Mrs H Green

Devonia EMI Home

Inspection report

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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?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

We carried out an unannounced comprehensive inspection of this service on 21 and 27 April 2015. Breaches of legal requirements were found. We served a warning notice to be met by 31 August 2015 relating to good governance. We carried out a focused inspection on 9 September 2015. The warning notice was not met and further breaches of legal requirements were found. We served four warning notices to be met by 20 September 2015.

We undertook this comprehensive inspection on 25 and 29 November 2015. We found that three of the four warning notices had not been met and identified additional breaches of regulation.

Devonia EMI Home is a family-run home that has been established for over 30 years. It provides accommodation and care for up to 12 ladies, over the age of 65, some of whom are living with dementia. At the time of our visit there were 11 people in residence.

The service did not have a registered manager. At the time of this inspection the manager who had been

Summary of findings

appointed and had applied to registered with us, was temporarily absent from the service. 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.

There was a lack of effective leadership. The provider had been in breach of regulations since September 2014. They had failed to notify the Commission of significant events that is required by law. They had not displayed their rating. Services are required to display their rating so that people can easily understand the performance of the service.

Despite requirements made by the Commission and other bodies including the local safeguarding adults' team and local fire service, the provider had failed to embed improvements.

People were at risk of harm. The provider had failed to assess risks to people's safety and to provide staff with the necessary guidance and training to meet their needs. Some people who used the service presented on occasion with behaviours that could be described as challenging. Staff had not been trained in how to support people with these needs and medicines prescribed on an 'as needed' basis to manage behaviours was not used appropriately. Where people needed support to move, staff did not always use safe practices and had not been trained in the use of some equipment.

Staff had failed to identify safeguarding concerns and to make timely referrals to the local authority. Where a staff member's fitness to carry out their role was being investigated, the provider had not taken robust interim measures to keep people safe.

People's rights under the Mental Capacity Act 2005 (MCA) were not supported because staff lacked understanding about how decisions should be made if a person lacked capacity.

People's care records did not provide staff with accurate information about the support required or that had been provided. People had access to healthcare professionals but contacts and referrals were not reliably documented.

Staff told us there had been improvements in staffing levels and we observed this during our inspection. However the rota did not demonstrate that safe staffing levels were consistently maintained or properly planned for. There were instances where just one staff member was recorded as having been on shift. This would not be sufficient to meet people's needs safely.

The provider did not have an effective system to assess, monitor and improve the quality and safety of the service. Known risks had not been addressed.

There was no system to handle verbal complaints and to ensure that they were investigated and responded to. The provider did not have a system to gather feedback in order to evaluate and improve the service.

There was a warm atmosphere at the service. People received more emotional and social support from staff now that there were more staff on duty during the morning. People received home-made food and were supported eat and drink enough to meet their needs.

People were supported by caring staff who knew them well and understood their preferences. Staff involved people in day to day decisions regarding their care and treated people respectfully.

We found several breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014, including continued breaches from previous inspections and failure to meet warning notices issued to the provider. We are considering what action to take in response to these continued and new breaches.

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

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

Summary of findings

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.

Summary of findings

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.

Staff had not taken prompt action in response to safeguarding concerns.

People were at risk of harm because risks to their safety had not been properly assessed or managed.

Staff told us that the provider had increased staffing levels and we observed this during our inspection. However staff rotas did not demonstrate that safe staffing cover had been planned or maintained consistently.

Pre-employment checks had been completed for new staff before they started work.

People received their medicines safely.

Is the service effective?

Requires improvement

The service was not always effective.

Staff had not received appropriate training and support to enable them to carry out their duties effectively.

People's rights under the Mental Capacity Act 2005 were not supported because staff lacked understanding of this legislation.

People were offered a choice of food and drink and supported to maintain a healthy diet.

People had access to healthcare professionals to maintain good health

Is the service caring?

Good

The service was caring.

People enjoyed good relationships with the staff who supported them. Staff understood what was important to people.

People were involved in making day to day decisions relating to their care.

People were treated with dignity and respect.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's care records provided inconsistent information and did not accurately record decisions taken.

The provider did not have a system to handle or respond to verbal complaints.

People and most relatives felt able to approach staff if they had concerns.

Summary of findings

Staff spent time with people and supported them to participate in activities

Is the service well-led?

