting my health and social care level two."

All the staff confirmed they felt supported to carry out their role. A nurse said, "We manage our own personnel, the management trust our judgement, and our clinical judgement. Management are there for us,

but we are experienced and knowledgeable to run the unit. Relatives are chuffed to bits and external professionals are positive."

All staff had a named supervisor who was responsible for ensuring staff attended a minimum of six supervisions per year. So far all staff had a supervision meeting in November or December last year and had attended two supervisions during 2017. This meant improvement's had been made and staff were on track to reach the providers minimum requirements. Some annual appraisals had been held, and all other were planned and due to be completed by the end of April 2017.

In addition quarterly checks of competency/knowledge were included within supervisions which covered workload, performance and conduct, safeguarding and whistleblowing, infection control, dignity and respect.

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 on authorisations to deprive a person of their liberty were being met.

The provider had submitted DoLS applications to a 'supervisory body' for authority to deprive people of their liberty. Some applications had been authorised and the provider was complying with any conditions that had been applied to the authorisation. For example reviewing and updating of care plans.

A log was in place which included details of all DoLS applications made, the outcome and the expiry date so monitoring could take place to ensure new applications were made in a timely manner if required.

Information on DoLS was recorded within people's care records although the detail of the deprivation and how this was managed was not always specific. One person's care records contained contradictory information about whether or not they had a DoLS in place. This person also had a hospital passport which stated they were not able to consent to treatment and that a mental capacity assessment and DoLS were in place. There was no evidence of this within the person's care records. We spoke with the senior care worker who said, "There is no DoLS unless someone has requested one." The deputy manager said, "An application has been submitted but we have no paper work as yet." They added that the information clearly needed to be changed to reflect the current situation.

Other people had mental capacity assessments which were not decision specific. For others the mental capacity assessment completed as part of a DoLS authorisation had been referenced as being the assessment of capacity to consent to the sharing of information.

We did not see any capacity assessments or best interest decisions in relation to the use of wheelchair lap belts.

This meant the principles of the MCA code of practice were not being followed. We recommend that the service consider current guidance in relation to mental capacity and best interest decisions.

Assessments for the use of bed rails were in place. Risk assessments and best interest decisions were completed as part of the assessment process to decide if people were at risk, how the risk should best be managed and whether or not bed rails were an appropriate control measure.

Care staff understood the principles of capacity and we observed they always asked permission before offering support and encouraged people to be involved in decision making. One senior care worker said, "The mental capacity act is there to protect people so we don't assume people don't have capacity. We assess them and get to know them and care plan around their capacity. If we needed to we would refer to DoLS."

Care staff were quick to respond when one person showed signs of behaviour that may have challenged others. Care staff were able to calm the situation using diversionary techniques and the person settled very quickly. One nurse said, "We have hand-picked the staff who work with people with dementia, they are motivated and confident to be here. It provides consistency as well. Staff are understanding of challenging behaviour and are aware of individual needs. As an RMN (registered mental health nurse) we are able to cascade our experience, and do teaching sessions re specific people's behaviour." Another nurse said, "The staff are self-directed, they are getting dementia training but they can watch methods of de-escalation and learn from us. Most times it is staff that trigger behaviour so we are using lots of role modelling to support the staff to manage situations appropriately." They added, "We have used team meetings as briefings to share information on behaviour management. There's not a huge amount of paperwork so we can get onto the floor and support the care staff. It's a calm environment, it's settled with calm staff so we can identify the peak times for behaviour and manage it."

Behaviour recording charts were in place and were analysed to identify any triggers for behaviour such as change, noise and personal care. Risk assessments and care plans for behaviour management included detail on who was involved in supporting the person, such as a community psychiatric nurse. Strategies were included for behaviour management in specific situations such as visiting the hairdresser.

Care plans were in place in relation to people's nutritional needs, and appropriate referrals had been made to dieticians and speech and language therapy (SALT). Any recommendations were recorded in care plans and food and fluid monitoring was in place. People were encouraged, guided and supported with their meals on a one to one basis if needed. Staff regularly spoke with people during the mealtimes checking that their needs were being met and if they needed anything else such as a drink or support.

Two of the people we spoke with commented about the food. One person said, "The food's terrible, but one chef is better than the other." Another person said, "The food could be better, it's the same stuff." Everyone else we spoke with complimented the food and said it had improved. We spoke with the registered manager and the deputy about people's comments and they acknowledged there were some concerns they were aware of which they were in the process of addressing.

