Shaftesbury Care GRP Limited

Donwell House

Inspection report

Wellgarth Road
District 2
Washington
Tyne and Wear
NE37 1EE

Date of inspection visit:
09 March 2016
10 March 2016
14 March 2016

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
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 9, 10 and 14 March 2016 and was unannounced. We inspected Donwell House in May 2014 and found it was not meeting all legal requirements we inspected against. We re-inspected in September 2014 and found improvements had been made.

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 57 people using the service; 30 of whom needed nursing care.

A registered manager was registered with the Care Quality Commission (CQC) at the time of the inspection.

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.

Medicines were not managed in a safe way. Protocols were in place for 'as and when required' medicines however they did not contain specific instructions for staff to follow in relation to dosage, time between medicine administration and indicators that a person may need their medicine.

The recording of transdermal patch applications was not robust, nor was the recording in relation to topical medicine applications, such as prescribed creams.

Risk assessments were completed but did not effectively assess and mitigate the risks to the health, safety and welfare of people. Some risks had not been assessed.
People were not safeguarded from the risks of receiving improper care and treatment because care plans and risk assessments were not sufficiently accurate and up to date to ensure care and treatment was appropriate to their needs.

Care plans were not sufficiently detailed, accurate or up to date to ensure people received person centred care and treatment appropriate to their needs.

People were unhappy with the variety of meals offered to them and they said meals were not appetising.

Staff were not effectively following care plans in relation to monitoring people's nutrition and hydration needs; specifically with regards to monitoring people's weight.

Emergency plans were in place, however personal emergency evacuation plans and the service user

evacuation register did not contain accurate information in relation to people's needs and the equipment they needed or used, such as oxygen therapy.

Quality assurance and governance procedures were not operated effectively to assess, monitor and improve the quality and safety of the service. Identified actions were not followed up and re-audits were not completed to ensure improvements had been made.

Feedback from people and their relatives was sought but it was not fully acted upon to improve the quality of the service people received.

Staff had not attended refresher training in practical moving and handling skills, nor had they attended care planning and risk assessment training.

A high number of staff had not received an annual appraisal.

Safeguarding alerts and concerns and accidents and incidents were recorded and reported to the appropriate professionals. Analysis was completed for any trends and lessons learnt were discussed.

A dependency tool was used to assess the number of staff needed to provide care and support for people. The registered manager was increasing staff levels based on the outcome of this tool.

Safe recruitment procedures were in place, which included disclosure and barring service checks.

Compliance with the completion of ELearning was high and all staff had regular supervision with their line manager. Staff told us they felt well supported.

Applications to deprive people of their liberty, known as deprivation of liberty safeguards (DoLS) had been submitted to the supervising body and where they had been authorised associated care plans were in place.

People and their relatives told us staff were kind, caring and compassionate and treated people with dignity and respect.

A range of activities were on offer and people and their relatives were actively encouraged to share ideas for events and to enjoy activities together. Community presence was very evident with people being involved in community events in the local area.

Formal complaints were recorded and responded to.

The overall rating for this service is 'Inadequate' and the service is therefore 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.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

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

Staff understood safeguarding but people were not always safeguarded from improper care and treatment.

Risk assessments did not reflect accurate and up to date information. Some risks had not been assessed.

The emergency evacuation register did not detail accurate information and personal emergency evacuation plans had not been completed in full.

Recruitment procedures were in place.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not happy with the food they received and had requested more variety.

Staff meetings were not held on a routine basis, and did not meet the registered managers' expectation for frequency.

Staff had not attended practical moving and handling refresher training.

Not all staff had an up to date annual appraisal.

Deprivation of Liberty Safeguards (DoLS) had been applied for and authorised where applicable.

Is the service caring?

Requires Improvement

The service was not always caring.

Care plans were not written from a caring and person centred perspective.

People felt able to speak with the care staff or registered manager if they had any concerns; however their concerns were not always acted on in a caring and respectful manner.

People and their relatives told us staff were caring, helpful and supportive.

Advocacy services were involved with some people.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans did not contain specific detail for staff to follow which meant people may not receive appropriate care and support.

Care plans were not updated in a timely manner following changes to people's care and treatment plans.

Staff told us they did not have time to read care plans and relied upon the handover to inform them of changes to people's needs.

A range of activities were available for people, specific activities for men were available.

Formal complaints were logged and responded to.

Is the service well-led?

Inadequate

The service was not well-led.

Quality assurance and governance systems were not operated effectively to assess, monitor and improve the quality and safety of the service.

Audits were not completed in a systematic or regular way, nor were actions confirmed as being completed.

Feedback was sought from people and relatives although it was not always acted upon to improve the quality of the service.

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.

This inspection took place on 9, 10 and 14 March 2016 and was unannounced. This meant the provider did not know we would be visiting.

The inspection team was made up of one adult social care inspector, one specialist advisor with a nursing background and one expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in dementia care.