Inadequate

The service was not well-led.

The quality assurance system was not effective. The provider had not taken action to mitigate known risks. Actions identified to make improvements in the service had not been completed. There was no system in place to monitor and drive improvements.

Action had not been taken to address previous concerns and breaches of regulation.

There was a lack of clear and stable leadership.

The provider had failed to display their rating received following our last inspection.

People and most relatives spoke positively about the 'homely' feeling at the service.

Devonia EMI Home

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 25 and 27 November 2015 and was unannounced.

Two inspectors undertook this inspection.

Prior to our visit we reviewed three previous inspection reports, warning notices issued to the provider following our inspection in September 2015, safeguarding information received from the local authority, an enforcement notice served by the West Sussex Fire and Rescue service and one notification regarding a person who had gone missing received from the service. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we addressed potential areas of concern.

We observed care to help us understand the experience of people who could not talk with us. We looked at care records for six people, medication administration records (MAR), monitoring records of people's weights, accident and activity records. We also looked at 11 staff files, staff training and supervision records, staff rotas, audits and the minutes a staff meeting.

During our inspection, we spoke with four people who used the service, four relatives, one person's friend, the provider, the manager, three care staff and the chef.

Inadequate

Is the service safe?

Our findings

People were not protected from abuse or improper treatment because staff had not taken prompt action to report concerns and were not always able to identify situations that constituted ill-treatment. In the daily notes for one person we read that they were, 'Aggressive to staff and residents walking around the home hitting people'. We discussed this with the provider as there was no evidence that action had been taken by the staff on duty to raise concerns. The provider expressed surprise that an incident between people who used the service should be raised as a safeguarding alert and that it was considered as abuse. This demonstrated a lack of understanding on the part of the provider. People were at risk of harm because staff had not identified abuse and neither the staff nor the provider had taken action to protect people from harm.

We had been made aware of some concerns that were being investigated under the local authority safeguarding procedures. An allegation had been made by one staff member about how another staff member had responded to a person when they were distressed. The staff member who witnessed the potential abuse did not raise their concerns with a senior member of staff until the next day and concerns were not raised with the provider until the following week. The incident was not reported as a safeguarding alert for ten days. During this time the staff member alleged to have abused a person living at the service was still working. Staff had not responded promptly upon becoming aware of an allegation of abuse. This put people at risk of harm.

People were not always protected from abuse and improper treatment. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the provider's safeguarding policy had yet to be updated, safeguarding information had been displayed in the office. A copy of the updated multi-agency safeguarding policy and procedures was also available.

The provider had not taken robust action to protect people when a staff member's fitness to carry out their role was being investigated. Following the above-mentioned allegation of abuse, the provider suspended the staff member. In a letter to the staff member, the provider advised that 'we cannot allow employees accused of gross misconduct offences to remain in work'. They went to say that the staff member should not contact anyone connected with the investigation or discuss the matter with any employee or client of the home. This letter was dated 13 November 2015. When we inspected on 25 November 2015, we found that the suspended staff member was working in temporary accommodation located just outside the garden of the home. They were working on people's care records and had contact with other staff members. During the course of our visit, the provider suggested that the staff member come into the home to speak with us. This was refused by us on the grounds that the investigation into the alleged abuse was ongoing and the staff member should not have contact with people using the service.

The provider did not demonstrate that robust interim measures were in place to minimise the risk to people using the service. This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found that the provider was unable to demonstrate that safe recruitment procedures had been followed. Of the five staff who had joined the service during 2015, criminal records checks were missing from two of the files. We issued a warning notice to be met by 20 November 2015. At this visit we found that the missing DBS checks were on file and that checks for new staff members had been completed before they began work at the service. The warning notice in relation to this section of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was met. The manager explained that there remained two vacant positions for care staff but that they were actively recruiting to these posts.

When we inspected in September 2014 and April 2015 we had concerns that the system for identifying and assessing risks was not fit for purpose and that staff lacked information on how to mitigate risks. The provider failed to take action and by September 2015, we found that the lack of a system to assess, monitor and mitigate risks to people was having a direct impact on their safety. We issued a warning notice to the provider. At this inspection we found that the provider had not taken sufficient steps to meet the warning notice and remained in breach of this regulation.