The menus were displayed in pictorial and written form in the dining rooms and people were asked at each meal time what they would like to eat. Alternatives were offered if people did not want either option and if people chose not to eat a main meal they were offered sandwiches and snacks throughout the day.

People told us their health needs were being met. One person said, "If I need to see the doctor I just need to say to one of the girls and they will sort it out for me." One relative told us, "Donwell provided everything the

hospital said was needed."

A visiting healthcare professional told us, "Appropriate documentation is used now, situations are managed appropriately, and I'm amazed at the difference."

Referrals to appropriate healthcare services were in place, and included speech and language therapy, community psychiatric nurses, dieticians, podiatry and district nurses.

A number of areas had been decorated to depict bakery shops, sweet shops, and Donwell village in order to stimulate discussion and support orientation. Various plaques were on the walls to indicate the different areas of the home; including the use of old style public toilet signs to indicate bathrooms. Bedroom doors had been painted in different colours and there were a range of themed pictures relevant to different eras. The registered manager explained they had used various best practice guides in developing areas of the home for people living with a dementia, including Stirling University.

A relative said, "The place is a lot brighter, we are a lot happier now. The décor, the stimulation for people, things are going well."

Good

Is the service caring?

Our findings

During our last inspection we found the provider had breached regulation 10 which relates to dignity and respect. People were not treated with dignity at all times. They were not always treated in a compassionate way and communication with people was not always respectful.

We found improvements had been made during this inspection.

All the people and relatives we spoke with were positive about the care and compassion they received from staff. One person said, "The carers are all very good." Another told us, "I feel very lucky to have carers who care." Another person said, "They do listen to you and try to help, they are very caring."

Relatives also told us staff were caring. One relative said, "The staff here help you in any way they can and they are our family." Another said, "I think they (care staff) are marvellous. If I have a concern I just mention it and it gets sorted but you can't fault the care." They went on to say, "[Family member] had a fall, there was no damage but they phoned to let me know. I can't fault them."

Another relative said, "I have good relationships and am comfortable with the care staff, I can pop in anytime. There's good communication. [Nurse] is brilliant with [family member]. [Family member] recognises the voices of staff and knows them, they are very content."

We spoke with people and their relatives about any improvements they had noticed. One relative said, "There's not much that can be done for [family member] and the family all agreed they should come back here (from hospital) because the place has improved so much. If it had been six months ago we wouldn't have brought them back." Another relative we spoke with said, "The nursing staff have been lovely with me, they will go out of their way to find answers, I'm quite happy. You can rely on the staff now." They added, "I can go home and be confident in the care. The staff give [family member] a kiss and a cuddle, they really do care."

People said they could get up when they wanted to and have a bath or shower when they choose. One person explained they enjoyed a pamper day on a Sunday. People also said they could choose to have meals in their room, dining room or lounge and could go to bed when they wanted to.

One person who had recently moved to Donwell House said the staff had been very helpful. Their relatives also commented that staff had been helpful and had made arrangements to ensure their family members needs could be met. They did say one required adaptation was not available and some maintenance to a door stop and an aerial was required. Staff commented that this would be sorted and attended to urgently.

One relative said, "The nursing staff are very receptive and share information. We all work together." They added, "I like to be kept in the loop for everything. Any concerns they will ring me, they have done before." They added, "I know about relatives meetings and I came to the first one with the new manager, but I don't really go to them as I'm here every day." Relatives meetings and family meetings were held bi-monthly and

included discussion around the management structure, improvements, concerns, environment, communication and staffing. Duplicate meetings were held in the evenings for any relatives who were unable to attend during the day.

Another relative told us, "The staff are lovely, all familiar, [staff member] is brilliant, a great woman. The staff here care and have been brilliant. There have been some agency staff but they are brilliant as well. They are doing a good job, they cope well with emergencies. It's fantastic they do a really good job."

People were supported to develop friendships and share their interests. One person said, "[Person] along the corridor likes reading books. I'm not sure what type of books but I've got some that I've read which they could have." Care staff took the books along to the person who was pleased to have been thought about.

