

Davenport Manor Nursing Home Limited

Davenport Manor

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 23 and 24 November 2016 and was unannounced on the first day.

We last inspected Davenport Manor on 13 and 14 April 2015. At that time, we rated the service requires improvement overall and identified breaches of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one regulation of the Health and Social Care Act 2008 (Registration) Regulations 2014. We asked the provider to make improvements in relation to the supervision of staff, provision of person-centred care based on an assessment of needs and preferences, management of medicines, the safety of the environment and governance and monitoring of the service. The provider sent us an action plan to tell us how they would ensure they would meet the requirements of the regulations.

At this inspection we found the provider had implemented their action plan and had made improvements in a number of areas. However, we identified three breaches of the regulations. These were in relation to the safety of the environment, working within the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards, good governance and keeping accurate records of care. You can see what action we told the provider to take at the back of this report.

We made five recommendations. These were in relation to reviewing guidance and procedures in relation to the administration of medicines, the use of surveillance in care homes, recruitment procedures, assessing staffing levels and the provision of activities.

Davenport Manor is a residential care home registered to provide care and support to up to 34 people. The home is situated in the Davenport area of Stockport close to local shops and churches. There is a regular bus service and Davenport railway station is approximately a quarter of a mile away. At the time of our inspection there were 31 people living at the home.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had not taken adequate steps to ensure the environment was safe for people living at the home. We found window restrictors in place to prevent potential falls from height were not sufficiently robust. The provider had not ensured timely action had been taken to address concerns raised following an electrical safety inspection. We received evidence shortly after our inspection that these shortfalls had been addressed.

Staff told us they had sufficient time to complete all their duties. Staff told us there were sufficient numbers of staff to meet peoples' needs, and people living at the home confirmed they did not have to wait long if

they required any support. Staff told us night shifts could sometimes be hard work but that the on-call manager would provide support if required.

Medicines were managed safely, and staff we spoke with demonstrated a good knowledge of requirements in relation to peoples' medicines. There were no clear instructions for staff to follow in relation to the administration of 'when required' medicines. However, our discussions with staff showed they were aware when to give these medicines and what they were for.

There were no vacancies for care staff at the time of our inspection, which meant care was provided by a consistent staff team. People told us they liked and got on with the staff. Care staff knew people well and were able to talk with us in depth about peoples' needs and preferences.

Care plans were reflective of peoples' current needs and had been reviewed regularly. Staff were aware of the guidance contained in care plans.

We received positive feedback from GPs who regularly visited the service, who told us staff followed their guidance and sought advice when required. We saw a variety of health professionals had been involved in peoples' care, and that referrals were made if health concerns were identified.

People were positive about the food and drink provided. However, peoples' intake was poorly monitored and there were significant gaps in these records. The issue in relation to the monitoring of nutrition and hydration had been recently raised by the provider and had been raised in a previous CQC inspection. Whilst measures had been identified to improve recording; these had not been wholly effective at the time of our inspection. We found daily records of care were sometimes lacking in detail.

Although actions had been taken to ensure feedback from people using the service and other stakeholders was received and analysed, we found continued shortfalls in the systems in place to monitor and improve the quality and safety of the service. For instance, there were no formally recorded medicines audits, and audits of the environment had not identified the issue with the window restrictors.

The registered manager was visible and accessible to staff, relatives and people living at the home. We saw frequent interaction between relatives and the registered manager, and relatives told us they were confident to approach the registered manager or a staff member with any concerns they might have. Staff told us they felt the service had improved since the return of the registered manager following a period of absence. They were consistently positive about the registered manager's support and leadership of the service.

The provider was not consistently working within the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The provider could not demonstrate that adequate steps had been taken to assess whether people should be given medicines without their knowledge (covertly). The approach taken towards the application for DoLS also meant there was a risk some people would be deprived of their liberty without proper authorisation being in place.

We saw some ad-hoc activities taking place during the inspection. We received a mixed response from people when we asked whether they had enough to keep them occupied. Staff told us they would like more time to be able to support people with activities or the support of a dedicated member of staff for activities.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not consistently safe.