People were at risk because there was a lack of consistent information on how to manage behaviours that might

challenge. Staff told us that four of the 11 people who lived at the home could present with behaviour that challenged. Care plans and risk assessments for these people lacked information on what might trigger known behaviours, how to support them when they presented with known behaviours and how to keep others safe.

Since our last visit in September 2015, the manager had introduced assessments entitled, 'Prevention and management of challenging behaviour'. On the first day of our visit, these were in place for two people. By the second day we visited plans were in place for four people. In three of the four plans it made reference to physical or aggressive behaviour but there was no guidance as to how staff should respond. Staff had not received training in managing behaviours that might challenge. The provider did not see the need for training in this area. They told us, "A lot of it is just common sense". One staff member said, "I don't know if I am doing it right". Another, speaking of their colleagues' knowledge in this area said, "They haven't got a clue". This lack of training, coupled with a lack of guidance, meant that people and staff were placed at risk of harm.

A behaviour monitoring chart was in place for one person; this described what preceded an episode of behaviour, what the person did and the consequence. This information could be used to identify patterns in behaviour and agree ways of preventing it from escalating. We cross referenced the dates with the daily notes and found that not all instances of behaviour had been recorded. This meant that monitoring systems may not be effective at spotting patterns in behaviour. Staff shared knowledge and tips on how they supported people in conversation with us but some of this information was not recorded in the care plan or behaviour support plan. Information recorded in other sections of the person's care plan had not been incorporated in the behaviour support plan. This included actions that were known to trigger particular behaviours and support that has proven to be effective in reassuring and calming people. For example, we read in one person's communication plan, 'Don't contradict what she says when upset'. For another person staff told us that when assisting them with personal care just one staff member should speak as, "She gets agitated if there is too much noise". The lack of monitoring, consistency of recording and formal information sharing meant that it would be difficult to identify triggers for the behaviour and put in place strategies to support the person and keep them safe.

When people presented with behaviour that could be described as challenging, there was unclear guidance as to when prescribed medicines should be given to help ease their distress. One person's care plan referred to giving an 'as required' (PRN) medicine but they were not prescribed any. The plans for two other people who were prescribed PRN medicine for 'agitation' made no mention of it. On the PRN medication protocol under 'How the decision is reached about how and when to give' the medicine stated 'When (name of person) gets agitated/aggressive' and, 'When (name of person) becomes distressed'. For one person we saw that the PRN medicine had been given on three dates in the current medicine cycle. The daily notes for this person recorded that they had been, 'very vocal' on one day, 'a bit restless' on another and 'agitated' on the third. On other days when PRN medicine had not been administered we also read that they had been, 'agitated' and 'very vocal'. It was not clear how the decision to administer the PRN medicine was taken. The lack of information and guidance for staff on how the person would present could mean that the medicines were administered inappropriately.

People were not protected from avoidable harm due to a lack of written guidance for staff and the use of inappropriate moving and handling techniques. One person was unable to stand without assistance and required a wheelchair to transfer. As at our last visit, this person's care plan for the person read, 'Depending on mood will stand with two carers and take weight well'. At this inspection, there was still no further guidance on how staff were to assist this person if they could not take their weight. We asked a friend of this person how staff supported them to move if they were unable to stand. They told us, "They lift her under her arms". The provider confirmed that this was the case when the person was unable stand. The manoeuvre described was a drag lift. The 'drag' lift is any method of handling where the care staff placed a hand or arm under the person's armpit. Use of this lift can result to damage to the spine, shoulders, wrist and knees of the carer and, for the person lifted, there is the potential of injury to the shoulder and soft tissues around the armpit.

We observed that two other people struggled to stand. They were assisted to stand with considerable staff assistance and the manoeuvre did not appear safe for the people or staff. Staff told us that none of the people who lived at the home currently used the stand-aid hoist. We

Is the service safe?

observed that another person who we had observed struggling to stand during our last inspection was able to stand more easily. This was because the provider had purchased chair raisers for two of the lounge chairs. One staff member said, "(Name of person) is fine in that chair, she can sit in it and get out of it". Since our last visit, the provider had also purchased a full body hoist. This was in response to concerns that if a person fell to the floor, staff did not have a safe method of assisting them to their feet. The hoist had been checked by an external company to ensure that it was in safe working order. Staff told us that no one had required assistance to get up from the floor so they had not needed the hoist. We found, however, that staff had yet to receive training in how to use this equipment. This meant that staff would still be unable to safely assist a person to their feet if they fell and were unable to get up independently.