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

We also contacted the local authority commissioning team, Clinical Commissioning Group and the safeguarding adult's team. We also spoke with the dietetic service.

We 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 11 people living at the service and four relatives. We also spoke with the registered manager, the deputy manager, three nurses, four care staff, one activities coordinator and a kitchen assistant.

We reviewed six people's care records and five staff files including recruitment, supervision and training information. We reviewed medicine records for 11 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

We looked at how medicines were managed to ensure safe administration. Medicines were listed in people's care files; however it was difficult to identify current and discontinued medicines. We saw one person had experienced an adverse reaction to a medicine; however this was not recorded on their medicine care plan or medicine profile.

One person had a handwritten note on their medicine administration record (MAR) which stated, 'advised crushed only if film coated.' The provider's medicine policy dated June 2014 stated, 'once the handwritten entry has been checked against the FP10 by two members of staff one of whom must be a trained medication administrator, both members of staff must then sign and date the MAR chart handwritten entry.' This entry had not been countersigned so the provider's own policy had not been followed.

Topical medicine application records (TMARs) were used for people who had been prescribed creams, however there were inconsistencies in the completion of the records. One person had no TMAR for the recording of prescribed creams. In the nursing unit we viewed 20 TMARs of which only four had been completed. A staff member said, "The nurses put the sheets in the file." They were unable to provide any further explanation as to why the TMARs had not been completed.

Transdermal patch application records were used to show the patches people were prescribed, including the instructions for use and associated body maps. For one person we saw the patch had been applied on 4 March 2016 and removed on 8 March 2016 but the MAR had been signed each day with no indication of why. For another person there were gaps in recording on 7 March 2016, 29 February 2016 and 1 February 2016. There was a record which stated, 'two patches removed.' The provider's medicine policy dated June 2014 stated, 'the next due date for patch change should be entered on the transdermal patch form.' This was not evident which meant the provider's own policy was not being followed.

Written guidance was kept with the MAR charts for the use of 'when required' (PRN) medicines, such as pain relief or medicines to reduce anxiety and distress. Protocols were not specific. One person had been prescribed lorazepam, the dose and maximum frequency in 24 hours was recorded as, 'half a tablet as necessary twice a day.' The length of time between doses was recorded as 'as required.' There was no specific instruction on the prescribed dose of if there was any guidance from the prescriber on the period of time needed between doses. The description of why the medicine had been prescribed and how it affects the person was noted as, 'anxiety, agitation.' It was not clear if this was why it had been prescribed or if this was how it affected the person. There was information in relation to a description of behaviours exhibited that may indicate the person needed PRN medicine. This stated, 'becoming agitated, verbal aggression, wanting to get out/go home.' Agitation and aggression were not well described indicators.

PRN instructions for two other people had no description of the behaviours which may lead to their PRN medicine being considered for administration. This meant people were at risk of inconsistent administration of medicines.

One person's risk assessment for pain management stated they could be administered, 'Co-codomol 500mg two up to eight times a day.' The British National Formulary (BNF) states, 'dose ADULT over 18 years, 1–2 capsules every 4–6 hours when necessary; max. 8 capsules daily. The registered manager said, "It's an error it should be four times a day." Had staff followed the instruction in the risk assessment, rather than the MAR the person was at risk of being overdosed.

The BNF was available for staff but was dated March 2010. The medication policy stated, 'an up to date copy of the BNF should be kept with the medication trolley for reference use by staff administering medication.' The most recent publication was 2016.

Risk assessments were completed and signed by the assessor but the space for them to be approved by the line manager was blank. We found information was not always an up to date reflection of the care and support people needed. For some people with specific diagnoses such as epilepsy we found risk's had not been assessed or mitigated against which meant they were vulnerable to potential harm.

One person had a care plan for mobility which recorded they used a four wheel rollator and had been assessed as needing a wheelchair. Over two months later the person had not received a wheelchair so we spoke to the registered manager. They said, "They must have come in with the zimmer." Their initial assessment stated they were independently mobile. The registered manager said, "The district nurse would have done the assessment, we have chased it, it should be recorded in the professionals contacts." We looked through the file together and could not find it.

The evacuation register for this person stated they were independently mobile and did not need any staff support. Their personal emergency evacuation plan (PEEP) stated they walked unassisted and required no equipment to aid mobilisation. This information was incorrect as on the second day of inspection the registered manager had been through the archived documents and confirmed the district nurse had provided the zimmer frame which had been triggered by a referral to the falls team.

Another person's moving and handling risk assessment stated they were at moderate risk as they could resist. The care plan stated the risk score was influenced by the person's behaviour. The aim was that, 'during any moving/handling activity staff to promote safety at all times as behaviour can have an impact on moving/handling activities.' The care intervention stated '[Person] can mobilise independently.' We spoke with the registered manager to seek clarity on the person's needs. They said, "They are definitely independent," They added, "It needs clarity and rewording of the care plan and a review of the moving and handling assistance." This meant incorrect information about the person's mobility had been recorded and not identified by staff who should be following the care plan and risk assessment.