The provider had not taken all reasonable practicable actions to ensure the environment was safe.

Medicines were stored and administered safely. Staff were aware when they should administer 'when required' (PRN) medicines. However, these details had not been clearly recorded.

There were sufficient staff on duty to meet peoples' needs in a timely way. However, there was no formal assessment to help inform staffing requirements.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

The provider was not demonstrating that they were consistently working within the Mental Capacity Act (MCA). There were no recorded best interests or capacity assessments for people receiving medicines covertly (without their knowledge).

People were positive about the food provided and told us they received sufficient quantities to eat and drink.

Staff were receiving regular supervision, and told us they received sufficient training to undertake their roles effectively.

Is the service caring?

Good ●

The service was caring.

We observed considerate and caring interactions between staff and people living at Davenport Manor.

There was a consistent staff team who knew people living at the home well. Staff were able to talk to us in detail about peoples' needs and preferences.

Staff had a person-centred approach and were respectful of peoples' privacy.

Is the service responsive?

Good 

The service was responsive.

Staff had regularly reviewed and updated peoples' care plans as their needs changed.

We saw some ad-hoc activities taking place during the inspection. Staff told us they would like more time to spend supporting activities.

Relatives told us they had a good relationship with the staff and would feel confident raising a complaint if they felt this was necessary.

Is the service well-led?

Requires Improvement 

The service was not consistently well-led.

Records of care provided were not always fully or accurately completed. This issue had been identified in a previous inspection in 2013 and also following a recent audit by the provider.

Systems of audits and checks were limited in depth and scope.

The registered manager was accessible and visible to staff, people living at the home and relatives. Staff were consistently positive about the registered manager's leadership.

Davenport Manor

Detailed findings

Background to this inspection

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

This inspection took place on 23 and 24 November 2016 and the first day was unannounced. The inspection team consisted of one adult social care inspector.

Prior to our inspection we reviewed information we held about the service. This included the previous inspection reports, the action plan the provider sent to us following the last inspection and statutory notifications sent to us by the provider. Statutory notifications are notifications the provider is required to send us in relation to safeguarding, serious injuries and other significant events that occur within the service.

We reviewed records of any feedback on the service provided to us via our website, email address or by phone to our contact centre. We sought feedback from Stockport Healthwatch, commissioners of the service, Stockport safeguarding, Stockport quality assurance team, the local health protection nurse and the clinical commissioning group (CCG) care homes officer. We received feedback from the local authority's health protection nurse, which we have referenced in the main body of the report.

During the inspection we spoke with nine people who were living at the home and three relatives who were visiting at the time of the inspection. We used the Short Observational Framework for Inspection (SOFI) and carried out observations of care provided in communal areas of the home. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with seven staff. This included the registered manager, four care staff, the cook and a kitchen assistant. We also spoke with two GPs who were visiting at the time of the inspection. We reviewed records relating to the care people were receiving, including five care files, four medication administration records (MARs) and daily records of care. We also looked at records relating to the running of a care home. This included staff rotas, records of accidents, supervision records, recruitment records for four staff, training

records, servicing and maintenance records, policies and audits and checks carried out.

Is the service safe?

Our findings

At our inspection in April 2015 we found some shortfalls in the maintenance of the premises, which we found to be a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the environment to be well maintained. However, we found the provider had not always taken reasonable steps to assess and control risks in relation to the safety of the environment.

We identified that window restrictors in place at the home were not robust and it was possible people could disengage them without the use of a key or special tool. The Health and Safety Executive (HSE) advise that window restrictors should be robustly secured using tamper-proof fittings. This meant there was a risk people living at the home could have disengaged the window restricts and been injured. We raised this issue with the registered manager who sent us evidence that the provider had fitted new restrictors of an appropriate design shortly after our inspection.

Access to and from the home was controlled by a remote switch used to disengage the lock on the front door. This would help prevent unauthorised access to the home, and would also prevent people leaving the home if they were subject to authorised restrictions on their liberty to keep them safe. However, we were concerned that there did not appear to be a means of people releasing the door in the event of an emergency. We shared this concern with the local fire safety officer who visited the home. They told us they were satisfied with arrangement in place to allow evacuation in the case of fire, but noted that the provider should have updated their fire risk assessment to reflect this significant change in relation to fire safety at the premises.

