Shaftesbury Care GRP Limited

Donwell House

Inspection report

Wellgarth Road
District 2
Washington
Tyne and Wear
NE37 1EE

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18 October 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 17 October 2016 and was unannounced. A second day of inspection took place on 18 October 2016 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 53 people using the service, many of whom were living with a dementia. 29 people had been assessed as needing nursing care.

We last inspected Donwell House on the 9, 10 and 14 March 2016 and found the provider had breached a number of regulations we inspected against. Specifically the provider had breached Regulations 7, 9, 12, 13, 14, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager had failed to demonstrate the necessary competence, skills and experience to manage the carrying on of a regulated activity. The provider did not do everything that was reasonably practicable to make sure people using the service received personalised care and treatment that was appropriate, met their needs and reflected their preferences. Care and treatment was not provided in a safe way. Assessment planning and delivery of care was not based on appropriate risk assessment. Not everything was done to reasonably and practicably mitigate risks. Medicines were not managed in a proper and safe way. Policies and procedures were not followed appropriately. People were not being protected from neglect and improper treatment. Systems and processes were not established and operated effectively to prevent abuse, neglect and improper treatment of people. The nutrition and hydration needs of service users was not being met. A variety of nutritious, appetising food was not available to meet people's needs. Up to date assessments for nutrition and hydration needs were not being followed. Systems and processes were not established and operated effectively to ensure compliance. Systems did not assess, monitor and improve the quality and safety of the service. They did not assess, monitor and mitigate risks. Accurate, complete and contemporaneous records of care and treatment were not maintained. Feedback was sought but not acted upon to improve quality. The provider did not ensure audit and governance systems were effective. Staff did not have appropriate training to enable them to carry out the duties they were employed to perform. Staff had not received regular appraisals of their performance.

During this inspection we found evidence of continued breaches of regulation. Specifically 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. 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 not registered with the Care Quality Commission at the time of the inspection. A manager was in post but they had only started the role on 3 October 2016.

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.

Premises safety was a concern. There were duplicate fire zones and room numbers within the building. The actions identified from a fire risk assessment completed in April 2016 had not been rectified, this included action in relation to an inadequate fire detection system and inadequate training for the evacuation of people. A service user evacuation register was out of date and the fire log book contained 29 personal emergency evacuation plans (PEEPs) when there were 53 people resident in the building.

Routine checks on fire and premises safety had not been completed in a regular and timely manner. At the time of the inspection there was no evidence of an in-date gas safety certificate or in date certificates of lifting operations and lifting equipment regulations (LOLER).

Risks had not always been identified and mitigated against. For example for people who had swallowing difficulties there had been no assessments completed in relation to the risk of choking. Where people could display behaviour that challenged others there was no assessment of risk.

Care records contained conflicting information, there were no specific and detailed strategies for staff to follow in relation to how to support people or how people wanted to be supported and care records had not been updated to reflect changes in people's needs.

Decision specific mental capacity assessment and best interest decisions had not been completed for the use of potentially restrictive care practices such as bed rails and wheelchair lap belts. Where mental capacity assessments had been completed they were not decision specific, did not relate to restrictive practice and had been completed by either one nurse or one senior care staff member. The mental capacity act (2005) code of practice was not being followed.

Medicines were not managed in a safe way. There was conflicting information in care records about the form of people's medicines, for example crushed medicines and liquid medicines. There was no evidence of mental capacity assessments, best interest decisions or specific care plans in relation to people whose GP had stated they could have medicines administered covertly. Protocols for the administration of 'as and when required' medicines were often not in place, and where they were in place they lacked specific detail to guide staff on when to administer the medicine.

A box of homely medicines were available in the treatment room, however the deputy manager told us they were not used.

The temperature of the treatment room often exceeded recommended guidelines which meant the effectiveness of some medicines may have been compromised.

Staffing levels were being maintained by the use of agency nurses and care staff. Staff had not received relevant training, supervision or appraisals to ensure they had the necessary skills and competence. There was no systematic approach to determining the number of staff and the range of skills staff needed to meet people's needs and keep them safe.

There was limited engagement and interaction from some staff during mealtimes. We observed one person was supported by three different staff during one meal, another staff member was observed to be touching a

person's mouth with a spoonful of food prompting them to open their mouth whilst they were still eating.

Records in relation to the management of regulated activity, such as safeguarding's, accidents, incidents and complaints were not available pre August 2016.

There was a continued failure to ensure an effective quality assurance and governance procedure was in place to monitor, assess and drive improvement in the quality of the service provided. An improvement plan completed by the provider had not identified the concerns noted throughout this inspection, even though it stated that some areas requiring improvement had been completed.

Some staff had warm and caring relationships with people and treated people in a kind, caring and sensitive way.

Staff were recruited appropriately and necessary background checks completed.

Some improvements had been made to nutrition and hydration; however food and fluid charts were not detailed and did not record the amount of food or fluid people needed to aim for each day. Nor did they detail the specific dietary needs of each person.