Falls risk assessments and falls logs were in place, however we saw for one person there was a record of falls, but this information had not been included in the falls risk assessment or falls log. This meant the assessed risk may not have been reflective of the number of falls the person experienced and as such appropriate action may not have been taken to address the concerns.

People had PEEPs in their care records as well as in a fire safety file. We saw one person's PEEP stated the room number they lived in which was different to the room number recorded on the service user evacuation register. We spoke to the registered manager about this who said, "They moved five days ago. I'll update it today." We also noted that the PEEPs contained in people's care records did not routinely have the risk level completed nor were questions answered about whether people had medicines which made them drowsy. One person who had prescribed oxygen therapy did not have this recorded on the evacuation register which meant the necessary information may not be readily available to the fire service in the event of an

emergency.

This was a breach of regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People were not appropriately protected from harm or improper treatment.

One person had attended a review meeting, this documented concerns with regard to money going missing from the persons room and another person entering their room. We asked the registered manager about this who said, "I'm not aware of that." They added, "I didn't know they had money in their room". The registered manager agreed to address this as a priority. We asked about the person going into other people's rooms, they said, "They now have one to one support." At the time of the concern being raised no action had been taken to safeguard these people from harm or abuse.

One person was living with epilepsy. The care plan stated if the person was to show signs of having a seizure staff were to ensure safety by removing objects and place the person in the recovery position. There was no information on the type of seizure the person experienced, any triggers or what a seizure might look like. There was no specific risk assessment in place or identified control measures other than the person being prescribed medicine for the management of epilepsy. The care plan stated the assessed need/risk as being, 'at risk of having seizures.' There was no evidence that an assessment of bathing risk in relation to epilepsy had been completed. It was noted that the person had been re-assessed as high risk of falls in August 2015 due to experiencing an increase in falls. No investigation or thought had been given to whether this could indicate an increase in seizure activity, which meant the person may have been at risk of not receiving appropriate treatment and intervention. We asked the registered manager about this who said, "They haven't had a seizure while they've been here." This meant staff did not have the information they needed to support them to recognise if the person was experiencing a seizure. Nor was the person being protected from potential harm in relation to the safe management of epilepsy.

We saw one person had renal failure which staff were directed to monitor. There was no information in the care records about what staff needed to monitor, nor did we see any evidence of monitoring sheets. This meant the person was not being protected against improper treatment because there was no information for staff on how to safeguard the person from the risk of renal failure.

This was a breach of regulation 13 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Assessments had been carried out which identified if people were at risk of developing pressure ulcers. Care plans detailed the action staff should take to maintain people's skin integrity and evidenced access to specialist support such as the tissue viability nurse.

Continence assessments and care plans were completed. However, one person had an evaluation dated February 2016 and the following one was January 2016. This meant errors had been made in the recording of evaluations.

One relative said, "[Family member] has complex problems but they are managing to balance them all to keep them safe and well." One person said, "Most of the time I feel quite safe. I shut my door sometimes because people wander about – the person across the way wanders about and I get frightened." The registered manager explained that some people received one to one support due to their needs.

A safeguarding file was in place with the relevant policy and procedure. Concerns and alerts were logged. We asked about outcomes and lessons learnt. The registered manager said, "I keep the minutes of meetings in a separate file but I can put them all together. We look at lessons learnt in team meetings, supervision and manager's meetings."

Accident and incident forms were completed and plotted onto an analysis document. The registered manager said, "It all goes onto the system and it's reviewed by the regional manager for trend analysis. The same with safeguarding's. They get back to us if there's anything noted."

An emergency contingency plan was in place which included the actions staff needed to take should people need to be evacuated from the building or if there was a loss of utilities or an infection outbreak.

We saw the fires zones in the nursing unit and the residential units were numbered the same. A nurse said, "If there was a fire one carer stays on the floor and we report to the panel. There's a picture frame next to each panel to identify the unit, but the zones are numbered the same." We asked about drills and they said, "The alarms are set off on different shifts, they use posters to tell us where the fire is to see how we manage. We don't do actual evacuations." We saw there were two fire panels; each one had a poster next to them identifying the specific zones.

Fire log books were completed and if deficiencies in lighting or doors were noted this was reported and actioned. A fire risk assessment was in place however we did not see evidence that the review date of November 2015 had been met. All the actions were recorded as 'actioned' but there was no date or signature to confirm completion.

An electrical installation condition report, gas safety checks, lifting equipment checks and so forth had been completed and where action was needed there was evidence that this had been completed.

A staff dependency tool was used to assess the level of staffing needed to meet people's needs. The registered manager said, "We are increasing the staffing based on the dependency tool, so we will have an extra staff member." We asked a nurse if there were enough staff. They said, "Yes, I think so, its high dependency so we are looking at [recruiting] more qualified nurses as it can be quite intense."