The care plans and risk assessments describing the support that people needed with their mobility lacked detail. Two people used a stair lift to access their bedrooms on the first floor of the home. The risk assessments in place listed risks regarding the equipment such as 'breaking down' and 'faulty/not working' but made no reference to specific risks relating to the person using it. For example, there was no reference to the person's individual mobility or behaviour which may need to be considered in order to use the equipment safely, or guidance to staff on what support is required. This may mean that people did not receive appropriate support to use the equipment safely.

We observed that one person was positioned in a way that looked uncomfortable as a staff member assisted them to eat lunch. The person was in a reclined position with their feet raised. We also noted that the staff member modified the texture of this person's meal by mashing it with a fork before supporting them to eat. A friend of this person told us that staff usually assisted the person to change position before a meal and the chef advised that they needed a fork-mashable diet. The person's care plan entitled 'food intake' made no mention of positioning the person or modified texture. The lack of detail in people's care plans presented a risk that their needs may not be met consistently or safely. In this case the person was at an increased risk of choking due to their reclining position.

The provider had not taken action to mitigate the risks associated with fire. Following our inspection in April 2015 we made a referral to West Sussex Fire and Rescue service because we were concerned for people's safety. The fire service visited the home in May and October 2015. The provider had failed to take action in relation to requirements such as ensuring that they had an updated fire risk assessment and had conducted a fire evacuation drill. Following a visit by the fire service in November 2015, an enforcement notice was issued. This was because the deficiencies in fire safety arrangements at the home had not been remedied. The provider had failed to mitigate the risks to people in relation to fire and had not taken action in response to concerns raised by both the Commission and the fire service.

The provider's failure to assess risks to people's health and safety and to take action in response to known risks was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Action had been taken in response to risks in some areas. Since our last visit, a risk assessment had been completed for one person who used bed rails to prevent them falling out of bed. The risk assessment considered the possibility of entrapment in the bedrails. We noted that the rails and padding used had been inspected in November and that monthly checks were planned to ensure that the equipment was safe to use. During our visit we observed that staff supported people to minimise risks to their safety. They supported people to walk between rooms, offering reassurance and assisting them to negotiate or lift their walking aids over the thresholds between rooms. To reduce the risk to one person of falling, staff explained how they had changed the person's footwear so that they had more grip. As some people were assessed as at risk of leaving the home without assistance, staff took care to make sure the garden gate was secured at all times. We observed that a staff member accompanied visitors if they left through the garden. In this way they could make sure that the gate was secured until a suitable lock mechanism was fitted.

The provider was unable to explain how the staffing level had been calculated or describe how this related to people's support needs. We found examples of dependency assessments, but the most recent was dated August 2015. Since that time, the occupancy of the home had increased and new people had moved to the service. Staff told us, however, that the provider had increased the morning staffing level from two to three care staff. In addition a chef had been employed. This meant that the staff on duty were able to focus on care tasks. One staff

Inadequate

Is the service safe?

member said, “It’s getting a lot better, there are more staff”. Another told us, “There is reliably three in the morning. There is more time to be on the floor and to spend with the ladies”. A third said, “It’s really good because if two go to help (name of person) we’ve still got someone watching”. The manager attributed a reduction in falls, from three in both September and October to one in November to-date, to the increase in staffing. She said that staff were able to monitor people more effectively and support them to move safely. During our visit we observed that staff were available to support people. They also took time to sit and spend social time with people.

Despite our positive observations of the increased staffing level, the staffing rotas did not demonstrate consistency in staffing levels being deployed as planned. The rotas did not demonstrate that staff cover had been planned effectively or that safe staffing levels had been maintained at all times. According to the rota of actual hours worked, during the weekend prior to our visit there had been just one member of night staff rather than two. It also showed that the staffing level of three staff in the morning, two in the afternoon had been achieved on just three of the seven days. We looked at the planned staffing rota which was arranged in weeks one to four. We found that on Monday of weeks two and four just one staff member had been scheduled to work in the afternoon. A shift with just one staff member on duty would put people at risk of unsafe care because they would be unable to monitor people’s safety. Furthermore, one person required the support of two staff for all personal care, with the exception of support to eat where one staff member was able to assist. We discussed these concerns with staff. They assured us that staffing had improved and that there were always at least two staff on duty. They added that provider also worked in the home but that their name did not appear on either rota.