We saw people were supported to access health care professionals however there was not always evidence that information had been followed up on. For example, a GP who had been contacted about a person's medicine management.

Activities coordinators were in post and there were various activities available for people.

Staff had confidence in the new manager to drive improvement. Staff felt listened to and supported and thought improvements were being made.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

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.

Premises safety was not being managed in an effective way. A fire risk assessment had been completed but there was no evidence that the action plan had been completed which meant there remained a potential risk to people.

There was a continued failure to identify and assess some risks. Risk assessments contained conflicting information and did not always contain accurate and up to date information.

Medicines were not always managed and recorded in a safe way.

There was no systematic approach to ensuring there were enough staff with an appropriate skill mix to meet the needs of people using the service.

Records of safeguarding concerns, accidents and incidents could not be found for the time period up to August 2016.

Is the service effective?

Inadequate

The service was not effective.

The provider had continued not to ensure staff had the appropriate induction, training and supervision to support them to ensure people's needs were met.

Annual appraisals had not yet been completed.

The principles of the Mental Capacity Act 2005 had not been followed in relation to best interest decisions with regard to potentially restrictive practices.

Some improvements had been made to ensure people's nutritional and hydration needs were being met.

Is the service caring?

Requires Improvement

The service was not always caring.

Engagement and interaction with people varied. We observed some staff still did not engage with people in a meaningful manner.

Some people were not supported in a dignified, caring, or considerate way during mealtimes.

Permanent staff had warm relationships with people and people were observed to be comfortable with staff.

People and relatives said their privacy was respected.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans had not been updated in a timely manner in response to peoples changing needs. They contained contradictory information; they did not contain the specific detail staff needed which meant people were at risk of receiving inappropriate care and treatment. This was an ongoing breach.

Information on any complaints made before August 2016 could not be found.

Activities were available for people.

Is the service well-led?

Inadequate

The service was not well-led.

Quality assurance and governance systems were not in place and audits were not completed.

An improvement plan developed by the provider had not been effective in identifying and addressing the ongoing breaches of regulation noted during this inspection.

One relative told us, "It's been badly run for a long time. I'm hoping the new man will bring it up."

Staff felt the new manager was addressing concerns and could drive improvement.

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 17 October 2016 and was unannounced. This meant the provider did not know we would be visiting. A second day took place on 18 October 2016 and was announced.

The inspection team was made up on one adult social care inspector and an Expert by Experience on day one and two adult social care inspectors on day two. 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, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also 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), the safeguarding adult's team, and various healthcare professionals 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 five people living at the service and two relatives. We also spoke with the manager, the clinical lead, the deputy manager, two senior care staff, a nurse and an agency nurse, three care staff including an agency staff member, one activities coordinator and one kitchen assistant.

We reviewed five people's care records and five staff files including recruitment, supervision and training information. We reviewed medicine records for fourteen 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.

Inadequate

Is the service safe?

Our findings

During our last inspection we found breaches of regulations. Care and treatment was not provided in a safe way. Assessment planning and delivery of care was not based on appropriate risk assessment. Not everything was done to reasonably and practicably mitigate risks. Medicines were not managed in a proper and safe way. Policies and procedures were not followed appropriately. People were not being protected from neglect and improper treatment. Systems and processes were not established and operated effectively to prevent abuse, neglect and improper treatment of people.

We found some improvements had been made, however there had been no improvements made in some areas.

Donwell House has two fire panels; one for each side of the building. Each side of the building continued to have duplicate fire zones and duplicate room numbers. Staff were aware of this however there was ongoing risks in relation to the potential for staff to access the wrong zone in the unfortunate event of a fire. We spoke with the manager about this who said, "[Fire company] are coming out so I will speak to them as it should be easy enough to change the zones."

A fire risk assessment had been completed in April 2016 and an action plan had been developed. The areas requiring action related to an inadequate fire detection system, inadequate training for the evacuation of resident, a lack of suitable firefighting equipment, and a lack of fire dampers and inadequate compartmentation. There was no record of any action having been taken to complete the requirements of the assessments. This meant the provider had known there were risks in relation to fire safety but had not taken action to resolve them.

Fire door checks had not been completed since 14 June 2016. The standard recorded for these checks was weekly. Emergency lighting checks had not been completed since August 2016. There had been no management reviews of the fire log book recorded since 27 April 2016 and building fire management monthly checks had not been completed since 10 August 2016. A document titled 'fire system in house weekly check' which included the fire panel, break glass units, fire signage, access/egress door checks and alarm sounders had been completed on 1 September 2016. This meant the provider was increasing the level risk in relation to fire safety by not ensuring appropriate checks were completed. We have shared these concerns with the local fire authority.