Appropriate recruitment procedures were in place which included, application forms and interview notes followed by the receipt of satisfactory references and disclosure and barring service checks (DBS). DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. If potential areas of concern were noted at the recruitment stage risk assessments were completed prior to staff being offered a post. The registered manager confirmed they had authorisation to appoint based on the outcome of the risk assessment. The registered manager also completed a check of nurse registrations prior to them being offered a post and on an ongoing basis.

We found systems were in place to ensure medicines had been ordered and were securely stored.

We observed staff checked people's medicines against the MAR before administering them to make sure people received the correct medicines. Staff explained what medicine people were taking and why, offering people time and support to take their medicines safely. MARs were initialled by staff to evidence medicine administration.

Arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse. We saw a daily stock balance, to ensure that the balance

documented tallied with the actual quantity of controlled drugs available.

Temperature checks of the medicine fridge were completed, as were those for the treatment room. These were within the recommended temperature ranges. This meant that the quality of medicines would not have been compromised, as they had been stored under required conditions.

The provider's policy in relation to covert medicines stated, 'The home should provide an objective assessment of the person's needs and proposed care or treatment, in this event the procedure for evoking a Best Interest Decision via the locality DoLS team should be followed. The method and initiation of administering medication must be discussed with the pharmacist and medical officer of the service user to establish the least intrusive method of administration."

Some people had letters from their General Practitioner (GP) authorising medicines to be administered covertly, i.e. crushed into food or drink. Family members had been consulted, and pharmacists had been contacted where there were queries. We did not see that a formal best interest meeting had taken place with the GP, the pharmacist and the care home staff to agree whether administering medicines without the person knowing was in their best interests, as recommended by the National Institute for Health and Care Excellence (NICE) guidelines. However, liaison and consultation had happened with all relevant parties. Letters from the GP authorising covert administration had been received.

Requires Improvement

Is the service effective?

Our findings

We asked people about the food. One person said, "The food's not very good and it's repetitive. We've brought it up at residents' meetings about wanting to have more vegetables like butter beans, new potatoes and different greens because all we seem to get is soft mash that falls off your fork and green beans but it does no good because nothing changes." Another person said, "The food's not very good. There's no variety. Look at today – fish & chips or Tuna pasta, if you don't like fish you've had it." We spoke with the registered managers about people's feedback on the food and they said some changes had been made.

There were systems in place to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs however, instructions were not always acted upon.

One person had been assessed as needing a low potassium diet but this was not recorded in the nutrition section of the care records. This left them vulnerable to the risk of receiving a diet high in potassium which may have led to harm.

People were assessed using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults were malnourished or at risk of malnutrition. Where people were identified as being at risk of poor nutrition staff completed daily 'food and fluid balance' charts. The food charts recorded the food and fluid a person was taking each day. Portion sizes and food and fluid goals were not recorded. This meant there was no information for staff on the amount of food or fluid people needed to aim to eat and drink each day and therefore monitoring was not effective.

One person's nutrition care plan stated daily weights should be recorded, this had not been implemented and weekly weights were noted. This meant staff were not following the direction in the care plan. The registered manager said, "No, we wouldn't do that it's weekly, it's an error on the care plan." This person had been losing weight and we saw an entry stating staff had contacted the GP. There was a professional record for a GP visit which noted a referral to the dietitian. There was no evidence of a referral or review by a dietitian in the records which meant the person may have been at risk due to lack of professional healthcare involvement. The registered manager said, "I can't see it."

For another person we saw records which showed they had lost 10.3kg between January and February 2016. The community cardiac nurse had visited the person and advised daily weights and twice weekly blood pressure. There were gaps in daily weight monitoring on five days in February 2016 and no weight monitoring had been recorded since 27 February 2016 to the date of the inspection. This meant staff were not following the advice and guidance of the community cardiac nurse.

One relative said, "[Family member] has carpal tunnel syndrome and can't grip a glass. They always leave a glass of water but [person] is too frightened to pick it up because they can't grip it and it will slip." We spoke with the registered manager about this who commented, "Oh." The registered manager was asked to address this and action will be taken to ensure this person is supported appropriately.

This was a breach of regulation 14 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We saw one person had been seen by the cardiology nurse but there was no information in the care plan as to the reason for this appointment or the outcome. When going through the archive section of the care file there was a letter from the cardiologist who was going to discuss future plans with another healthcare professional. We asked the registered manager about the future plans; they said, "There's no formal system to chase or act, all information would be part of the care planning process." This meant follow up information may not have been sought by the staff so people may not have received care and treatment appropriate to their needs.

Another person had been referred for a scan but there was no information in the care records about the outcome of the scan. The registered manager found this information had been archived following two scans determined no further treatment or investigation was required.