The records of staffing levels did not demonstrate that the provider had maintained a consistent staffing level in order to meet people’s need safely. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were administered safely. Competency checks had been completed for staff who administered medicines and an up-to-date record of staff signatures was available. Daily checks were made to ensure that medicines had been administered correctly and were all accounted for. Where errors, such as a missed signature, had occurred these had been documented and addressed promptly.

We observed as staff administered medicines to people. Staff provided information to people and supported them to take their tablets. Each person’s record included a photograph and details of any allergies. The records of administration were completed, indicating if a medicine had been taken or refused. Where authorisation had been given to administer a medicine covertly, that is without the person’s knowledge, the letter from the GP was held on file. Staff maintained records of when creams and ointments were opened, how long the manufacturer recommended it could be stored after opening and when it should be disposed of. We checked the stocks of medicines and found them to be in date. A senior staff member told us, “Once I month I check all the dates”.

Requires improvement

Is the service effective?

Our findings

At our last visit we found that training records were not available for three of the care staff employed. Two other care staff were overdue training updates. We issued a warning notice to be met by 20 November 2015. At this visit we found evidence of some training that had taken place, but it was not sufficient to demonstrate that all staff had received appropriate training to enable them to carry out their duties effectively. The warning notice was not met.

People's needs may not have been met because staff had not always received appropriate training and lacked the skills to support them effectively. We identified gaps in staff knowledge relating to managing behaviours that challenge, the Mental Capacity Act 2005 (MCA) and fire safety. The training records indicated half of the care staff had not received training in dementia care, the MCA or fire safety. They had not been supported or equipped to meet people's needs. Although some people who lived at the home had complex behaviours that might challenge, staff had not received specific training in this area.

The provider was not able to monitor the training needs of staff because they did not maintain accurate information about staff training. We looked at the records of staff training by reviewing the certificates in individual staff files. The provider told us that they had a training matrix detailing all training staff had attended but this was not provided. We asked the provider and manager to send this to us within 48 hours of the inspection but, while some further individual certificates were sent, the matrix was not provided. We reviewed training records for 11 care staff. There was no recorded training for one staff member. Of the remaining ten staff, two were overdue the annual update stipulated by the provider in moving and handling, safeguarding, infection control and health and safety.

People were at risk because staff may not have had the necessary knowledge and information to support people with their needs. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People spoke well of the staff who supported them and relatives were generally positive about the support they observed. One relative said, "There is a core of staff that are excellent here, the more senior staff have been excellent". One staff member told us, "The training is good. The trainer says it in more than one way so you understand it". Staff told us that they felt supported and that they had the opportunity to discuss their role and development during supervision meetings. Records confirmed that supervision meetings had taken place between June and November 2015. Eight staff had attended an annual appraisal. We saw that dates were booked for those staff who had not yet had their appraisal.

Following our inspection in April 2015, we made a recommendation that the provider reviewed how capacity assessments and best interest decisions were recorded. This was because the records did not clearly demonstrate that assessments and decisions had been made in line with the MCA that people's rights had been protected. The 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's rights were not always protected because staff lacked understanding of the MCA and how to apply it to people's care. Staff were not able to demonstrate a clear understanding of how the person's capacity should be assessed or how decisions should be made in the person's best interest. One staff member said, "The next of kin would decide". Speaking about one person staff said, "(Name of friend) makes all decisions for her". This friend did not have power of attorney to make health and welfare decisions on behalf of the person. In the notes we read, '(Name of person) did not attend hospital today for a CT scan as (name of friend) did not feel it was required'. We spoke with this friend who explained that the decision not to attend had been made in conjunction with the hospital clinician. Based on the records in place, staff had not checked to ensure that this decision had been in accordance with the MCA.

