Devonshire Manor Homes Limited

# Devonshire Manor

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

We undertook this comprehensive inspection on the 14 March 2017. The inspection was unannounced.

Devonshire Manor provides personal care and accommodation for up to 15 people. The home is a detached three storey building in Birkenhead, Wirral. It is within walking distance of local shops and had good transport links. A small car park and garden are available within the grounds. A stair lift enables access to the bedrooms located on upper floors for people with mobility issues. There are 13 single bedrooms and a double bedroom for people who wish to share. Communal bathrooms with specialised bathing facilities are available on each floor. On the ground floor, there is a communal lounge and dining room for people to use.

On the day of our visit, there was no registered manager in post. 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. At the time of our visit, there was an acting manager in post who assisted with the inspection.

We looked at the care records belonging to five people. We saw that people's needs and risks were identified but found that risk management information was not always sufficiently detailed or followed, to ensure safe and appropriate care was provided. Records relating to the delivery of care and the management of risk were not always complete. This meant they did not consistently show that people received the care they needed in accordance with their risk management plans. This did not demonstrate that risks to people's health, welfare and safety were managed appropriately.

Care plans contained some person centred information about people's needs and preferences but it was limited. Some also contained the person's life story which helped staff get to know them but not everyone whose file we looked at, had one of these. When we checked one person's nutritional preferences we found that they had been provided with food items that they had already advised staff they disliked. This did not indicate that this person's preferences were always respected. When we asked the manager about this, they told us the person had just recently started to eat these food items.

On the day of our visit, we identified issues with the safety and cleanliness of the premises that had not been picked up and addressed by the acting manager or the provider. We spoke to the acting manager and provider about these issues and they acted on them immediately however, it should not have taken CQC inspectors to point these things out before anything was done. Safety certificates were in place for the gas, electric and fire alarm systems and the equipment used within the home.

We found that where people had mental health conditions that sometimes impacted on their ability to make specific decisions, capacity to consent was not always assessed in accordance with the Mental Capacity Act 2005. Some people's right to choose for themselves and take informed risks was not always

respected.

Staff recruitment was satisfactory but we spoke to the provider about the systems in place to respond robustly to information received about staff once they were employed. We found that staffing levels were sufficient to meet people's needs and everyone we spoke with told us that staff came quickly when they needed support. Staff received training to meet people's needs and received appropriate support in their job role.

Medicines were managed safely and people received the medicines they needed. When people became unwell or required the support of other healthcare professionals this was organised accordingly so that people received the help they needed.

People told us they felt safe and it was clear they thought highly of the staff team. They said that the staff were kind, caring and looked after them well. Relatives we spoke with were also positive about staff at the home. We saw that staff supported people in a pleasant and patient manner. It was clear that people were relaxed and comfortable with the staff that supported them.

People comments about the food and drink provided at the home were positive. They told us they had a good choice of what to eat and drink. People were observed to enjoy the social activities on offer and during our visit participated in a sing-along, a nail pampering session and a game of bingo. This promoted people's emotional well-being.

Safeguarding and accidents and incidents were recorded and responded to appropriately.

The provider has a range of audits in place to monitor the overall quality and safety of the service but these were not always effective. They had not identified the environmental hazards we found during our visit. They had not picked up on the lack of adequate risk management information or poor record keeping in relation to people's care and they failed to ensure people's right to consent to their care was obtained by following the Mental Capacity Act 2005. This did not demonstrate that the governance systems in place were adequate or that the service was always well –led.

## 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.

Risk management plans did not always provide staff with sufficient information on how to manage people's risks and were not always followed.

Safety checks were regularly carried on the home's systems and equipment but environmental risks were not always identified and addressed.

Staff were recruited safely and there were a sufficient number of staff on duty

Medicines were managed and administered safely.

People told us they felt safe and any potential safeguarding incidents had been responded to appropriately.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

People's capacity to make specific decisions was assessed but the assessment process did comply in full with the Mental Capacity Act 2005.

People said the food was good and they were given a choice of what to eat and drink. Some people's dietary records however did not always show that their nutritional risks were managed appropriately.

Staff received training and support in their job role and had an annual appraisal of their skills and abilities.

### Is the service caring?

**Good**

The service was caring.

Staff were observed to be kind, caring and compassionate in their approach to people's needs.

People told us the staff were kind and treated them well.

People looked smartly dressed and we saw that their dignity was maintained by staff at all times.