This was a breach of regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the support and training that was available for staff. The registered manager told us, "I try to do them [staff meetings] three monthly." We found these meetings had not taken place routinely. There were minutes from a meeting in February 2016 which included discussions around training. It also stated staff were to ensure people were well looked after and well-presented and documentation needed to be completed in a timely manner following intervention. A heads of department meeting had also taken place in February 2016. Prior to that a staff meeting had been held in August 2015 which again included training but also staffing levels, and infection control. The meeting before that had taken place in February 2014. This meant the frequency of the staff meetings had not met the registered manager's own expectations.

We went through training with the registered manager and found 68% of staff did not have in date practical moving and handling training. The registered manager said, "The handyman has done train the trainer and is rolling it out." The registered manager provided us with dates that the training would be rolled out but staff had not been allocated to a specific training date. We asked about care plan training. The registered manager said, "We have done it in the past but it's not on the matrix." They said of risk assessment training, "It needs to be done." We asked whether any staff had had training in oxygen therapy. The registered manager said, "No, I've never been asked about it."

There was an appraisal log in place which showed that 22 staff had not had an annual appraisal. We asked the registered manager if the information on the log was complete and up to date. The registered manager said, "We've worked really on it, but that'll be right."

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

One staff member said, "I feel well trained and supported by the manager. I am supported to develop my skills and I'm doing training now. I get regular supervision." There were high levels of compliance with ELearning such as fire safety, safeguarding, medicines awareness, mental capacity and manual handling. We asked about dementia training and the registered manager said, "It's been done by the majority of staff. It's not on the training log." They added, "Nurses have training in catheter care and PEG feeding."

A staff training and development strategy was in place which specified the delivery of training and refresher

timeframes. The registered manager said, "Parkinson's training is coming up as is stroke awareness." Staff said they attended a lot of training such as moving and handling, fire, food safety, equality, safeguarding and mental capacity. One care staff member said, "We do the mandatory training on the computer." They added, "I've just done my assessor training for the Care Certificate and inductions will be linked to it." The Care Certificate is an identified set of standard skills, knowledge and behaviours for care staff to provide compassionate, safe and high quality care and support.

All staff had attended supervision during February 2016 and had attended four or five supervision since March 2015. Supervisions are used to discuss staff performance and competency and give the opportunity for one to one discussion with the line manager.

We asked a nurse about the support they received; they said, "The registered manager is supportive, they are arranging a qualified nursing meeting to support better communication as we are often on opposite shifts."

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. Applications had been submitted to the 'supervisory body' for authorisation to restrict a person's liberty where it had been assessed as in their best interest to do so. Appropriate assessments were in place to support this. Where authorisations had been approved associated care plans were in place.

One person had conditions applied to their DoLS authorisation. We asked the registered manager about these as the information to confirm the conditions had been met was not easily accessible within the care record. The registered manager was able to evidence that all conditions had been acted upon and met.

Where people had made advanced decisions their care files held do not attempt cardio-pulmonary resuscitation orders (DNACPR's). The DNACPR's had been completed appropriately recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals completing the form. Emergency Health Care Plans (EHCPs) were in place which meant healthcare information was available to inform staff of the person's wishes at this important time, to ensure that their final wishes could be met.

People's records showed details of appointments with and visits by various healthcare professionals for example GPs, community cardiac nurse, tissue viability nurse and the urgent care team.

One area of the building contained a beach themed area with beach huts painted on the walls and items to evoke memories and stimulate conversation as well as sensory and tactile items. There were posters in the units asking relatives for old photograph's of people and information about their past. The registered manager explained this was going to be used to improve the environment for people living with dementia.

Requires Improvement

Is the service caring?

Our findings

Care records were not person centred and were not kept up to date. The lack of detail and completeness meant care plans were not written from a caring and inclusive perspective. People and their relatives told us they could not recall having been involved in care plans and reviews. People's views about the food were sought but this was not acted on in a caring and respectful manner.

One person told us, "Most staff are pretty good but, like anywhere, you get the odd one who isn't."

All the people we spoke with told us the staff were caring, helpful and supportive. They also mentioned the staff treated them with both respect and dignity. One person said, "Carers deserve tremendous credit," They added, "Couldn't wish for better." Another said, "Staff are good, I've no complaints."

Everyone confirmed that staff knocked on their bedroom door before entering and sought their permission before providing care. One person said, "If I need something I just ask and it's usually no problem and I don't have to wait too long."

One relative told us, "The girls are all fine and the manager's great – they know by the look on my face if something's wrong so they ask what's up and we sort things out. Generally I just mention things to the girls and they sort things. The girls are great they understand [family member] because usually it's their mood that causes the problems not what the girls do but they know how to coax [person]."

One person said, "I tend to stay in my room because I don't like mixing but they don't mind. They are always going past the door, so if I want something I just shout – I don't like to press the buzzer."