Records showed that regular servicing, maintenance and checks of equipment and building were completed. This included servicing of lifting equipment and checks of gas and electrical safety. However, we saw that the electrical safety check carried out in 2013 had identified faults, including one fault that required immediate action to ensure the system was safe. There was no evidence this work had been completed as required. Shortly after the inspection the registered manager sent us evidence that the required works had been completed following us raising this concern.

These gaps in relation to the safety and maintenance of the environment were an on-going breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in April 2015 we found assessments in relation to risks to peoples' health and wellbeing had not always been properly reviewed, and did not always identify the actions staff should take to reduce risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The provider had made improvements and was now meeting the requirements in relation to this regulation.

We saw from peoples' pre-admission assessments that potential risks to their health, safety and well-being were identified before they moved to the home. Recently reviewed risk assessments were in place in relation

to a range of risk areas, including falls, malnutrition and pressure sores. Where potential risks had been identified we saw appropriate actions were identified in risk management plans, or the care plans to inform staff how they should reduce such risks. For example, we saw measures such as frequent observations, staff support and pressure sensors had been identified to help reduce peoples' risk of falling. Assessments identified equipment to help reduce the risk of people developing pressure sores and we saw items including pressure relief cushions were being used as directed in care plans. Measures such as providing nutritional supplements and making referrals to GPs or dieticians had been taken for people at risk of malnutrition. We found one person's nutritional risk assessment had not been fully completed, despite them being at potential risk of malnutrition. However, we found appropriate actions had been identified to reduce risks of malnutrition for this person. We raised this with the manager who assured us they would address this issue.

Staff we spoke with were aware of procedures to follow in the event of an accident, such as someone falling, and were aware of how to reduce the likelihood of people falling. For example, one member of care staff told us; "If people are at risk of falls they have regular checks. We ensure their call bell and equipment is to hand and that pressure alarm mats and crash mats are in place if needed. We check peoples' slippers aren't worn."

At our last inspection in April 2015 we found some medicines had not been signed for on the medication administration records (MARs) without a reason being stated for why they had not been administered. Some cream medicines were not recorded on peoples' MARs. We found this to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we found improvements had been made and the provider was now meeting the requirements of this regulation.

The home used a 'monitored dosage system' (MDS) for medicines. This is a system that is designed to simplify the storage and administration of medicines that can be stored in the blister packs. The registered manager told us they would contact the pharmacy to get any medicines prescribed part way through the monthly medicines cycle added to the blister packs, which would reduce the risk of errors occurring. Staff had completed MARs without any omissions in the records. We reviewed the medicines records of a person who had recently moved to the home and saw a hand-written MAR was in place that had been checked and signed by two staff. This would help ensure any errors on the MAR would be identified.

Cream medicines were detailed on the MAR and staff had signed to show they had been administered as directed. We reviewed the MARs for two people who were prescribed when required (PRN) medicines that staff told us were prescribed for anxiety or agitation. There were no PRN protocols in place that would inform staff when these medicines should be administered, the reason for administration or the desired effect. However, when we discussed the administration of these medicines with the staff member carrying out the medicines round, they demonstrated an in-depth knowledge of such details as advised by the prescribing health professionals.

We recommend the provider reviews national good practice guidance in relation to the administration of medicines in care homes.

People living at Davenport Manor and their relatives we spoke with told us they felt safe living at the home. One relative told us; "[Relative] is safe here. They used to wander and they get the help they need here." People living at Davenport Manor said; "I feel comparatively safe here. If anything comes up I tell the staff" and; "I think [I feel safe]. The staff seem to know what they're doing." We saw the registered manager had a copy of the local authority's guidance in relation to reporting safeguarding concerns, and staff told us they were aware how to access a copy of the safeguarding policy. This would help ensure staff could report and

escalate any concerns appropriately. The registered manager had submitted regular logs of low level safeguarding concerns to the local authority in line with their procedures.