Relatives we spoke with said that they had been involved in discussing people's care. It was unclear if people themselves had been involved.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Care plans contained some person centred information but it was basic. People's preferences were sometimes stated but not always respected.

People had access to other healthcare professionals in support of their health and wellbeing.

Activities were provided and people were observed to enjoy these. People's feedback on the activities was mostly positive.

A complaint policy was available and any compliant received was responded to appropriately by the acting manager.

## Is the service well-led?

**Requires Improvement**

The service was not always well led

There were quality assurance systems in place but they were not always effective in identifying areas for improvement or risks in the delivery of care.

The culture of the home was not always open and transparent.

There were systems in place to gain people's feedback on the service provided.

# Devonshire Manor

**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 14 March 2017 and was unannounced. The inspection was carried out by an adult social care inspection manager, an 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 service.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider since the home's last inspection. We also contacted the Local Authority to seek their feedback on the home.

On the day of the inspection we spoke with five people who lived at the home, three relatives, the acting manager and two care staff.

We looked at the communal areas people shared and visited a sample of people's individual bedrooms. We reviewed a range of records including five people's care records, medication records, staff recruitment and training records and records relating to the management of the service.

Requires Improvement

# Is the service safe?

## Our findings

We spoke with five people who lived at the home. They told us they felt safe at the home. One person said "I feel safe because there are plenty of staff and they are kind and friendly". Another said "They are a good group of staff, all doing work correctly".

We looked at the care files belonging to five people who lived at the home. We saw that risks in relation to people's care were assessed. For example, risks in relation to moving and handling, falls, nutrition and the development of pressure sores were all assessed. We found that some of the risk management advice given to staff in relation to people's needs was not always sufficiently detailed to enable safe and appropriate care to be provided.

For example, one person was at risk of pressure sores due to poor skin integrity and required repositioning every two hours. The risk management advice given to staff however, failed to advise staff how to ensure the person was repositioned safely in accordance with their moving and handling needs. It also advised staff to apply barrier cream to the person's 'pressure points' but failed to identify where these were, what cream to apply and how often. The repositioning records we looked at were also incomplete and did not demonstrate that staff were repositioning the person in accordance with their risk management advice.

One person lived with diabetes and a physical health condition that meant they found it difficult to swallow. We found that no adequate assessment of the risks associated with each condition had been undertaken. For example, the risk of a hypoglycaemic episode occurring in respect of the person's diabetes, or the risk of choking incident with regards to the person's swallowing difficulties. This meant staff had no clear information on the potential risks that may arise in the delivery of care or the action to take, to mitigate those risks and prevent harm.

One person's nutritional risk management plan gave staff specific safety guidance to follow when supporting the person to eat and drink. During our inspection we observed that the acting manager did not follow this advice in accordance with the person's risk management plan. We spoke to the acting manager about this and discussed the potential consequences that may occur as a result of their failure to follow this advice.

We looked at records relating to the safety of the premises and the equipment in use at the home. We saw that all of the safety checks were up to date and were carried out regularly. During our tour of the home however we identified a number of concerns that had not been picked up by the safety checks in place. For example, we found there were trip hazards on the home's staircases, an unclean bathroom and a wobbly bannister that increased the risk of a fall. We pointed these things out to the provider and they actioned them immediately, however it should not have taken CQC inspectors to point them out. This indicated the provider's approach to health and safety required improvement in order to mitigate risks to people's health and wellbeing.

We checked that each person who lived at the home had a personal emergency evacuation (PEEPS) in place

to mitigate risks to their safety during an emergency situation. PEEPS provide emergency service personnel with information about a person's needs and risks during an emergency situation such as a fire. This information assists staff and emergency service personnel to quickly identify those most at risk and the best method by which to secure their safe evacuation. We found there were no adequate PEEPS in place.

The acting manager told us that people's current PEEPS were out of date and that they had plans to update them. We asked to see the PEEPS due to be updated but the acting manager told us they had been archived and were unavailable. This meant there was no PEEPS information in place in people's files for staff and emergency personnel to use during an emergency evacuation.

On the first day of the inspection we noted that some parts of the home were malodourous and unpleasant to be in. This included some people's bedrooms. On the second day of the inspection we walked around the home again and could see that these areas had been cleaned. Again, these concerns should have been recognised by the acting manager and provider. It should not have taken these issues to be pointed out by CQC inspectors before appropriate action was taken. We looked at the infection control audits in place. We saw they were regularly carried out but were concerned that they were not robust as they had failed to pick up the issues we had identified.