We saw staff treated people with patience and kindness and spoke to them in a respectful manner. We did note one staff member who referred to some people as 'the wanderers.' We raised this with the registered manager who was considering options for how to address language use with staff. We observed one person enjoying a laugh and a joke with staff, chatting about how they were spending their time and what support they needed. This person was very independent and staff actively encouraged and supported this.

One relative said, "They are great here, they really do care and do everything to make sure [family member] is comfortable."

We observed lunch time and saw people were supported by staff if appropriate and there were specialised cutlery and crockery for people to use if needed. People were not rushed and were given the time they needed to eat and enjoy their meal. Some people had lunch in the dining room whilst others chose to eat in the lounge or in their rooms. One person did wait a considerable amount of time for their meal to be served after lunch had started but staff let them know what the delay was.

A compliments file was in place which contained thank you cards and letters from relatives and friends. Comments included, 'nothing but praise; thanks for the care; thanks for the care and compassion and you

always treated [person] with respect and compassion and maintained their dignity.'

We saw some people had advocates who supported and enabled them to express their views and concerns. Some people also had independent mental capacity advocates (IMCAs). IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions themselves; this includes making decisions about where they live and about serious medical treatment options.

Inadequate

Is the service responsive?

Our findings

We looked at care planning records and found the service was not responsive to people's needs. One person who received specific medical therapy had a care plan which had not been updated following a prescribed change in their medical regime. The changes to the regime were noted in the monthly care plan evaluation records however if staff did not read all the evaluations they would not have known about the change in regime so the person was at risk of receiving incorrect care.

In order to receive the appropriate therapy equipment was provided which needed to be set at a specific rate. It was recorded in the evaluations that the person was changing this rate themselves so intervention had been sought from the equipment provider to lock it at the required rate. This information was not in the care plan, so if the rate needed to change following further assessment staff may not be aware of the need to contact the equipment provider in order for them to reset it.

Some people in the home received oxygen therapy. A policy was in place for the use of oxygen which stated, 'Service users having oxygen therapy should be encouraged to drink or receive mouth care frequently.' We found this information was not transferred to care plans.

We saw one person's professional contacts recorded they had been checked by a respiratory nurse. The recorded outcome was to contact the oxygen nurse but there was no information about the reason for this. However, we saw there had also been a visit by the oxygen nurse. The entry, completed by care staff, stated the oxygen level and a time frame for therapy, but also stated, 'or more if needed.' There were no specifics on whether this was more oxygen or more time, nor how staff would recognise if 'more was needed.' We asked the registered manager about this who said, "It would have been the nurse who said it." The letter from the home oxygen therapy team gave specific detail on the level and time of oxygen therapy the person needed. There was no instruction that staff should offer 'more if needed.' This meant the person was at risk of receiving inappropriate care and support if staff followed the instruction in the professional contacts. It was noted the care plan detailed the specific dose and time frame that the person needed therapy for.

One person had two care plan indices which stated different information, i.e. different identified needs. We did not see evidence of investigation or reassessment into why the person's needs had been identified differently. This may cause confusion for care staff in accessing the relevant information to ensure the person was cared for appropriately.

One person's sleep care plan stated, '[Person] is reluctant to sleep in bed and will sleep in chair in bedroom or lounge, staff to encourage them to sleep in bed due to fluid retention in legs'. We did not see any evidence of an assessment of risk if the person slept in a chair, nor was there detail on how to encourage the person to sleep in the bed.

There were some gaps in the recording of dressing changes. For one person who needed support with both legs there was an initial wound assessment for the right leg which detailed dressing changes on 20, 22 and 30 January 2016 and 3 February 2016 but there was no information beyond that point. There was no on-

going wound assessment record for the left leg. The Waterlow pressure ulcer risk assessment had been evaluated monthly.

We spoke with staff about how they kept up to date with changes in people's care needs. One staff member said, "We don't have enough time to read care plans, we are told in handover, we have the communications book for any major changes such as fluid and nutrition and a daily diary."

We saw limited handover records to evidence that changes to people's needs, daily care, treatment and professional interventions were communicated with staff on a daily basis. Entries in handover sheets were general, such as, 'slept long periods during the day, poor diet, drank well.' Another entry was, 'dressing renewed.' One entry did state, 'see care notes, Frusemide 1 lunch time, insulin 12 am and 10 (this entry was difficult to read) as BMs (downward arrow), poor diet fluids restricted limited to have anything within reason, legs redressed very red, enjoyed soup and yoghurt.' Care staff did say the handover was verbal as well as written however if staff needed to refer back to the handover record it was difficult to assess what this entry was updating the staff about specifically.

This was a breach of regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We found care and treatment records were not sufficiently detailed, accurate or up to date to ensure people received person centred care. As care plans were not up to date or accurate they did not reflect care and treatment that was appropriate or met people's needs.

