Devonshire Manor Homes Limited

# Devonshire Manor

## Inspection report

38-40 North Road
Birkenhead
Merseyside
CH42 7JF

Tel: 01516522274
Website: www.devonshiremanorcarehome.co.uk

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
Devonshire Manor is a care home that provides accommodation for up to 15 people who need help with their personal care. At the time of the inspection 9 people lived in the home. Most of the people living in the home, lived with dementia.

People's experience of using this service:
At the last inspection, the provider was rated inadequate and placed in special measures. At this inspection, we found the service had not improved and remained inadequate.

We undertook a focused inspection. A focused inspection was undertaken to specifically check whether sufficient improvements in the safety of the service and people's care had been achieved and to assess whether the manager and provider now had sufficient oversight of the service. At this inspection we continued to have serious concerns about the safety of the service and its leadership.

People's risks were still not adequately assessed, and staff lacked clear and sufficient guidance on how to support them appropriately. Records did not show that people received the right support with regards to their nutrition, skin integrity, medication needs and overall care.

Fire safety arrangements remained poor and did not ensure people were protected in the event of a fire. Personal and protective equipment was not being used in accordance with Public Health England guidance to mitigate the risks associated with Coronavirus.

Robust staff recruitment procedures were still not being followed and improvements to the way medicines were managed had not been made to ensure its administration was always safe.

The systems in place to monitor the quality and safety of the service remained ineffective. At the last inspection, the provider and manager did not have sufficient knowledge of the care people needed, or their regulatory responsibilities. At this inspection, this remained the same.

This meant people had continued to be exposed to ongoing risks of inappropriate and unsafe care and poor management.

Rating at last inspection and update:
The last rating for this service was inadequate (published 16 January 2020). After this inspection, the provider completed an action plan to show us what they would do and by when, to improve. At this inspection, the provider not achieved the improvements identified in their action plan. Multiple breaches of the regulations remained and the provider's rating remains inadequate.

Why we inspected:

This was a planned focused inspection based on the previous rating.

Follow up:
Shortly after the inspection, we referred two people's care to the Local Authority Safeguarding Team for further investigation. We notified the Local Authority Quality Improvement Team of the ongoing failings of the service. We referred the provider to Merseyside Fire Authority due to the fire safety deficiencies identified at the service. We will work with the local authority and Merseyside Fire Authority to monitor progress.

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will also request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service will be placed in special measures. 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Inadequate

The service was not safe.

Details are in our Safe findings below.

**Is the service well-led?**

Inadequate

The service was not well-led

Details are in our Well-Led findings below.

# Devonshire Manor

**Detailed findings**

## Background to this inspection

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

Inspection team
This inspection was undertaken by two inspectors.

Service and service type
Devonshire Manor is a care home. People in care homes receive accommodation and personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This inspection was announced 24 hours prior to the inspection taking place. This was because infection control arrangements had to be agreed with the provider prior to our visit to mitigate the risk of any cross contamination or transmission of Coronavirus.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. At the last inspection, the provider was rating inadequate. Since then, the Local Authority have continued to monitor the service and we have maintained communication with the Local Authority with regards to this. Since our last inspection, we have also contacted the provided to discuss any concerns received about the service and to gain an update on any improvements they have made with regards to the service. We used all this information to plan our inspection.

During the inspection:
We spoke with two people who lived in home, two care staff, the manager and the provider.

We reviewed a range of records. This included two people's care records and a sample of medication records.  Four staff recruitment files and records relating to the management of the service.

Inadequate

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection, this key question was rated as inadequate. This meant that people were not safe and were at risk of avoidable harm. At this inspection this key question has remained the same.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong.

At our last inspection the provider failed to ensure people's risks were properly identify and managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, improvements had not been made and the provider remained in breach of regulation 12.