These examples were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there was no suitable system in place to ensure that identified risks in relation to people's care were adequately managed to keep people safe.

We looked at the medicines management in the home. Very clear procedures were in place with regards to the handling, storage, recording and administration of medication. We saw that these procedures were closely followed to ensure medicines were stored, managed and administered safely. Care plans were in place for 'as and when required' medicines for example, painkillers and prescribed creams. These provided staff with guidelines on when people's 'as and when' required medications should be administered. This was good practice. All of the people we spoke with told us they received the medicines they needed.

We checked staff files to ensure that staff were recruited safely. All of the files we looked at, contained at least two previous employer references, personal identify checks and confirmation that a criminal conviction check (DBS) had been carried out before staff started to work at the home. This showed that the provider had checked that staff were safe and suitable to work with vulnerable people prior to commencing in employment.

We requested to see the staff file of one particular member of staff. This was because we were aware that the provider had received further information about this staff member after they had started working at the home. We asked the provider how they had investigated and responded to this information and asked the provider to ensure, that in future, all information in relation to staff members was taken into account when assessing whether they were a 'fit and proper' person to work at the home.

We observed that the number of staff on duty was sufficient and the people we spoke with confirmed this. One person said "I think there are plenty of staff and they are all really nice". A second said "I think there are two on at night but if you ever need them they come quickly" and a third person told us "Staff are very good, they come quickly if I use my call bell".

We looked at records relating to safeguarding and accident and incidents. We saw that satisfactory records were maintained and showed that appropriate action had been taken.

Requires Improvement

# Is the service effective?

## Our findings

People we spoke with confirmed that they were able to choose how they lived their life at the home and we saw examples of this throughout the day. For example, we saw that people had a choice of either having their meals in their room or coming into the dining room and we saw they were able to choose how they spent their day.

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 to 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 looked at five people's care files. We saw that where people's capacity to consent to decisions was in question, a capacity assessment had been undertaken. The way in which this assessment was undertaken did not comply in full with the Mental Capacity Act 2005 (MCA) as people's capacity assessments were generic as opposed to decision specific. There was also no information on how the assessment had been undertaken and the person's involvement. We spoke to the acting manager about this.

We also saw that at times people's right to make their own decisions was not always respected. For example, we saw that one person's mobility aid was placed out of their reach when they were in their bedroom. We asked a staff member about this. They told us that the person often tried to mobilise on their own so to discourage them they placed the person's mobility aid out of the way. We checked this person's care file and saw that their care plan stated that they liked to walk short distances but needed a staff member's to assist as them as they were afraid of falling. We saw that the person had capacity to make their own decisions about their mobility and therefore had the right to choose from themselves whether they wished to mobilise unaccompanied. We found no evidence that any discussions had taken place with the person about their mobility, the risks involved in mobilising unaccompanied in their own bedroom or evidence that the removal of the mobility aid had been discussed and agreed with by the person. Restricting a person's mobility in this way could be considered as a restriction to the person's liberty or a form of restraint as it physically limits the person's freedom of movement.

When we asked the acting manager about why the person's mobility aid was out of reach they gave us a completely different reason to the one given by the staff member and one that was not evidenced in their care records.

These examples were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to have suitable arrangements in place to seek and obtain people's consent in accordance with the Mental Capacity Act 2005.

People we spoke with told us they felt well looked after by staff. People's comments included "I'm spoilt rotten" and "They take me to the bathroom for a bath or wash; they do anything for me".

A relative we spoke with said "They (the person) always looks clean and well looked after, and they are not as agitated (as they were at home)". Another said "It was really difficult to give them (the person) their medication. The staff have preserved and they now take it fine".

We observed staff supporting people throughout our visit. We saw that staff were attentive to people's needs and supported them in an unhurried manner. They interacted with people in a friendly and respectful way.

We looked at staff training records. There was an updated training schedule that showed the training topics that staff had completed and the dates of when this needed to be refreshed. We saw that generally staff had received training in the required areas. Staff files also contained evidence that each staff member had received a staff induction when they first started to work at the home. We found the induction undertaken by staff however was very basic and needed to be more robust in order to ensure that staff had all the information they needed when they commenced work.

We saw evidence in staff files that staff received regular supervision in their job role. Again, the records we reviewed indicated staff supervisions were very basic and in order to offer staff better support these sessions required improvement.