We observed staff treated people with dignity and respect, discreetly supporting people with personal care as needed. We noted one person wasn't feeling too well and care staff were very attentive, offering them various drinks and asking if they wanted to go to bed due to feeling unwell. The person wanted to stay in the lounge so staff discreetly placed a disposable sickness bowl near the person in case it was needed. The staff member spent time sitting at the person's level with them offering comfort and reassurance. When the staff member was called away to support with drinks they kept a close eye on the person ensuring other staff members were aware and that they were never left unsupported.

We saw another staff member supporting someone who seemed unsettled. They asked if they wanted to help do some paperwork which settled the person who was then included in the conversation whilst staff explained that it was lunch time so people were moving into the dining area. If people chose to remain in the sitting room this was respected and staff made sure people had access to an over chair table so they could have their meal in comfort.

None of the people currently living at Donwell House had an advocate. An advocate is someone who represents and acts on a person's behalf, and helps them make decisions.

All the units were now named after flowers and had been refurbished, providing a warm, welcoming environment to support people's well-being. The nursing units were Blossom and Primrose and the residential units Poppy and Jasmine. It was explained that people and visitors, as well as local school children and football teams had been involved in choosing the names.

Detailed resources and management of palliative care were in place and had been developed with the involvement of a local hospice. This included support for people nearing the end of life, the involvement of family members and end of life care planning. A palliative care register was completed and an end of life checklist was in place to ensure appropriate care was delivered to meet people's needs and wants.

Requires Improvement

Is the service responsive?

Our findings

During our last inspection we found ongoing breaches of regulations 12 and 9. The provider had not done all that was reasonably practicable to ensure people received person centred care and treatment that was appropriate, met their needs and reflected their personal preferences. Care plans contained contradictory information in relation to the support people needed. They did not provide sufficient detail on the strategies staff should follow, nor was their detail on the exact nature of the support people needed or how they wanted this to be provided. Care plans had not been updated in response to peoples changing needs and they were not always based upon appropriate and relevant risk assessments.

During this inspection we found improvements had been made.

The registered manager said, "Staff will say if people's needs haven't been met, they will assess people's needs and say if certain staff are not meeting them." A nurse said, "The care plans are top notch."

People and relatives told us they were involved in planning their care. One relative said, "I've been involved in [family member's] care plan and we review it three monthly I think." Another said, "I was involved with the care plan in the beginning, and I attend all appointments, I was involved with reviews and everything." A third relative told us, "We reviewed the care with (registered manager) and all the family were involved in decision making."

The clinical lead said, "We have spent time doing the care files. The nurses and the senior care staff are involved in them. We have mentoring in place and staff have also signed up to do extended training in care planning. Family and residents are involved." A senior care worker said, "The clinical lead wrote the care plans initially and we do the evaluations. We are getting used to the new plans now and they are easier to do and more detailed, they are more effective."

One page profiles were in place which included people's photograph and key points about what was important to the person, how best to support them and what others liked and admired about them. 'This is my life' documents were also in place which provided staff with a summary of the person's life story so staff could get to know the person well.

Care plans where completed for each person and reviewed on a monthly basis. This included health and keeping safe, communication and supporting choice, eating and drinking, personal care, mobility, mental health, pain, skin care, cognitive ability, support choice and maximising independence, medicines and sleeps. In addition people had care plans for activities, social interaction, end of life care and additional care plans for any specific individual needs.

For one person we found a care plan had not been amended following a change to their personal care needs due to a leg dressing being removed. There were also some contradictions in relation to the person's assessed capacity and DoLS application.

For another person the care plan for mobility contained no information on their specific needs in relation to how to use a hoist, for example which straps on the sling staff needed to use to maintain the person's safety. A risk assessment was in place which specified the use of a sensor mat at the side of the bed to manage a falls risk, however this detail was not in the care plan.

Another person had been assessed as needing a thick pureed diet and stage one fluids; however it was also recorded that she needed to have food cut up. This presented a potential risk due to inconsistent recording of information. Staff we spoke with were aware that the person needed a pureed diet.

There were four activities co-ordinators who worked together to ensure activities were available at weekends and evenings as well as during the day. One activities co-ordinator said, "I'm planning on doing both one to one activities and group activities. We have a range of resources to utilise but more are needed." Activities included games with bean bags and soft balls, music, and quizzes. The deputy manager said, "Activities are seven days a week now, people go to the Baltic, the Sage, we have had chilli nights. People are asked what they want to do and we can fundraise or we have a budget available for activities."