People we spoke with were not aware of any involvement in developing or reviewing their care plans. Only one relative we spoke with said they had been involved in their family members care plan. This meant we could not be sure that care plans reflected people's preferences for how they wished to be cared for.

This was a breach of regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We asked the registered manager how people were involved in developing their care plans. They said, "People are involved at pre-admission stage. They help build and review the care plans." They added, "There's a form for relatives and residents to sign for their agreement to the care plan, photographs and things." We saw pre-admission assessments were completed before people moved into the home and this initial assessment was signed by the person.

One page profiles had been used to record key personal information about the person, such as what was important to the person and how best to support them. For one person this included, 'support to make choices, maintain privacy and dignity and encourage interaction.'

Communication care plans were in place. Some contained more detailed information than others in relation to how to engage with people who had communication needs. One person's stated, 'staff to say what day and date it is, use pictures and clocks.' This approach meant staff provided some responsive care, recognising that people living with communication needs could still be engaged in decision making and interaction.

One person's care plans in relation to their behaviour management were very personalised and specific. They detailed the exact support staff were to provide, how they should monitor after the incident and who they should contact for additional support if needed. Triggers for the behaviour were well documented so

staff could recognise them and offer intervention before the person became increasingly anxious and distressed. There was also information on why the person may be presenting with the behaviour such as pain, being unwell, being over stimulated or having a low mood. Staff were directed to offer support to resolve the problem by offering the person time, using verbal and non-verbal cues to communicate and to show they were listening to the person.

A complaints file was in place with the policy stating a response would be received within 28 days. Complaints were recorded and a monthly analysis of areas of concern was completed. This included concerns over laundry and the involvement of other professionals. This complaint was fully recorded and responded to with the outcome stating that the family were satisfied with the planned intervention moving forward.
Everyone we spoke with said they could talk to the care staff or the registered manager if they had a concern about anything. One person said they had complained and it had been acknowledged and resolved.

One relative told us, "I complained a few days ago about the state of [persons] toilet pan, nothing happened so I mentioned it again yesterday but it's just the same today – that's not right is it?" This information was not in the complaints log. We spoke to the registered manager about it and they were unaware that a complaint had been made.

There were two activities co-ordinators employed. We saw photographs from various activities including, the discovery zoo who brought various animals into the home for people to touch and spend time with. There were lots of community activities which included events at the local schools and church. A men's group attended the local pub for meals, dominoes and a drink. Local entertainers performed in the home and the photographs showed people getting involved and having fun.

Arts and craft sessions were held as well as baking activities. The activities coordinator said, "I always make a sample [of the thing being made] so people know what it looks like so they have something to copy and can join in." They added, "People might not know what I mean if say Easter bonnet or painting but if they can see one it makes all the difference." Various activities involving gentle exercise were available such as floor dominoes, hoopla, and parachute games. Parachute games provide sensory input and gentle physical exercise for people. The activities coordinator explained they held monthly residents' meetings to talk about activities and if there's anything people want to do or take part in. They said they were given a budget each month but also did fund raising for activities. We saw that people had been out on day trips which relatives were able to attend as well.

A monthly newsletter was produced which included activities and planned events, as well as photographs which people had consented to sharing. These were available at the home for people and their relatives to view.

Inadequate

Is the service well-led?

Our findings

We looked at quality assurance and governance systems and found that systems were not operated effectively to assess, monitor and improve the quality and safety the service.

We asked the registered manager about the process for auditing care plans. They said, "I am supposed to do three a week. They are done by nursing staff, the deputy manager and me."

We found that during January 2016 five people's care records had been audited. The audit consisted of a list of documents which had a tick or a comment in the action required, such as 'needs a signature.' For actions there was a column to record who needed to complete the action and by when but this had not been completed. The audits included a section to record whether findings had been discussed with the named nurse or senior care assistant, and when the actions should be completed by and the date of the re-audit. These sections had not been routinely completed in full. One re-audit was completed almost a month late and two had not been done.

We saw other care plan audits had been completed using a different format. During March 2016 one audit had been completed by the registered manager which recorded some documents as 'incomplete.' Comments stated 'see identified actions' which need to be addressed but there was no record of who was completing the actions and when they should be done by. In September 2015 we saw three audits had been completed. Actions were recorded as being required but there was no evidence of who was completing them or if they had been completed.

We did not see any evidence of care plan audits having been completed from September 2015 to January 2016; some audits had been completed in May and February 2015 but the registered manager's expectation that three care records would be completed each week was not being met.

We saw one audit which had been completed in February 2016 which stated the following recommendations, 'blank MCA, diet notification needs dated and signed and ticked, body maps needs evaluated, relatives communication record needs completed stated completed, social profile needs completed.' We saw a specific date had been recorded for a re-audit of the file; however we did not see any evidence that this had been completed. We looked at the relatives' communication records and saw this document remained blank as did the social profile.