Staff we spoke with were aware of their responsibilities in relation to safeguarding people living at the home. They told us they had not had to raise any safeguarding concerns, but would be confident to report any concerns they had to the registered manager. Staff were able to identify potential safeguarding issues and told us they would report concerns including altercations between people living at the home and potential issues of neglect such as a person wearing unclean clothes.

Staff, people living at Davenport Manor and their relatives told us they thought there were sufficient numbers of staff on duty to meet peoples' needs in a timely way. One relative told us; "There are enough staff. You can always do with more [staff], but I don't see people having to wait for extended periods." A person living at the home said; "They seem to be alright. [The staff] do get busy, but they always come quickly if I need help." Staff told us shifts were always covered and the registered manager said they would use agency staff to cover shifts if they were not able to cover within the permanent staff team. During our inspection we observed there were sufficient staff to provide people with the support they needed in a timely way.

Staff told us they had sufficient time to complete their duties and provide people with the care and support they needed. However, one staff member commented that night shifts could be 'tough' if a person living at the home was ill for example. They went on to tell us that they were able to contact the 'on-call' who was usually the registered manager at night if they were struggling. They told us the registered manager was 'brilliant' and would come into the home to assist staff if required. We asked the registered manager how staffing requirements were determined, and they told us they worked on a basis of a ratio of one staff member to eight people during the day. There was no dependency tool or other formal process in place to help ensure staffing levels were appropriate to meet the needs of people living at the home.

We recommend the provider reviews the process for determining staffing level requirements.

The local authority's health protection team had undertaken an infection control audit at the home the week prior to our inspection. The findings of this audit were generally positive, and although some areas for improvement had been identified, there were not any 'urgent' or 'priority' actions recorded. The registered manager was required to provide an action plan to address the issues identified by December 2016. We found the environment at Davenport Manor to be clean and tidy and there were management processes in place to help ensure risks of infection were reduced. The registered manager showed us an award that the home had recently received for achieving a high rate of flu vaccination amongst staff. This would help protect people living at the home from the risk of contracting this virus, which can be dangerous to vulnerable people.

We looked at records of recruitment and saw the provider had followed safe procedures. This included obtaining references, suitable identification, a full employment history and a disclosure and barring service check (DBS) prior to staff starting work. DBS checks show whether an applicant has any convictions or is barred from working with vulnerable people. This helps employers make safer decisions when recruiting staff. The registered manager told us staff were interviewed as part of the application processes, but that minutes of interviews were not kept. Interview records help demonstrate that a provider has fully considered an applicant's suitability for the role they applying for.

We recommend the provider reviews processes in relation to the recruitment of staff.

Is the service effective?

Our findings

At our inspection in April 2015 we found staff had not received regular supervision. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found the provider had made improvements and the home was now meeting the requirements of this regulation.

Staff told us they received regular three monthly supervisions and the records we looked at confirmed this. Supervision records contained limited details of discussions, but showed topics of discussion had included training, achievements and feedback from the registered manager. One member of staff told us; "I get three monthly supervision. It's useful; you get good feedback on areas for improvement."

People and relatives we spoke with told us they felt staff were competent and had the skills required to provide effective care and support. Staff told us they received sufficient training to enable them to undertake their roles effectively. Records showed staff had received training in a range of areas, which included; infection control; fire safety; moving and handling and medicines. Approximately one third of the staff had current training in dementia, and we saw other specific training had been provided where a need had been identified. For example, we saw staff had received training in catheter care. The training matrix indicated training in safeguarding and the MCA and DoLS had expired for the majority of staff. The registered manager told us this training had been recently updated, but the training matrix had not been amended. Staff we spoke with confirmed they had recently received this training. The registered manager supported and encouraged staff to undertake vocational qualifications. This included two senior care assistants who were completing a level five diploma in leadership in health and social care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People we spoke with told us staff would ask for their consent before providing care or support, and staff we spoke with had a good understanding around key concepts of the MCA. However, we found systems and processes in place at the home were not robust to ensure the home acted in accordance with the MCA.