We saw that staff meetings took place regularly. We looked at a sample of the minutes from staff meetings. We found that the minutes of these meetings were mainly a list of things that staff did wrong. This did not demonstrate a collaborative approach to continuous improvement or the development of a positive working culture.

People we spoke with told us that the food was good, of sufficient quantity and that they were offered a choice. Everyone we spoke with spoke positively about the food on offer. People's comments included "We get a roast dinner twice a week – that's my favourite"; "I enjoy the breakfasts, cornflakes with hot milk and a bacon or egg butty" and "I was in hospital and lost four stone. I've been here a couple of months and put two stone back on. I like the food, it must be doing me some good".

We saw that the dining room were the majority of people ate their lunch was pleasantly set. The tables were set with place mats, paper serviettes and there was a menu on each table. The dining room itself however was rather dark which made it appear gloomy. People had access to fruit juice and a choice of meals. There was a friendly atmosphere during lunch and people seemed to enjoy their meal. We saw that one person was provided with an alternative meal to what was on the menu that day. As they had been feeling a bit poorly, the cook had provided them with a light lunch that was easy for them to digest.

People's nutritional needs were assessed and people at risk of malnutrition received drinks fortified with cream and prescribed dietary supplements. People's weights were monitored monthly. We found however that information about how to promote people's dietary intake required improvement and when we spoke with a member of the catering team they did not demonstrate they knew people who lived at the home required a diabetic diet.

Some people's dietary intake was recorded by staff. The purpose of this was to ensure people had sufficient amounts to eat and drink to prevent them becoming malnourished. There were however gaps in some people's food and drink records. This did not demonstrate that people's dietary intake was monitored effectively to mitigate the risk of malnutrition and it was difficult to tell if people's dietary and fluid intake was accurate or sufficient. We asked the manager about why some of the records relating to people's dietary intake were incomplete or missing. They were unable to provide a satisfactory explanation.

Good

# Is the service caring?

## Our findings

People we spoke with during our visit, told us that staff were kind and caring. People's comments included "Staff are kind, friendly and really helpful" and "The boss is very nice – they gets things sorted".

Relatives we spoke with also spoke highly of the staff team. One relative told us "There's a great atmosphere here – we have no issues at all". Another said "All they (the person) needs is a smile and a hug and staff do this".

Relatives told us they had been asked about people's needs and care on the person's admission to the home. One relative told us "We told them exactly what they (the person) needs".

A second relative said "We were asked on the first day about their care plan" and another said "I'm made up because we were worried about them at home. They have really settled since they had been in. I feel contented". The comments made by relatives indicated that that they had been involved in discussing the person's care with staff at the home. It was unclear whether people themselves had been involved in providing this information as most of the people we spoke with were unaware of their care plan.

During our visit, we saw that staff were kind and compassionate in their approach to people's needs. Staff were observed to know people well and interacted with them in a friendly way. The atmosphere in the communal lounge were people sat was positive and we observed the activities co-ordinator putting on some music to sing with the people who lived at the home whilst doing the nails of some of the ladies who lived at the home. We saw that people chatted companionably with each other and staff. Visitors to the home were made welcome throughout the day and the atmosphere was warm and homely.

We observed the manager spending time with one person who had become anxious about returning home after a short stay at the home. The manager was patient and spoke to the person about the alternatives to the person going home if they had changed their mind about going. This discussion was unrushed and the person seemed to be reassured by the discussion they had with the manager.

People looked smartly dressed and comfortable. We saw that staff maintained people's dignity throughout the day. We saw that two people shared a bedroom and that a privacy screen was in place to protect people's right to privacy and dignity. Care plans contained some information about what people could do independently and what they needed help with. People were provided with mobility aids and assistive technology to keep the safe for example, falls sensor mat and bed bumpers to prevent a fall from bed.

There was a lack of end of life care planning in all of the files we looked at. This meant there was a risk that should a person's health decline, staff would not have clear information on how to provide end of life care in accordance with their wishes.

Requires Improvement

# Is the service responsive?

## Our findings

People's assessment and care planning information was designed to identify people's needs and preferences in the delivery of care in a range of areas. For example, people's needs in relation to eating and drinking, continence, mobility, personal care requirements and mental health were all described but information was limited.

All of the care files we looked at during our visit contained elements of person centred information about people's needs and preferences. For example, there was brief information on what people liked to eat and drink and how they liked to take their medication.