A service user evacuation register was in place dated 23 September 2016. The deputy manager told us this needed to be updated. The fire file also contained personal emergency evacuation plans (PEEPs) for 29 people however there were 53 people resident in the home at the time of the inspection. We spoke with the manager and deputy manager about this who said, "They are also in the care records." Care records were stored on each of the four units and would not have been accessible to the fire service in the event of an emergency.

Whilst some premises checks had been completed in a timely manner there was no evidence of a gas safety

certification or lifting operations and lifting equipment regulations (LOLER) certificates. We spoke with the manager about this who immediately took action for the work to be completed. Relevant certificates were forwarded to CQC after the inspection.

Risk assessments in relation to the premises were in place however they were not dated or signed so we were unable to assess the timeliness of the assessments.

Doors to sluice rooms (a sluice room is where used hygiene disposables are dealt with, and reusable products are cleaned and disinfected) and linen cupboards were unlocked which meant they could be accessed by the people living at Donwell House. We raised this with the manager however the doors remained unlocked during the course of the inspection. We were told that keys were not available however the doors also had key code pads on them which were not in use. One sluice door which had a large notice on it stating that the door should be kept closed was propped open with a bin.

One bathroom had exposed pipework and a toilet had a basin with no tile surround. Not all the bins were pedal bins which could constitute an infection control risk.

We found not all risks had been identified, assessed and mitigated against. People whose care plans stated they had swallowing difficulties had no assessment in place with regards to managing the risk of choking. For some people whose behaviour may, at times challenge others, there was no evidence of assessment of risk.

Another person had a pressure area assessment. The outcome was that they were 'at risk' however there was no care plan in place in relation to supporting the person with skin integrity or pressure care. The same person had a moving and handling checklist which stated they needed two staff and the use of a stand aid hoist and sling for transfers, dressing, toileting and dining. The falls risk assessment did not include any reference to this information. Their care plan for mobility and risk of falls had an addition which stated they had been assessed for the use of the stand aid but there was no detail for staff to follow on how to use the stand aid hoist to safely support the person.

Some people's records contained conflicting information in relation to the risk of falls and mobility and how this should be managed by care staff. One person, who needed the support of two staff to manage their mobility needs, had a falls risk assessment however this did not mention the need for two staff nor did it mention that the person needed the use of stand aid hoist and sling.

We looked at the management of medicines and found improvements had not been made. One person had a record within their professional contacts that the GP had been contacted about liquid medicines due to them spitting their tablets out. The GP response was that they would find out about covert medicines. We found no other information in relation to this so asked a staff member. They said, "[Person] isn't on covert meds, I find with persistence they take them." This person had a medicine profile which stated they had difficulty swallowing and weren't always compliant with their medicines. It also recorded that they took their medicines off a spoon one at a time with plenty of fluids. We saw a letter from their GP which stated one medicine could be crushed and others were of liquid consistency. There was no information in either a care plan or risk assessment in relation to the person's swallowing difficulties, how the crushed medicine should be administered or that the person should be taking their medicine in liquid format. This placed the person at risk of receiving their medicines via an unsafe administration route.

We saw two people had been prescribed 'as and when required' medicines however there was no protocol for administration in place for staff to follow. Where people did have protocols they lacked detail as to when

the medicine should be used and why. This meant there was no guidance in relation to when or how often to administer the medicine. We also found records of the administration of 'as and when' required medicines was not always appropriately recorded.

A homely medicines box was kept in the treatment room which contained paracetamol, antiseptic lozenges, calamine lotion, antihistamine cream, senakot and dioralyte. A homely medicines records book was maintained and records showed the last time a homely medicine had been administered was on 17 April 2016. We spoke with the deputy manager about this and asked for a copy of their homely medicines policy. They said, "We don't have one as we don't administer homely medicines."

We saw hand written medicine administration records (MARs) had not been signed by staff. This included a hand written update to one person's MAR in relation to insulin administration.

A list of staff names and signatures for administration of medicines was in place but it was not dated so we were unable to assess if this was up to date.

Temperature checks of the treatment room were not completed on a daily basis. When records were completed we found that on seven days in August and 16 days in September 2016 the recorded temperature exceeded the recommended limit of 25 degrees centigrade. Action was taken on some occasions but not on all. This meant the effectiveness of medicines could be compromised due to overheating.

Daily checks of controlled drugs were sporadic during July and August 2016 and only five daily checks had occurred in September 2016. During October 2016 daily checks had been completed and were correct.

Prescribed ointments were in bathrooms together with other toiletries which were unattended and not returned to individual rooms.

The clinical lead showed us a competency checklist they planned to introduce for medicine administration but this had not been implemented at the time of the inspection.

These findings were an ongoing breach of regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

At the time of the inspection staffing levels included a nurse and four care staff on each of the two nursing units. The residential units had a senior care worker and two care workers on the downstairs unit and a senior care worker and three care workers on the upstairs unit where more people were resident. The manager explained that a dependency tool wasn't yet being used. They added that dependency would be assessed as part of the new care planning system which was to be implemented.