The registered manager told us that they would submit a DoLS application for anyone who lacked capacity and asked to, or tried to leave the home. In March 2014 a Supreme Court judgement clarified that a deprivation of liberty occurs when an individual lacks capacity, is subject to continuous supervision or control and is not free to leave. The individual does not need to be making active requests or attempts to leave. The registered manager's approach therefore presented a risk that people at the home were being

deprived of their liberty without proper legal authorisation. We raised this concern with the registered manager who told us they would ensure people were re-assessed and DoLS applications submitted if required.

The registered manager said one person living at the home had a deprivation of liberty that the supervisory body had authorised. We reviewed this authorisation and saw that the current authorisation had a condition that a formal best interests meeting in relation to the person's placement at the home was carried out by the local authority's adult social care department. The DoLS authorisation also raised concern that this best interests assessment had not been completed as was a condition of the previous DoLS authorisation. We discussed this with the registered manager who was unclear about whether this meeting had taken place, and they were unable to locate a record of it. Whilst this action was the responsibility of the local authority, this shows that DoLS were not being well managed. We requested that the registered manager follow this action up with the local authority.

Two people were being administered medicines covertly. This means their medicines were administered without their knowledge, for example by disguising them in their food or drink. A judgement by the Court of Protection in July 2016 clarified the steps required in relation to the administration of covert medicines. This judgement indicated that covert medicines can be considered in exceptional circumstances, but that a best interests meeting should be held prior to providing medicines covertly. A record of the decision making should be contained in the person's care records and should be easily accessible. There was evidence that the home had consulted the peoples' GPs and family about the decision to provide medicines covertly, and that medicines were administered covertly in the best interests of the individuals. However, there was no recorded capacity assessment or formally recorded best interest decision in relation to the decision to administer medicines covertly in the medicines file of the peoples' care files.

These issues show processes at the home were not operated effectively to ensure staff were working within the requirements of the MCA 2005. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Records showed a range of health professionals had been involved in peoples' care, including GPs, district nurses, podiatrists and dieticians. The registered manager told us a GP from a local practice completed a weekly round at the home, but that they would not delay contacting a GP for advice prior to the round if they thought this was necessary. This would help ensure effective monitoring of peoples' health and timely intervention if needed. During our inspection we saw a GP attending who the home had contacted in relation to concerns they had about one person's health. We also saw information in the handover records that showed staff had contacted the GP in relation to redness observed on another persons' skin. This showed the home were pro-active at identifying and responding to changes in peoples' health. We spoke with two GPs during the inspection who were both positive about the management of the home and the response of staff to potential health concerns. One GP told us the information they required was always available and that there appeared to be good handover of any advice given within the staff team. The second GP told us; "The home provides really good care and it's well managed."

Peoples' care plans contained information on their dietary requirements, allergies and preferences. This information was also made available to staff working in the kitchen. One person had recently returned from hospital and we saw staff had updated the guidance in their care plan in relation to the support they needed with eating and drinking following advice received from the hospital on their discharge.

People we spoke with told us they were able to choose from a choice of meals and were positive about the food provided. Comments received included; "Yes I definitely have enough to eat and drink. I'm putting on

weight!" "The food is excellent, they make delicious sandwiches," and "The food is good. Nothing special." We saw people received assistance to eat and drink when needed and equipment such as plate guards and beakers were used to help people eat and drink independently when possible. We found records of peoples' food and fluid intake were poor, and there were significant gaps in these records. However, people told us they received sufficient amounts to eat and drink and we found staff were aware of peoples' intake when we asked them about it in relation to specific people. We were therefore confident this was an issue in relation to the keeping of accurate records, and we have discussed this further in the well-led section.

We saw that some limited adaptations had been made to the environment to help make it more 'dementia friendly'. This included contrasting colour grab rails, and some people had memory boxes outside their rooms that contained items that were significant to them and they would recognise. Such adaptations would help enable some people living with dementia to retain independence around the home and recognise their room for example. We discussed the potential for further adaptations to be made within the home and the registered manager agreed they would consider this when undertaking any future refurbishment or redecoration.