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

Is the service effective?

deprive a person of their liberty were being met. We found that DoLS authorisations had been granted for three people who lived at the home. A further nine DoLS applications had been submitted and were awaiting review by the local authority. Staff told us that one person who moved to the service at the end of October 2015 lacked capacity to consent to living at the service, was under continuous supervision and would be prevented from leaving. They had not, however, made an application under DoLS. This meant that staff were restricting the person without a lawful decision to do so and without appropriate safeguards, such as time limits and review mechanisms in place.

We observed that one person had a stair gate across the doorway to their bedroom. Staff explained that this had originally been put in place to prevent the previous occupant from falling down the stairs. They told us that it was closed at night time. We looked in the file and confirmed with the staff on duty that the use of the stair gate had not been assessed. The person's capacity to consent to its use had not been assessed and alternative less restrictive options had not been considered.

The above represents a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we observed that staff supported people to make day to day decisions regarding their care. This demonstrated some of the core principles of the MCA such as the presumption that people had capacity to make decisions, asking questions to maximise their decision making ability and respecting the choices people made. One staff member told us,

"They can go to bed when they want to, they can get up when they want to. It's a home from home. We try our best for them".

People were positive about the food on offer at the home. One said, "There's not much waste here". The chef told us, "It's all homemade; there is fresh veg every day. They love liver and bacon and roast dinners. They clean their plates". Lunchtime appeared to be a happy occasion, enjoyed by all those in the dining room. The food looked and smelt appetising and staff facilitated and joined in conversations to make it a social occasion. One person who had been with a visitor over the main lunchtime was served their meal later in the afternoon. Throughout the day, people were offered regular drinks and snacks. Those who required assistance to eat or drink were supported. One relative told us, "I think the food's quite good, (they offer) drinks all day".

Staff used a recognised screening tool to monitor people's risk of malnutrition. Where possible, people's weights were recorded on a monthly basis. The information had been reviewed to identify any changes. For one person we read, 'Has lost a bit of weight and this has pleased her'. It was noted that they had a score of zero (not at risk) on the screening tool so this was no cause for concern. In another person's record, it was noted that a person had lost almost two kilograms between July and September. There was a note dated September to say, 'Has lost another kilo. Will discuss with manager involving dietician again'. There were no further records but staff confirmed that they had contacted the dietician who did not feel a referral was required. A friend of this person said, "At that period she went off it but she's back eating now".

People had access to healthcare services to maintain good health. Staff maintained records of visits by healthcare professionals. These included the district nurses, chiropodist and older person's mental health services. People had also been supported to attend external appointments such as for diabetic eye screening. One relative told us that staff were alert to changes in people's health. One said, "They do contact us when something is going on. We feel involved".

Good

Is the service caring?

Our findings

People told us that they were happy and that they enjoyed the company of the staff. One told us, "People are kind generally and there is a good atmosphere". Another said, "It's nice here, it's friendly". We observed care during the morning and the afternoon. We observed two people fully engaged in a conversation with a staff member. The conversation included topics such as memories of Liverpool and memories from schooling. Everyone appeared to enjoy their time together. On another occasion a staff member was offering to do people's nails and supporting them with this. At one point a group of people joined in singing jingle bells with a staff member. There was lots of chat and laughter.

Most relatives spoke highly of the support provided by the home. One said, "The carers are really caring and helpful. Because it is a small place she's been looked after well". They also told us, "When we have all visited the staff have always been helpful, courteous and informative with what's going on. There seems to be a good rapport with staff and residents; a homely feel".

We observed that the provider and staff had genuine affection for the people who lived at the home. They appeared to know them well and were able to engage them in meaningful conversation. Where a person became confused, staff did not challenge their reality. For example when one person dashed upstairs saying, "Quick I've left the iron on!", the provider joked with them responding, "You shouldn't be ironing at this time of night". A relative of one person who had been very unwell told us that the staff had been kind and caring. They said, "We were here until quite late at night and there was always somebody by her bedside".

People were encouraged to be independent in day to day decisions regarding their care. We observed that people spent time in the communal areas or in the lounge according to their wishes. People were able to walk freely around the home and garden. At lunch time we saw that one person was helping staff to lay the tables and to clear away. The appeared to really enjoy this task and the fact that they were able to assist.

Since our last visit, staff had started to wear uniforms. Staff told us that they had noticed people were reassured by the uniforms, they thought because they knew staff were present. Staff also explained that a keyworking system had been introduced. This is where a staff member is linked to a small number of people who use the service. They were encouraged to get to know each person, to understand their preferences and to make sure that their support plans reflect their needs and wishes.