The manager explained there was currently only one permanent nurse employed, in addition to the clinical lead and the deputy who were both working off the floor to support improvements. All other nursing staff were agency nurses. They told us, "Nurses have been recruited and four are due to start in November." They also told us there were currently seven care staff vacancies. These vacancies were being filled by agency staff or permanent staff working additional hours. Some care staff had been recruited and were going through the appropriate checks before starting in post.

An agency nurse said, "Yes, there's enough staff but it depends on the skill mix." A senior care worker said, "Yes, there's enough staff." They added, "Agency staff are regular so they get to know residents. The new staff will need guidance." There was no systematic approach to determining the number of staff and range of

skills required to meet people's needs and keep them safe.

This was an ongoing breach of regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

We asked the manager for records in relation to safeguarding, complaints and accidents and incidents. They told us there were no records prior to August 2016. We confirmed that they meant there were no records as opposed to no occurrences prior to August 2016 which they confirmed. This meant there had been a failure to follow guidance in relation to the time frames for keeping records and for the safe storage of confidential information.

This was an ongoing breach of regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

The people we spoke with said they felt safe at Donwell House.

A new safeguarding file had been introduced which included a new log of information on the alert, the multi-disciplinary team members involved in the care, who the lead staff member was, an update and whether the CQC had been notified. For a recent concern an enquiry form had been completed which included a deadline for completion of the investigation.

An earlier log was in place which included a brief summary of the concern with an outcome. This recorded concerns from 8 August 2016 onwards. There was no information of any concerns before this time.

An accident file was in use for October 2016 and recorded any falls or accidents. The manager explained it was a new system and they wanted staff statements for any accidents as well. We found one had been completed in relation to a fall where a person had attended hospital due to a bump to the head.

We observed nurse call buzzers were responded to in a timely manner and people confirmed that buzzers were responded to quite quickly. During the inspection one person slipped in the bathroom. There was a quick response from the care staff, manager and nurse. The person recovered and was soon in the dining area having their meal.

Since the last inspection we saw recruitment practices continued to include the receipt of two satisfactory references and a clean disclosure and barring service check (DBS). DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

Nursing and midwifery council nurse pin number checks had been completed and were in date.
For agency staff the manager received a profile which included information on the DBS check and NMC checks for the nursing staff.

People told us they got their medicines regularly. One person said, "The girls are quite capable. I've got no complaints." Another person said, "The problem is that it's a different agency nurse who's on nightshift and they don't understand what's needed."

All the medicine administration records we checked were completed in full apart from one person's. We spoke with the clinical lead who looked into this and confirmed the medicines had been administered but they had not been signed for.

Inadequate

Is the service effective?

Our findings

During our last inspection we found breaches of regulations. Staff did not have appropriate training to enable them to carry out the duties they were employed to perform. Staff had not received an annual appraisal of their performance. The nutrition and hydration needs of people were not being met. A variety of nutritious, appetising food was not available to meet people's needs. Up to date assessments for nutrition and hydration needs were not being followed. Care and treatment was not always provided in a safe way.

We found some improvements to meeting the nutrition and hydration needs of people but other areas were still in breach of regulations.

We spoke with the manager about training. They said, "There hasn't been any since March [2016]. A matrix has been started." They added, "The clinical lead is checking medicine competencies of the nurses." We asked to look at training records. A training matrix was in place; however the only training it recorded was infection control. 41% of all staff had completed this training in September 2016. We asked the manager to confirm if the matrix meant staff hadn't received any other training and they confirmed that without going through all 66 individual staff files to look for training certificates there was no other evidence of training.

The deputy manager said, "I didn't have any training or induction when I stepped up in July." An agency nurse said, "Staff need dementia and behaviour training, even the permanent staff do." Training had been booked for skin integrity, dementia, Mental Capacity Act 2005 (MCA) & Deprivation of Liberty Safeguards (DoLS), moving and handling, health and safety, safeguarding and medicines. The deputy manager said they wanted staff to put themselves forward for the training in the first instance. This approach placed people and staff at potential risk of harm as training had not been prioritised to ensure staff had the necessary skills and knowledge to effectively carry on their role.

A senior care worker said, "Training is being delivered and will be ongoing which is good. I've had no supervision as yet, a team meeting happened though."

We asked about supervisions and appraisals. The manager said, "I'm going to do every staff member's supervision as a meet and greet before rolling it out to nurses and seniors to be supervisors. Everyone's will be done by November 2016." They added, "I'm hoping to do appraisals in the next six months." We asked the manager to confirm if staff had received supervisions and an appraisal. They said, "It's fair to say they haven't been done."

Of the staff files we looked at none had evidence of induction or probation review. There was no evidence that agency staff had received a formal, documented induction to the service.

These findings were an ongoing breach of Regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014 -Staffing.

The Mental Capacity Act 2005 (MCA and The Act) 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.