Is the service caring?

Our findings

All the people we spoke with were positive about the care they received and the caring approach of staff. One person told us; "I like all the staff, they are very good. I've never known girls so nice. They really want to help you." Another person said; "[The staff] are very nice. We get on very well." During our inspection there was a new admission to the home and we saw staff took time to introduce them to people and to show them around the home. We spoke with this person who told us they found staff to be nice and had made them feel welcome.

The registered manager told us there were no staff vacancies and some of the staff we spoke with, including the registered manager had worked at the home for a number of years. This had helped ensure staff got to know people well and develop positive and caring relationships with them. During our discussions with staff, we found staff members were able to talk in depth about peoples' care needs, social history and preferences as was documented in their care plans. One person we spoke with told us; "It's a very nice place. I'm very pleased with everything they do for me, I've never been so comfortable and happy. [Staff member] is my keyworker. She is a nice lady."

Staff had a person-centred approach and talked about the importance of respecting the fact that Davenport Manor was peoples' home. People we spoke with told us staff respected their privacy and dignity and this was our observation during the inspection. For example, we observed staff speaking discreetly when offering people care and assistance, and staff were conscious to ensure people's clothing was properly arranged. One relative told us their family member liked to have time to themselves and said staff were respectful of this and did not pressure them into taking part in things they did not want to. A second person's care plan documented that they liked to spend time in a quiet environment and we saw staff had supported them to sit in one of the quieter communal lounges. Records such as care files were stored securely where unauthorised persons could not easily access them.

We observed positive and caring interactions between staff and people living at the home. One staff member and one relative commented that time available for staff to spend interacting with people could sometimes be limited. This was also our observation and we saw staff were in and out of the different communal areas checking on people's welfare rather than engaging with them. However, we did observe staff taking time whenever possible to sit and talk with people about their interests and families for example. At one point in the inspection we observed a staff member singing and one person who had previously been watching passively responded positively to this by smiling at the staff member. At another point we saw the chef talking with a person and complimenting them on their hair cut. We observed staff responded promptly when people required assistance and support was provided patiently at a pace that suited the individuals.

We saw staff provided people with reassurance and support if they showed signs of anxiety or agitation. For example, we observed one person was struggling to hold their walking frame when mobilising and was getting upset. Staff reassured this person and supported them patiently to walk back to their seat independently.

Relatives told us they were able to visit without restrictions and one relative said staff were; "Good, friendly and helpful." It was apparent from our observations that staff had developed good relationships with relatives and relatives were comfortable to approach staff and discuss any concerns they might have. For example, we saw the registered manager had frequent discussions with relatives about their family members' care, and communication with relatives was natural and friendly. Peoples' care plans had documents in them that indicated the level of involvement relatives would like to have in their family members' care planning where this was appropriate.

Peoples' care plans contained information about their communication support needs, including any equipment such as glasses or hearing aids they required. We observed staff communicated clearly and effectively with people, and people told us that staff listened to them. We saw one person ask if they could have extra sugar in their cup of tea for example and staff responded; "Of course you can," and saw to this request.

Is the service responsive?

Our findings

At our last inspection in April 2015 we identified a number of shortfalls in relation to the provision of person-centred care. Care plans had not been regularly reviewed, were not always personalised and did not always accurately identify peoples' care and support needs. We also found there was a lack of evidence to show staff were following care plans, a health concern had not been acted upon and there were limited activities provided. We found this to be a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made improvements and was meeting the requirements of the regulation.

Relatives we spoke with told us their family members' needs had been assessed prior to them moving to the home. We saw staff had completed pre-admission assessments and 'getting to know you' documents when people had moved in that contained further details on peoples' preferences in relation to their care and support.

Care plans contained the information staff would need about peoples' health and social care support needs. We saw care plans had been reviewed on a monthly basis or sooner if there were significant changes in a person's support needs. Information was recorded about peoples' preferences in relation to their care. For example, people's preferred routines at different times of the day were documented, as well as information on preferred gender of care staff and where people preferred to eat their meals. Information was also recorded about peoples' interests and the things or people that were important to them. Staff were aware of this information, which helped them provide care in a person-centred way. For instance, one person's care plan stated that they liked cats, and we observed staff talking with this person about cats.