One nurse told us they had empathy dolls which brought comfort to some people and that people were safe to explore their environment as they wanted to. The activities co-ordinator said, "We plan on a Monday what the week will look like, we go out a lot on day trips and ask people what they want to do. We recognise changes in people and change activities according to need. We try to meet people's personal preferences and have later finishes to do this. People have come into a home it should be a new chapter in their lives, activities shouldn't just stop." They also said, "We have reminiscence, gentle exercise, weekend activities, and singers. We have fiddle muffs but people aren't keen and we have plans to have memory boxes outside people's rooms." This would support people with orientation and reminiscence. They added, "I treat everyone like family, I love all the residents. It's a joy to come to work."

One relative said, "It would be nice if there was some spiritual activity. My [family member] used to go to church and it was a focus for them and they miss it now." Another relative said, "There are good local connections and a good community spirit." A third relative told us about their family member's love of poetry and how staff hadn't really spent time with them reading to them. We spoke with the registered manager and the activity co-ordinator about this who said they would arrange it straight away. Another relative said, "[Family member] spends most of their time in their room. The staff spend time with him. The cleaners and laundry girls all know him and pop in and have a chat."

One person said staff supported them to go the shops and also to the pub two or three times a week. Another person said, "There's a lot more trips now and there's activities every day, including weekends, which is much better than it was. Yesterday there was a trip to the Sage but the bus couldn't be parked so we went to the fish quay for fish and chips and then to Lickety Lick (Ice cream shop) but it was closed so we went to the Discovery Museum. I could have stayed there all day."

The nurse manager brought their qualified Pets as Therapy (PAT) dog into the service with them. PAT dogs are used to bring joy, comfort and companionship to many people who appreciate being able to touch and stroke a friendly animal. The dog provided stimulation, warmth and reassurance to lots of people and generated discussion amongst people, relatives and staff. People were often heard asking when the dog would be visiting them. We were told very clearly by one person, "You are not having [PAT dog] she is mine, I love her."

People and relatives confirmed they knew how to make a complaint if they needed to and that they felt listened to. One person said, "I've nothing to complain about, on the whole they're all good. You can eat

when and where you want, have a bath or shower and we go out on visits. We had fish and chips yesterday." Another person said, "Everything's fine, it all suits me ok." One relative said, "I've complained about (equipment) numerous times and it was previously dismissed. It was immediately assessed and completed by [regional manager]."

A complaints file was in place and included an audit and a trend analysis system. All complaints received had been investigated, findings were shared with the complainant and discussions held to ensure they were happy with the outcome. Complainants were then invited to sign the complaints form. Actions taken following complaints included staff disciplinary, training, reviews of care needs and improvements to premises and equipment.

Requires Improvement

Is the service well-led?

Our findings

During our last inspection we found ongoing breaches of regulation 17 which relates to good governance. The provider had failed to establish systems and processes to ensure compliance and drive improvement. They had failed to assess, monitor and improve the quality and safety of the services provided. They had failed to assess, monitor and mitigate risks. Accurate and complete records of care and treatment had not been maintained. Other records including safeguarding, complaints, accidents and incidents had not been maintained. There had been a failure to evaluate and improve practice in relation to the carrying on of regulated activities.

During this inspection we found improvements had been made.

The latest inspection report and ratings were on display in the entrance foyer, and the website was updated to reflect the rating and the current registered manager's details whilst we were inspecting.

The manager, who had been in post at the last inspection, was now registered with the Commission. They said improvements had been made and told us, "Systems are in place now, we have our own staff, and the environment has improved. Staff are here because they want to be and the people are well cared for. Relatives can approach us with any issues and it's a nice home to work in." They also said, "We are proud of what's happened (the improvements). Care plans are a work in progress but they are person centred and written with people and their families."

We found some care plans lacked some detail in relation to moving and handling, personal care and nutritional needs however they had improved since the last inspection.

A wide range of governance and quality assurance systems had been introduced following the last inspection.

The nurse manager told us, "Updates to care plans are monthly unless there is a change in need, they all have an allocated date and are completed by the nurse or senior care. I complete a visual check to ensure they have been completed." They explained a system of daily, weekly and monthly quality control checks had been introduced based on the concerns found at previous inspections.