One person's friend had signed to give consent to a flu vaccination. We asked the deputy manager if the person had lasting power of attorney for personal welfare which would give them authority to make this decision on the person's behalf. They contacted the friend who said they only had lasting power of attorney for property and finances.

We found some people had letters from their general practitioner (GP) which stated their medicines could be crushed due to difficulty swallowing. There was no evidence of a mental capacity assessment or best interest decision in relation to crushing medicines.

One person also had a sleeping care plan and assessment for the use of bed rails which stated bed rails should be used. A decision specific mental capacity assessment was in place for mobility. It stated the exact decision that capacity was being assessed for was, 'mobility to encourage and assist [person] so that he remains as mobile as possible.' This is a non-specific decision and did not include the use of bed rails.

Decision specific MCA assessments had been completed inappropriately. They were in place for areas of care which were not restrictive, they were not decision specific, and the decision making had been completed by one person only, either a nurse or a senior care worker.

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.

These findings were an ongoing breach of regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment.

For some people authorised applications for Deprivation of Liberty Safeguards (DoLS) were in place. A log was being developed to ensure the manager was aware when authorisations expired, and applications that had been made and authorised.

The manager said, "I'm looking at further training, including staff doing dementia friends sessions, I'm a dementia friend champion and I want a few more to do it by the end of November." One care staff member said, "I've had plenty of training but I'm keen to do more as I like learning."

The relatives we spoke with both confirmed they thought the permanent staff had the skills and personal characteristics to support their family members.

The manager told us, "New staff will have one week of induction including their mandatory training. They will do the care certificate if they are new to care. They will then start on the floor and have at least two days

of shadowing and any further training."

We found some improvements had been made to nutrition and hydration. Food and fluid charts were in place but they did not record a target amount the person needed to be supported to achieve, nor did it include information on any specific dietary requirements. The amount of fluid drank was recorded but there was no specific detail in relation to the amount of food people had eaten.

We observed meal times during the inspection. We noted that drinks were not offered to people until after they had received their meal and it was a choice of orange or blackcurrant fruit juice. Only on the upstairs residential unit did we observe people were offered a choice of hot or cold drinks or both.

One relative said, "The food was terrible but it's improved since the new chef came." Another relative said, "Some of the men are canny sized in here and I worry that they don't get enough to eat." We observed meal sizes to be reasonable but noted all people were asked if they wanted anymore to eat. We raised this with the manager.

A kitchen assistant told us about improvements that had been made. They said, "There's more variety now in the food and the menu, we are still looking at them though." They added, "We have a file from the nurses with everyone's diet notifications so we have all the info we need. Changes come through on the day so we are up to date with people's needs."

We saw that referrals had been made to healthcare professionals, however there was not always information recorded on the outcome of the referral.

One relative said, "Just two to three weeks ago my [family member] needed her catheter changed – it was 10pm at night and the agency girl didn't know how to do it. She phoned for an ambulance but they said it wasn't a blue light job so it would be hours before it would come, so they phoned me. I came at 1.00am in the morning and took her to hospital. They changed the catheter without a problem but we were both exhausted. Then another time the catheter was blocked and [nurse] knew what to do but there wasn't the correct size syringe so again my [family member] had to go to hospital to have it unblocked. I just hope they've now got what they need and the girls are trained." As part of the role of the clinical lead they were assessing nurse competencies, starting with medicines.

Aside from the above relatives confirmed their family members had access to GPs, opticians, hospitals as needed. They said some appointments were made by themselves and others were done by staff at Donwell House. One relative did say, "There doesn't seem to be a chiropodist – I asked about it but they are in short supply." During our inspection the clinical lead challenged one GP practice in order to ensure a person was seen that day by a doctor.

The general appearance of Donwell House has improved with a number of areas being recently painted, for example, corridor walls, lounges and dining rooms. Some of the communal areas, especially doors and bathroom needed some attention and improvements to equipment and décor. Soft seating in the lounges were seen to be stained.

Communal corridors and rooms had minimal pictures to engage and stimulate people and it was noted that a beach themed area which provided reminiscence and sensory stimulation had been removed and painted over. Whilst some people's rooms had name plates others did not and there were no pictures or memory boxes outside rooms to orient people. There was very little evidence of the environment being adapted and decorated to orient and support people living with a dementia.

An environmental audit had been completed by the provider in June 2016 but this had not been seen by the current manager and many areas noted for improvement were still in need of attention. We spoke with the manager who said environmental work was ongoing. Staff were aware that some baths were being replaced and they were expecting new seating. The manager also explained that themed areas would be developed to provide stimulation; particular reference was made to the future development of a chip shop area.

Requires Improvement

Is the service caring?

Our findings

During the inspection we observed interactions and engagements between people and staff, some of whom were agency staff members. We saw that staff spoke to people kindly however the quality of engagement and relationships varied.