People told us they could make day to day choices such as when they received support with bathing, and the times at which they got up and went to bed. During the inspection we saw people got up and were supported with their breakfast at different times of the day dependent on their preferences. When we asked one person whether they were able to make these choices, they responded; "Of course. I'm quite free to do that." Another person said; "You can do what you want. I can eat my meal in my room or downstairs if I want."

We received a varied response when we asked people if they had enough to do to keep them occupied. Comments included; "I've got enough to do. I've got the telly," "I watch TV, sometimes have a game. I'm alright," "There's not really enough to do but I don't care. I watch the television," and; "There's not much to do in the winter. In the summer you can access the garden." During the inspection there was one arranged activity, which was a person who had come in to do bible readings. Other than this, we saw limited activities and stimulation, and long periods where people were unengaged or sat watching TV. Records showed that some activity took place on a daily basis, which included board games, card games and chair exercises. We observed staff engaging people in ad-hoc activities including nail painting and singing when they had opportunity to do so. However, this was generally for short periods and staff told us they felt additional help was needed in relation to the support of activities. One staff member said; "We really don't have time for activities. I really think they need an activity person."

We recommend the provider reviews their procedures in relation to the provision of activities.

People and relatives told us they would be confident to raise a complaint if they felt this was necessary. One relative told us "I've not had to raise a complaint. I would see [registered manager] or speak to one of the staff as I have a good relationship with all the staff." People told us staff listened to, and acted upon any non-formal complaints or concerns they might have, although most people told us they did not have anything to complain about. One relative we spoke with told us they had raised a formal complaint and that they were satisfied with the outcome of this. We asked to see records in relation to the complaint and found there were not any at the home. The registered manager told us this was because the complaint had been raised directly with the provider. It is important that clear records of complaints are kept to ensure the provider can demonstrate actions taken in relation to concerns and to help enable tracking of complaints. We have discussed this further in the well-led section of this report.

Is the service well-led?

Our findings

At our last inspection in April 2015 we found feedback on the service had not been sought from people using the service and other stakeholders, audit systems had not been effectively implemented and policies were not up to date. These issues were found to be a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection, although improvements had been made in relation to some of these previously raised issues, we found there was an on-going breach of this regulation.

We saw surveys had been carried out to obtain feedback on the service from both people living at the home and staff members. The provider had reviewed the feedback and had identified actions and recommendations to make improvements within the service. The registered manager told us they held meetings for relatives and people living at Davenport Manor and we saw records of these meetings that confirmed this. Our observations during the inspection showed that staff, people living at the home and relatives were comfortable to freely enter the registered managers' office and ask her for advice or discuss a family members' care. This demonstrated that the registered manager was approachable and would help ensure effective communication within the home.

Despite improvements to the process of receiving documented feedback about the quality of the service provided, we found systems of checks and audits were limited in scope and detail. The registered manager completed a quarterly infection control and health and safety audit. However, the health and safety audit had not identified the issue in relation to the suitability of the window restrictors. Care plan audits were limited to a record of a simple check undertaken by the registered manager in some of the files, and there was no overview of which files had been audited. There was no medicines audit in place, and records such as the training matrix were not always up to date. There was a log of any accidents and incidents occurring at the home that detailed any immediate actions taken by staff, such as calling for an ambulance. The registered manager told us they would review this on a regular basis to monitor any patterns or trends that might indicate further actions were required to keep people safe. However, they had not formally recorded this check.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems were not in place to ensure adequate monitoring and improvement of the quality and safety of the service.

At our last inspection in April 2015 we noted the presence of CCTV in the communal areas of the home. Following discussions with the registered manager we were satisfied that the CCTV had been put in place in the best interests of people using the service, and there was evidence that people living at the home, relatives and staff had been consulted about the use of this surveillance. Whilst we remained satisfied that CCTV was in place for the legitimate reason of helping ensure peoples' safety, the registered manager was only able to provide limited information in relation to the steps the provider had taken in relation to the consideration of putting CCTV in place. It is important such steps are clearly recorded to enable the provider to demonstrate they have considered factors including the potential impact on peoples' privacy, procedures around data security, operational procedures and factors relating to mental capacity and best-interests of

people using the service.