- Risks relating to people's care were still not adequately assessed and staff lacked clear guidance on how to manage them.
- Care records did not show people always received the right support with regards to health conditions, skin integrity, nutrition or moving and handling.
- Fire safety arrangements remained poor. The provider had commissioned an external company to complete a fire risk assessment in February 2020. A number of fire safety deficiencies were identified but the provider had not acted upon them. This meant people were not adequately protected from harm in the event of a fire.

Using medicines safely
At our last inspection the provider failed to ensure that medicines were managed safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, improvements had not been made and the provider remained in breach of regulation 12.

- Some people's medication records were still being handwritten. There were no staff signatures or evidence that a second member of staff had checked that this information was correct. This poor practice had been brought to the manager's attention at the last inspection but no action had been taken.
- Some people were prescribed 'as and when' required medications such as painkillers. At the last inspection no suitable 'as and when' required medication plans were in place to advise staff how and when to administer these medicines. At this inspection this remained the same.
- Some people needed their medicines to be given covertly (crushed or hidden in food or drink). Some medicines can become unsafe or unsuitable when given in this why and its important staff have clear guidance on how to administer them safely. At our last inspection, the guidance given to staff was poor. At this inspection, the guidance remained inadequate and contradictory.

The above issues were a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risks in relation to people's care were not safely managed to protect them from harm.

Preventing and controlling infection

● There was access to personal protective equipment such as gloves, aprons and antibacterial gel for staff to use to prevent the spread of infection.

● Staff including the manager and provider however were not adhering to Public Health England guidance in respect of this equipment to mitigate the risk of Coronavirus.

● Personal protective equipment including the use of masks were not in use by staff working in in communal areas to prevent and mitigate the risk of this infection.

● When spoken with, the manager did not have a clear understanding of Coronavirus and the infection control standards required to prevent its transmission within the home.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as good infection control procedures were not being maintained.

●The home was visibly clean and there were checks in place to prevent legionella bacteria developing in the home's water supply.

Staffing and recruitment

At the last inspection, the provider's recruitment procedures were not robust and did not ensure only fit and proper persons were employed. This was a breach of regulation 19 (Fit and proper persons) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, no improvements had been made and the provider remained in breach of Regulation 19

● The application forms completed by some staff did not give an accurate account of their employment history.

● Some previous employer references were not verified as being from a reliable and authorised source.

● Some previous employer references identified issues with the conduct of staff members. There was little evidence that the manager had undertaken a robust investigation into these issues prior to their employment at Devonshire Manor.

●The personal identity of some staff members had not been properly checked.

Inadequate

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

At the last inspection this key question was rated as inadequate. At this inspection, this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care.

At the last inspection, the provider and manager failed to ensure that the governance arrangements in place ensured safe and good quality care. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, improvements had not been made and the provider remained in breach of regulation 17.

● The management of the service remained ineffective. The manager was not effective in driving up improvements in care planning, risk management, medication management, the delivery of safe care, infection control and quality assurance.
● The provider's governance and oversight of the service was poor. There was little evidence that any positive and open communication between the manager and the provider took place to ensure improvements to the service were made.
●The provider had failed to act on any improvements identified by their own quality audits or those of external parties.
● For example, environmental audits over a five month period identified that practical improvements in some bedrooms were needed to make them a safe and nice place for people to live. A number of fire safety deficiencies were also brought to the provider's attention in February 2020 by an external company. Despite this the provider had taken no effective action and did not have a satisfactory explanation as to why these improvements had not been made.
● At the last inspection, neither the provider or manager had an adequate understanding of how to provide good care in accordance with their legal responsibilities under the Health and Social Care Act. At this inspection, this remained the same.

The above issues were a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) as the service was still not well led.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong;
● Since the last inspection statutory notifications had been made by the manager in accordance with their

legal duties.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Since the last inspection, the manager had made appropriate referrals to other health and social care professionals in support of people's needs.
● Staff meetings took place with staff to discuss the running of the service. These meetings were ineffective however in driving up sustainable improvements.