When we looked at one person's dietary preferences and their dietary records. We found that some of their preferences had not always been respected at mealtimes. For example, they had indicated that they disliked milky puddings, cheese and fish yet when we checked their food and drink charts, we saw that they had been given all three of these food items over the last few months at mealtimes. When we asked the acting manager about this, they told us the person had just started to eat and enjoy those items.

Some people's care files included information about their personal life history. Personal life histories capture the life story and memories of each person and help staff deliver person centred care. They enable the person to talk about their past and give staff, visitor and/or and other professionals an improved understanding of the person they are caring for. Personal life histories have been shown to be especially useful when caring for a person with dementia. We found however that dementia care planning in general was poor and required improvement. There was little information on how people's dementia presented, how it impacted on their lives and how staff could promote people's mental health in the delivery of care.

People records showed that people had access to other healthcare professional when they became unwell or required medical care. For example, records showed people had support from district nurses, GP's, opticians, speech and language therapy services and continence services.

People we spoke with told us that staff got the doctor quickly when they felt unwell and that staff followed the advice given by the doctor when providing care. One person said "The staff do my blood pressure as the GP wants it done". Another said "I did need to see the doctor once, so the staff rang and the doctor came in. I think the doctor gave me antibiotics".

Activities were promoted on a noticeboard just outside of the communal lounge. The provider employed an activities co-ordinator who organised a variety of activities for people who lived at the home to participate in. On the day we visited, a small group of people enjoyed a sing-along, chair based ball exercises, a nail pampering session and bingo. One person said "I like it when the music is on, especially country music".

When we asked people about the activities in the home, they were mostly positive. One person commented that they "Would like to go on trips out but the weather has not been so good" and another said " The activities co-ordinator doesn't seem to work at the weekends so there is not much to do in the afternoons,

but I usually watch TV a bit more. A relative stated that their loved one would like to go to church on Sunday now that they had settled at the home. They said they were happy to talk to the acting manager about this.

We read the complaints policy and saw that it was available throughout the service. We looked at the complaints log and saw that the acting manager had recorded any concerns and complaints received. These included minor concerns and we saw that appropriate action had been taken by the acting manager to put things right.

Requires Improvement

# Is the service well-led?

## Our findings

The home did not have a registered manager in place and had not had one since June 2016. The acting manager had been in post for six months but was leaving. We were unclear as to the reasons why and when we asked the acting manager and the provider, they each gave us different reasons. The provider told us that they were currently advertising for a new manager. We raised our concerns as to who would be responsible for the service whilst this recruitment process was underway. The provider was unable to provide a satisfactory explanation. We raised our concerns about the lack of suitable management arrangements in place to ensure the home was safely managed until a new manager was appointed.

We looked at the governance systems in place to audit and check the service was safe, effective, caring, responsive and well-led. We saw that the provider had a range of audits in place to assess and monitor the quality and safety of the service. Some of these audits were not effective.

Audits were completed with respect to health and safety, infection control, medication administration and accident and incidents. The audits were regularly carried out but during our visit we identified concerns that had not been picked up and addressed by the systems in place. For example, we identified issues with risk management, the environment in which people lived and a lack of adequate emergency evacuation planning. There were also concerns identified with the systems in place to assess people's capacity to make specific decisions in accordance with the Mental Capacity Act 2015. This did not demonstrate that the governance systems in place were effective in identifying areas of improvement and mitigating risks to people's health, safety and welfare.

During our visit, we found that some of the explanations given by the acting manager in relation to irregularities with regards to people's care were unsatisfactory. For example they were unable to explain why some people did not have a complete set of records showing they had received appropriate care. When we had queries about the care people received, some of the acting manager's responses were not evidenced in people's care files, yet would have been important to document. This did not demonstrate that their management of the service was organised, transparent and well-led.

These examples were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider's governance systems were ineffective.

There was a system in place to gain the feedback of people who lived at their home and their families. A satisfaction questionnaire was sent out to ask people's opinions about the service provided. We looked at the people's feedback. We saw that people's feedback had been sought in January and February 2017 and was positive.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>There were no suitable arrangements in place to ensure that the service obtained the consent of people who lived at the home in accordance with Mental Capacity Act 2015.<br><br>Regulation 11(1),(2),(3) and (4). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Risks in the delivery of care were not appropriately mitigated against in the delivery of care to keep people safe.<br><br>Regulation 12(1),(2)(a) and (b). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider did not have effective systems in place to assess, monitor and mitigate risks to the health, safety and welfare of people who used the service.<br><br>Regulation 17(1),(2)(b). |