We recommend the provider reviews guidance in relation to the use of surveillance in care homes, including that issued by CQC.

Staff did not always maintain accurate and complete records of care provided. Some records of daily care provided were limited in detail. This would make it more difficult for other professionals involved in peoples' care and assessment to understand peoples' support requirements, and what care and support staff had delivered. We saw the registered manager had completed some of the daily records. The records the registered manager had completed were detailed and person-centred. The registered manager told us they would support all staff to improve records to a similar standard.

We identified significant gaps in peoples' records of food and fluid intake. This would impact the services' ability to effectively monitor whether people were receiving sufficient quantities to eat and drink, and also meant they would not be able to evidence that people had received appropriate support in relation to nutrition and hydration. The provider had also identified the issue in relation to records of food and fluid intake during an audit they carried out the week prior to our inspection. As a result, they had put in place a new file to support staff to keep accurate records. However, this had not been entirely effective as we found on-going issues in this area. We also found peoples' weights were not consistently recorded in their care plans. Although they had been recorded in a separate file, this would make it more difficult to monitor peoples' health effectively.

During the inspection we also found two care plans were not present in peoples' care files. The registered manager printed copies of these care plans off for us during the inspection. However, it is important that such records are quickly and easily accessible by staff and other professionals to ensure they have the information required about peoples' care and support needs. There was also no record of a complaint that had been made kept at the home, as discussed in the responsive section of this report. Issues in relation to the completion and accuracy of records had also been identified as an issue at an inspection of the service we undertook in June 2013. This showed that the provider was not always ensuring improvements were sustained.

The issues in relation to the keeping of accurate and complete records of care was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

There was a registered manager in post at the time of our inspection, as is a requirement of the homes' registration with CQC. The registered manager told us they had worked at the home for over 20 years. There was no deputy in post, but two senior care assistants supported the registered manager. The two senior care assistants were undertaking a recognised qualification in management in social care, and the registered manager indicated in the provider information return (PIR) that it was their intention that these staff would start to support the registered manager in providing daily oversight within the service.

At the time of our last inspection in April 2015, the registered manager had recently returned from a period of absence. Staff we spoke with told us they felt the service was being better managed, and that improvements had been made since the registered manager's return. One staff member said; "We went through a rough patch when [registered manager] was off and we had no actual manager. It is definitely a lot better than it was."

Feedback from the visiting GPs we spoke with indicated that the home worked effectively with them to help ensure people's health needs were well managed. Staff were consistently positive about the registered

manager's leadership of the service. From our discussions with the registered manager it was apparent they had an open and caring approach towards both people living at the home and staff. One staff member said; "It's great. You couldn't ask for a better manager." We spoke with a member of staff who had been recently recruited who told us they found the registered manager to be much more 'involved' compared to the manager at their previous place of employment. Staff talked positively about their jobs roles and told us they felt supported and valued for the work they did. Staff told us the staff team worked well together, and the recently recruited member of staff we spoke with told us staff had been supportive and welcoming. One staff member told us; "It's a good team of staff. Everyone brings something different."

At our inspection in April 2015 we found the home's statement of purpose contained inaccurate information about the service provided. A statement of purpose is a document that providers' are required to produce that contains key information about the service provided. We found the registered manager had reviewed and updated the statement of purpose as required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>The provider was not working within the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.</p> <p>Regulation 13(1)(2)(4)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 15 HSCA RA Regulations 2014 Premises and equipment</p> <p>The provider had not taken reasonably practicable steps to ensure the environment was safe.</p> <p>Regulation 15(1).</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Systems in place to monitor and improve the safety and quality of the service were not effective.</p> <p>Complete and accurate records of care and support provided were not consistently maintained.</p> <p>Regulation 17(1)</p>