Some staff diverted people's attention when they were upset however we saw one person who repeatedly banged on a locked door in between the units in the home. This happened several times during the inspection before staff approached them and diverted them to another activity. We noted several people on the ground floor nursing unit enjoyed walking around. They frequently tried to exit the area and spent time sitting with the inspectors for prolonged periods, with no staff presence to ensure they were safe or to enquire as to their whereabouts. This was particularly so for one person who was assessed as needing 15 minute observations from staff.

We observed some people who needed staff to support them to eat their meal. Engagement varied and it was noted that some agency staff provided very little meaningful interaction with people and repeatedly asked, "Is that yummy," and "Open your mouth." One agency staff member was observed to touch a person's mouth repeatedly with a spoon of food whilst they were still chewing food. This was raised with the manager.

Another person who needed support to eat their meal was supported by three different care staff during one mealtime. There were gaps between each staff member's support which meant there was inconsistency and disruption to the person's mealtime experience.

Plate guards for three people were provided part way through the meal time which meant they had initially struggled to eat their meal. Some people had finished their main course by 13.00 but waited at the table for 40 minutes before being served their pudding. During this period of time some people left the dining room and others became anxious and agitated with the delay. We spoke to the manager about this who said, "We have started doing dining room observations and once we have a few more they will be analysed for trends and improvements." We saw the observations were recorded.

These findings were a breach of regulation 10 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014 - Dignity and respect.

The permanent staff had warm relationships with people and engaged people in general conversation whilst supporting them with their meal in a personalised manner, prompting people appropriately, explaining what their meal was and waiting for the person to finish each mouthful before offering more.

One person told us, "I've got no complaints about the care, the girls are great." Another person said, "You can get anything done if you just ask them." A third person said, "Some of the girls are really nice, the ones on today are great." A relative said, "I've got no issue with the girls or the care but things need to improve and it is improving little."

People were observed to be comfortable with the staff, and all staff knew people's first names. We observed a minimal amount of meaningful engagement and interaction unless staff were providing refreshments or actively engaging people in support. This was especially evident from some of the agency care staff.

All the people and relatives we spoke with expressed the view that staff were generally caring, helpful and supportive and that staff sought permission before providing any care or support. Three people we spoke with who had limited verbal communication, nodded in agreement when we asked if staff were kind, caring and helpful.

People confirmed their privacy and dignity was respected at all times and that staff knocked on doors before entering. Relatives also confirmed this and told us they were aware of their family member's care plan.

We observed staff supporting people using the hoist. Staff were sensitive to people's needs and when one person became distressed one member of agency staff took the lead in offering reassurances and calming the person. They kneeled down so they were at eye level with the person and explained what they were doing and why whilst also using appropriate touch to soothe the person. Once they were calm staff continued with supporting person and completed the move in a safe, confident and swift manner in order to reduce the person's distress. The staff member who had taken the lead spent time with the person once they were safely moved, again offering reassurances and explaining why they needed to move.

The manager said, "Care seems alright, the staff are generally caring." One care worker said, "I love it here it's absolutely great. I love looking after people."

Residents meetings had taken place in September 2016. Discussions included activities, meals and menu planning, building renovations and refurbishments and future events. The activities coordinator told us residents meetings happened each month.

Inadequate

Is the service responsive?

Our findings

During our last inspection in March 2016 we found breaches of regulation. The provider did not do everything that was reasonably practicable to make sure people using the service received personalised care and treatment that was appropriate, met their needs and reflected their preferences. Care and treatment was not provided in a safe way. Assessment, planning and delivery of care was not based on appropriate risk assessments.

We found improvements had not been made.

We spoke with the manager about progress made in relation to care records. They said, "They aren't fit for purpose. We started implementing new care plans last week. Starting with the higher risk people first. We are looking at end of December to have them all on the new format." A senior care worker said, "I write care plans, we are taking a look at them and sorting them. A new system is coming out. [Clinical lead] is taking a good look at things." An agency staff member was asked about care plans. They said, "I've not really had a chance to see them. I've heard rumours though. They need updates and evaluations." This meant agency staff were supporting people without having read care plans and were reliant on handover of information and shadowing to ensure they were supporting people in a safe and appropriate manner.

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.

One person had a letter from their GP stating tablets could be crushed due to swallowing difficulties. The care plan stated, 'Will put tablets in [their] own mouth from a pot or spoon. [Person] has no problems swallowing tablets.' This meant staff had access to contradictory information in relation to the persons care.

The same person had been assessed as being at risk from falls. A falls care plan dated 14 August 2016 stated, '[Person] has cognitive issues around the use of bed rails and lap belts so these are not used.' An assessment for the use of bed rails had been completed on 13 October 2016 which concluded bed rails should be in place. It also stated that a care plan was in place. A sleeping care plan dated 14 October 2016 included the use of bed rails however this information had not led to an update of the falls care plan, mobility care plan, mobility and falls risk assessment or the moving and handling check list. This left the person at risk due to contradictory and out of date information within care records.