We looked at medicine audits. The registered manager stated that medicine audits were done monthly by the registered manager or the deputy manager. The nursing unit on the first floor had only one audit completed on 29 April 2015 between 31 January 2015 and February 2016. The ground floor nursing unit had been audited January and April 2015 then not until February 2016. The residential first floor unit had audits in July, August and October 2015. The residential unit downstairs had been audited more frequently but not on a monthly basis. There were no signatures on the audits to indicate whether they had been reviewed by the registered manager or the regional manager.

Medicine audits did have actions noted, such as, 'staff signature list incomplete; not all staff received annual updates, 1 staff overdue annual competency checks, room fridge temperatures are being conducted once daily instead of twice daily.' During the course of the inspection we saw some of these actions had been addressed, however there were no completion dates or evidence that actions had been completed recorded on the audit tool.

We asked if any audits were completed by senior managers or the provider. The registered manager said, "The regional manager did one in February which generated an action plan." We did not see this audit or action plan during the inspection.

A health and safety audit had been completed in February 2016 with a self-assessment score of 85% compliance. We saw that on every audit completed from 30 January 2015 to the February audit it was noted, 'not all staff have received moving and handling refresher training' and 'not all staff have completed refresher training in all areas.' There was no evidence of action taken to address these areas of non-compliance rather the findings had been continued over each audit.

We raised the findings of audits with the registered manager who did not offer any explanation.

Systems were in place to seek feedback from people and their relatives. A relatives' survey had been completed in April 2015, the outcome of which was that nine people raised they did not like the food and ten people wanted to be more involved in decision making. A service improvement plan was in place in August 2015 however we did not see any action in relation to food and decision making, it related more to activities notice boards and making people aware of the complaints policy and procedure.

A residents' meeting held in January 2016 discussed activities and birthdays. People were asked if they had any complaints and people said they were very happy. A residents' meeting in February 2016 recorded that people would like a few changes to the meals from time to time and suggestions had been noted. Again in November 2015 people had raised they would like fresh tomatoes instead of tinned, more variety to meals and there were too many jacket potatoes and eggs. The two earlier meetings again raised issues around the menu stating unhappiness with the fish and vegetables being 'over cooked and soggy.' None of these comments had been recorded as formal complaints. The people we spoke with said they were still unhappy with the food and would like more variety.

This was a breach of regulation 7 and 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

A suggestion box was in place and suggestions made included more hand wash and a clock in the foyer area. These had both been completed.

We spoke with staff about the service provided at Donwell House. A nurse said, "We have a bunch of good carers who actually care, the frustrations are over the building but they always fight people's corner." The registered manager said, "We are good at end of life care, activities and accessing the community. Staff training and developing staff, there isn't much turnover, we retain a core group of staff." They added, "We care, there's a nice atmosphere, we hold our hands up if we do things wrong, we do things as a team, there's a no blame culture, we are open and honest." We asked the registered manager if they felt there were any areas for improvement. They said, "The environment really, it's a landlord owned building."

Staff told us they felt well supported by the registered manager. A nurse said, "Their door is always open, they are there to support us."

The registered manager said of their role, "It's everything, health and safety of residents, staff, visitors, to abide by the Regs, provide good quality safe care, well trained staff." They added, "Cleanliness, infection control management, safeguarding, to employ the right staff."

The registered manager said, "Yes, I'm supported, the regional manager is at the end of the phone or they'll come in and support." They added, "It's a while since I had a one to one but I do feel supported." They said they attended managers' meetings which were helpful as they discussed training, company information, lessons learnt, best practice and generally supported each other.

The registered manager said they were doing a 'my home life programme.' They said, "It's helping me look at things in a different way." This is a leadership support programme for care home managers. The programme aims to develop skills, engage managers in evidence-based, relationship-centred practices and resolve complex everyday issues that impact upon the quality of services.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not do everything that was reasonably practicable to make sure people using the service received person centred care and treatment that was appropriate, met their needs and reflected their preferences. Regulation 9(1)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not have appropriate training to enable them to carry out the duties they were employed to perform. Staff had not received regular appraisal of their performance. 18(2)(a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way. Assessment planning and delivery of care was not based on appropriate risk assessments. 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. 12(1); 12(2)(a); 12(2)(b); 12(2)(g)

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment 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. Regulation 13 (1); 13(2): 13(6)(d)

The enforcement action we took:

We took enforcement action which resulted in the cancellation of the managers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs 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. 14(1): 14(4)(a)

The enforcement action we took:

We took enforcement action which resulted in the cancellation of the managers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance 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. 17(1); 17(2)(a); 17(2)(b); 17(2)(c); 17(2)(e); 17(2)(f)

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 7 HSCA RA Regulations 2014 Requirements relating to registered managers The registered manager failed to demonstrate the necessary competence, skills and experience to manage the carrying on of the regulated activity. Regulation 7(2)(b)

The enforcement action we took:

We took enforcement action which resulted in the cancellation of the managers registration.