People were treated with dignity and respect by staff. Staff listened to people and respected their wishes. On the provider's website, one piece of feedback from August 2015 read, 'Residents at Devonia EMI Home are treated with respect and dignity, the home provides an active daily life and a safe and comfortable environment for the residents'. Six staff had completed training in privacy and dignity. We noted directions in people's care plans to encourage staff to maximise their independence and respect their privacy. For example we read, 'Monitor visits to the toilet but allow privacy in bathroom'.

During our visit we noted that the provider was not always respectful of people's privacy when having conversations in the office or with staff. For example, they called out across the lounge, "What were (name of person) levels this morning?" This referred to blood sugar readings and was asked in front of one of the inspection team and two people who used the service. Later in the day the provider was in conversation with a family member discussing financial affairs and this could be heard upstairs. There was limited space for conversations to be held in private but we discussed this with the provider as it was not representative of the general respectful approach observed throughout our visit.

Requires improvement

Is the service responsive?

Our findings

People did not always receive care that met their current needs. This was because their support plans had not always been reviewed and updated promptly when changes occurred. Support plans included detail on people's needs in areas including mobility, nutrition, medication, washing and dressing and skin integrity. These had been reviewed monthly and staff had often signed to say, 'No changes to care plan' or 'No changes to record'. There was very little detail included as to how well their current support plan was working.

People were at risk of receiving inappropriate care because when their needs changed, previous guidance had not always been removed from the care plan. We read that one person had a mattress on the floor as they were at risk of falling from bed. This risk assessment was still on file, although bed rails were now used and the mattress was no longer required. Similarly we read that the person needed assistance with walking as they were unsteady on their feet, but later in the care plan it stated that a wheelchair was required for transfers. This presented a risk that staff may provide inappropriate or unsafe support if they were not aware of the person's updated support needs.

Staff had not reviewed people's support plans in response to incidents such as falls or admission to hospital. Two people had returned to the home from hospital in the week prior to our visit. Their care plans had not been reviewed to assess whether any changes were needed to meet their physical and mental health needs. Falls risk assessments and mobility care plans had not been reviewed promptly following falls to ensure that action to mitigate the risk of repeat events had been taken.

Records of the action taken to meet people's needs were not always complete to evidence how people's needs were being met. Staff recorded that one person had lost weight and that as a result they would contact the dietician. This was recorded in September. When we visited in November there was no further update. Staff told us that they had been unable to check the person's weight since September but that they were eating well once again. They also explained that they had contacted the dietician who did not feel that a referral was required. These actions had not been recorded. Staff had not maintained a complete and contemporaneous record of the support provided and the decisions taken in relation to the person's care.

At our last visit we raised concerns that monitoring records for people at risk of constipation were not used effectively to safeguard people's health. A new monitoring system had been introduced from 19 October 2015. We found gaps in the records for four people. The records indicated that these people had not had a bowel movement for between 9 and 13 days. We looked in the daily records to see if staff had raised concerns of if any action had been taken. In some cases we found that staff had recorded a bowel movement in the daily notes but not on the monitoring information record. Therefore it was unclear how people's bowel health was being monitored and responded to when changes arose.

Although staff held handover meetings between each shift and were generally aware of changes in people's needs, the failure to maintain accurate records presented a risk of inconsistent or unsafe care. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were available to respond to people's emotional and social needs. Throughout our visit people were involved in conversations with staff or in activities. There was no formal activity programme in place but staff told us that they had appointed one of the care staff to take responsibility for activities. We observed that staff had more time available to spend with people in addition to providing support with their care needs. A staff member said, "It's so good (with three staff in the morning) because one of us can actually spend time in the lounge and do things with them". Another staff member told us, "We make up our own activity, puzzles, singing, nails, reading books". They told us that they were able to accompany people to the shops and that at Christmas a choir had been booked to visit the home. A music therapist visited the home on a weekly basis.

People could not be assured that verbal complaints would be handled appropriately. This was because the provider's updated policy made no reference to how verbal complaints would be managed. One relative shared a number of concerns that they had raised with the provider and staff in the weeks prior to our visit. They were not satisfied with the response that they had received. As there was no record of the issues raised, we were unable to determine how the provider had handled the information or responded to the issues raised.