Another person had contradictory and out of date information in their care records. Their continence assessment but this did not include information on the products they used. Their continence care plan stated they may require help from one staff member however their moving and handling checklist stated two staff were needed for toileting with the use of a stand aid and sling. Their care plan for personal care stated they needed support from one staff member to have a bath and assistance to get in and out of the

bath but again, it did not specify what assistance was needed. An evaluation stated two staff needed to offer support however this had not led to an update of the care plan.

A further person had care records which lacked detail. Their personal hygiene and skin integrity care plan stated staff were to assist with daily hygiene and dressing but there was no detail on what support was needed or how the person liked to be supported. It stated they needed the assistance of two staff when getting in and out of the bath, but did not specify what support was needed. An evaluation stated the person could become resistive to care interventions and become agitated and at times aggressive. There were no specific strategies for staff to follow in these situations placing themselves and the person at risk of harm or injury.

This person had a care plan for behaviours/moods which stated staff should try distraction and de-escalation techniques but it did not explain what these techniques were or what worked best for the person.

We saw no evidence in relation to pain assessment and the Abbey pain tool was not being used for people living with a dementia. The Abbey pain tool is used to measure pain for people who cannot verbalise.

Evaluations of care plans were completed on a monthly basis until August 2016, however most care plans we reviewed had not been evaluated beyond this point.

These findings were an ongoing breach of regulation 12 and 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment and person centred care.

Two activities co-ordinators were in post and a third was due to start in post. Activities plans were in place and were on display in each unit. There were no pictures on the plan to support people to understand the activity.

We saw some people were engaged in arts and crafts or playing board games. Some people were supported to attend Roker lights which they enjoyed. Some people also joined in with a reminiscence/memory discussion one afternoon.

We spoke with the clinical lead about activities. They said, "I'm working on getting the care right first, then I can focus on care plans. The staff are a great bunch here. There was too much duplication in paperwork for staff to complete so I'm trying to address that." The activities coordinator said, "We put a new activities timetable up every week. We try and change it so people get variety. We do arts/crafts, reminiscence, jigsaws/puzzles, discussion groups, bingo, movies, singalongs, go bowling and out for walks." They went on to say, "We run sweets trolley and also have an activities trolley with games, books, arts and crafts and sell toiletries. We've asked for training or people who can't come out of their rooms. We're trying to improve the activities and would like to do more sensory activities. They added, "We organise trips out and have events in the home such as a visit from the discovery zoo, miniature ponies and PAT dogs. We fill the 'This is Me' document in with the family. We're trying to compile an activities book with people's individual interests."

The manager explained that as with records for safeguarding concerns and accidents and incidents they were unable to find information for complaints received before August 2016. The manager had introduced a new system though and was addressing one complaint that a person had made in an appropriate manner. One person said, "There's nothing to complain about, everything is just fine."

We asked about resident and relatives meetings. One relative explained they had not been aware of any meetings for about a year and another said that there had been a meeting a couple of months ago but only

two relatives attended because no-one else knew about it. The manager had dates for future meetings on display and explained they were going to arrange to have the dates sent out to relatives.

Inadequate

Is the service well-led?

Our findings

During our last inspection we found breaches of regulations. The registered manger had failed to demonstrate the necessary competence, skills and experience to manage the carrying on of a regulated activity. Systems and processes were not established and operated effectively to ensure compliance. Systems did not assess, monitor and improve the quality and safety of the service. They did not assess, monitor and mitigate risks. Accurate, complete and contemporaneous records of care and treatment were not maintained. Feedback was sought but not acted upon to improve quality. The provider did not ensure audit and governance systems were effective.

During this inspection we found improvements had not been made. The service had been without a registered manager since 29 April 2016. The registered manager had their registration cancelled through enforcement action following findings at the last inspection. Since that time there had been several managers in post. The most recent manager commenced their employment on 3 October 2016 and as such were not yet registered with the Commission. A temporary clinical lead was in post who had a specific brief to develop standards and oversee clinical practice.

We found lessons had not been learned in relation to the safe management of the premises and fire safety despite a public prosecution in relation to multiple breaches of fire regulations.

We looked at quality assurance and governance systems and found the provider had continued to fail to operate an effective system to assess, monitor and improve the quality and safety of the service.

An action plan had been developed by the provider following the last inspection but the current manager said they had not seen this action plan. An improvement plan dated 22 May 2016 with progress updated on 5 September 2016 was sent to the commission. During the inspection we found that areas in this improvement plan which had been recorded as being completed had not been effective in ensuring improvement. For example, the improvement plan stated, 'An audit of all unit medications has been completed and an action plan is being produced.' This was recorded as 'completed.' We saw no evidence of the audit or action plan during the inspection. The most recent audits of medicines were dated April and May 2016. There continued to be concerns found in relation to the management of medicines.