Daily quality controls were in place for controlled medicines, staff allocations, admissions, records and so forth. Meal time observations and room audits were completed. Weekly quality control checks included a medicines stock check, a review of falls, weights, wound care and pressure mattresses. Monthly quality control checks included a review of bed rail risk assessments, a falls audit, infections, pressure care and the palliative care register. In addition a catheter care register was in place and a monthly bed rail audit. This ensured a physical check of the bed rail and bumper had been completed as well as a review of the risk assessment to ensure bed rails were still appropriate. A review of the best interest decision in relation to the use of bedrails was also carried out.

Service quality monthly audits, monthly home audits and regional manager monthly audits had been recently introduced. Whilst the audits had not all been completed on a monthly basis improvements were evident in all areas that had been audited, such as training, quality assurance processes and accident and incident management. The regional manager explained that the frequency of audits was yet to be finalised and the audit process was being reviewed to ensure consistency, effectiveness and timeliness.

An integrated action plan was in place which included any areas for improvement identified through internal and external audits. The action plan covered areas such as the presentation of the home, dignity, dementia, safeguarding, care plan, involvement, medicines and infection control. All actions had a responsible person allocated and a timeframe for completion. It was also colour coded so staff were able to see the progress made.

Medicines audits had been completed in January, February and March 2017 and had been instrumental in driving improvements. The registered manager advised audits had also been completed in October, November and December 2016 however these could not be found on the days of the inspection.

The regional manager said, "It's good to see improvements for the residents and families. We went back to basics to see what works and what doesn't work." They also told us, "We started with the essentials and developed quality assurance controls and audits. [Registered manager] and I have a tremendous working relationship, [nurse manager] has run with improvements and built things up. Findings are actioned, it's a continual process. [Registered manager] is an outstanding leader. He has brought a highly skilled positive and dynamic team in. They are proactive in sharing experience to improve services across the board."

People and their relatives said they thought Donwell House was well led. People said they had no complaints, and when one relative had complained they said it had been acted upon and resolved. Everyone told us there had been big improvements over the past few months.

One relative said, "We can approach management about anything at any time. Things are put in place straight away. Anything I need or I want, it's dealt with straight away. We see [deputy] and [registered manager] every day." Another relative said, "I've seen improvements, it's a lot brighter, a lot cleaner, there's no shortage of anything. It's improved 100%. I'm confident the manager can manage." A third relative told us, "99% change for the better. The care is 100% better, the place as a whole is fantastic." They went on to say, "I am happy with the manager, we had a meeting and I feel much more comfortable than before. The staff cope well. Everything has changed, the food, the cleanliness, the refurbishment."

A nurse said, "There's a lot of respect. Funding doesn't seem to be an issue. If we need something we get it. The owners seem responsive to the needs of the home. It's brilliant, exciting. It's fantastic." They also said, "I'm impressed with the management, it's a different home, the staff feel rewarded and it cascades to the residents." A second nurse told us, "There are many improvements, it's a good team, systems are in place and processes. It's improving all the time."

Team meetings were held on a regular basis, and minutes were available for staff who couldn't attend. Agenda items included documentation, issues and concerns, updates about the home, staffing structure and compliance with regulations.

Several notice boards displayed activities, outings, policies and procedures, safeguarding information and invites to meetings around the home. A Twitter account had also been set up, and with permission this contained details of visits and trips, including photographs. This was managed by the registered manager who had to approve all information before it appeared on the account.

One staff member said, "I joined Donwell House almost a year ago when there was negative stuff on social media but I took a leap of faith and I'm pleased I did. We are all working together as a team and the management are good. I love my job." Another staff member said, "I feel completely supported and everyone is happy. I love my job and I can't think of anything that could be improved." A nurse said, "It's the happiest I've been in my 40 years' experience. It's a lovely place to work. We all have the same goals in mind. There's very little grumbling. We all know the expectations and the staff all want to be here. We have a strong team in place. As care homes go it's the place to be. I wouldn't hesitate putting a relative here."

The clinical lead told us, "We all pull together to the same vision, definitely. [Registered manager] is supportive, very much so, everyone is very supportive and approachable. Everything we have asked for we have got." The registered manager explained that there was a pop in system to ensure some level of management presence over the weekends, the clinical leads worked weekends on a regular basis and the on call system was shared by the management team.

A nurse told us, "Everything is improving and we all want things to be as good as they can be. Everyone is motivated and enthusiastic and we all have the same vision and treat everyone as an individual."