The improvement plan also stated, 'A full audit will be done of all legal aspects to support and protect residents in the service. This will include; mental capacity assessments, DoLS, DNACPRs (do not attempt cardio pulmonary resuscitation) and power of attorney.' It was stated this has been completed. We saw no evidence of this audit, nor did our findings during the inspection confirm that action had been taken in relation to these areas of care.

This improvement plan did not include care records as an area for development, even though the original action plan stated all care plans would be audited and all care plans where the need for improvements had been identified would be rewritten. The original target dated for this was 29 May 2016. The findings from this inspection were that care records, including care plans and risk assessments still required a full audit and

improvements.

The overall findings of this inspection, specifically in relation to the ongoing breaches of regulation noted throughout this report, do not support the providers own assessment of progress and completion of actions as detailed in the improvement plan.

The provider had also completed an environmental action plan which was sent to the Commission in June 2016. The manager told us they had not seen this plan, and an update on action taken had not been received by the Commission. The manager did tell us the home was undergoing refurbishment and redecoration and we saw there had been some new flooring in some areas and some redecoration. We found no evidence to support changes in relation to creating a dementia friendly environment nor could we see that many of the actions noted as being needed within the kitchen area had been completed.

We spoke with the manager about quality assurance, audits and governance. They said, "There's been no meds audits to date and no care plan audits. There's been no audits of anything other than the ones I'm introducing. Meds audits were handed out yesterday; there's been none since March 2016."

We looked at audit files and found care plan audits and infection control audits had not been completed since the last inspection. A catering audit was last completed in May 2016 and scored 92%.

The manager told us that some records, as detailed in safe and responsive, could not be found for the period prior to August 2016. This meant the provider had failed to maintain records in relation to the management of the regulated activity at Donwell House.

These findings were an ongoing breach of regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

One relative told us, "It's been badly run for a long time. I'm hoping the new manager will bring it up." They went on to say, "I thought Donwell House was going to close so I've been looking at other places but I think the new manager will bring it up. There's not many visitors come and I asked one of the carers about this and she said they don't encourage visitors. I told her, they won't stop me coming." Another relative said, "Things are improving a little. The food was terrible but it's improved a bit since the new chef came." The manager told us they were encouraging relatives to visit and to attend relatives meetings.

The manager said, "We had a team meeting last week, there's been no support, no leadership or guidance and no consequences. Some staff are coming forward with ideas and suggestions, especially the activities staff."

One staff member said, "It's been a difficult few months and it's not easy working with so many agency staff but hopefully things will improve with the new manager." The activities coordinator said, "The new manager is supportive and it seems as if they are really listening [to staff]. The atmosphere has changed completely since [manager] came here. Things are much better and staff feel much more supported now than before."

The deputy manager said, "Staffing levels are being maintained with the agency staff. Meals have improved, we have a new head chef. We are trying to pull staff around in terms of trust. Changes in management is unsettling and [staff] need familiarity." They added, "We are bringing in new paperwork. You can see [manager] and [clinical lead] are leading and taking control. I'm going round the floors and putting things right, spot checking."

A senior care worker said, "Things are starting to happen. Morale is low, there's disruption from managers leaving, but there's a new manager is place." Another senior care worker said, "There's been lots of change in the company and the managers; lots of paperwork change but it seems this company are investing in the home, there's agency staff rather than just working short. We've had meetings about getting things done to get back to a good reputation. Lots of changes but positive. New equipment is being brought in." They added, "Care plan training is coming in and fire training, it's much better to have face to face training. [Manager] said he is going to do everyone's supervision, we've had team meeting. He's supportive which has been lacking, morale is on the up. A few staff have left and those who don't want to adapt will but we are definitely happier. We get praise and [manager] comes out and speaks to people, makes positive comments."

An agency worker said, "I love it, lovely staff. Everyone's a bit worried due to all the changes but it seems to be getting on the ball. You can see improvements, the atmosphere, its feeling better. Staff need guidance though, there hasn't been enough. There hasn't been enough praise either, there's more now though."

Team meetings were recorded in June and August 2016 and included infection control, health and safety, and handover. There was no recorded discussion in relation to actions plans to improve the quality of the service provided for people.

The new clinical lead told us, "We are working hard to prioritise the things that need actioned, including replacing flooring in people's rooms and a lot of regular deep cleaning as well as updating and reorganising paperwork to make it more effective." They went on to say, "I'm here to drive forward the care and provide clinical leadership. To introduce effective and person centred documentation. I'll be supporting the new permanent nurses and oversee care on a daily basis. My role is really to bring the care up to a higher standard. I believe [manager] is solid, has control of things and will bring the standard up." They added, "My role's also about role modelling, I've been on my knees cleaning mattresses and scrubbing, if they see me doing it they'll learn they need to do it too. I've trimmed back the documents for care staff with a priority on nursing clients. Things need to have a purpose."