Requires improvement

Is the service responsive?

Failure to investigate complaints received was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The updated complaints policy included information on the timescales within which the home would respond to written complaints. It also advised that if people who had complained were not satisfied with the home's response they could contact the CQC. We discussed with the manager that the local government ombudsman contact information should be provided. This is because they are able to further investigate complaints. Information on how to make a written complaint had also been displayed in the entrance to the home. We found that the recommendation to review the complaints policy and make it accessible, made following our inspection in April 2015, had been partially addressed.

The provider was present at the home when we visited. We observed that they and the staff on duty were available and engaged in conversations with people and visitors. One relative told us that they would speak with the senior care staff if they had concerns or wished to make a complaint. They told us, "There is nothing I would be afraid to ask, everybody is straight". The provider did not hold relatives' meetings, she told us that she preferred to deal with any problems as they arose on a one to one basis.

Inadequate

Is the service well-led?

Our findings

People were at risk of harm because the provider did not have an effective system to assess, monitor and improve the quality and safety of the service. The provider had been in breach of the regulations concerning good governance since September 2014. They had failed to meet a warning notice issued with a deadline of 31 August 2015. At this visit, we found that the provider had failed to meet the warning notice issued with a deadline of 20 September 2015.

The provider did not have an effective system to monitor the service or to ensure compliance with the regulations. Although the provider had started to complete a self-assessment of their compliance with the regulations, this had not been finished and there had been no update since February 2015. When we inspected in September 2015 we identified further breaches of the regulations when compared to April 2015. Similarly at this visit, new areas of concern were identified, specifically regarding how safeguarding concerns were responded to, the protection of people's rights under the MCA and how complaints were handled. While improvements had been made in some areas, such as in the recording of staff pre-employment checks, three of the four warning notices issued following our inspection in September 2015 had not been met.

People were at risk of receiving unsafe care because risks to their health, safety and welfare had not been assessed. The system of audits did not assess whether risks to people had been mitigated and monitored effectively. Although staff had completed monthly reviews of people's care, there had been no audit to ensure that they understood their responsibilities or to satisfy the provider that people were receiving safe care that met their needs. We found that care plans did not always include guidance for staff on how to meet people's needs, particularly with reference to managing behaviours that challenge and moving and handling. The manager told us that the provider was waiting for templates from an external company to be delivered in order to review risk assessments and care plans. The former monthly audit of risk assessments had not been completed since August 2015.

The monthly accident audit did not demonstrate that the recorded information had been used to determine whether there were any patterns in when or why individuals might have fallen or injured themselves. The audit consisted of a summary of the incident and any action taken by staff. The information recorded did not include the time and location of incidents and there was no review over a longer time period. This could mean that patterns in falls or injuries may not be identified and steps to mitigate risks to people could be missed.

There was no formal system in place to improve the quality of the service. The manager shared with us some 'to-do' lists based on actions identified during our last inspection and from a visit from the West Sussex Fire and Rescue Service. There was evidence that action had been taken in some areas but the system was not definitive. For example, the provider's safeguarding policy had not been updated despite this being highlighted in our inspection reports from April and September 2015. At our last visit we identified some environmental hazards such as rucked lino in one person's bedroom. This had not been addressed and there was no record of a plan to repair the flooring or to make it safe in the meantime. Similarly there was no plan to address the fact that the flooring in the upstairs toilet was not sealed meaning that it could not easily be cleaned and could be an infection risk. When we asked how actions identified through the home's audits were monitored, the manager said, "Just by word of mouth". This meant that necessary actions could easily be overlooked and that measures needed to improve the safety of the service would not be taken promptly. Following our last inspection, the provider failed to return an action plan within the specified deadline. The provider has not accounted for how they plan to ensure they will meet the requirements of the regulations and provide safe, person-centred care to people living at Devonia EMI Home.

There had been some improvements to the way the cleanliness of the home was monitored. A nightly cleaning rota was in place covering the laundry, bathroom, toilets, lounge and hallway. This had been signed off daily. There was also a monthly cleaning and an infection control audit. We noted that cobwebs around top windows had been removed and that paper towels had been provided in the downstairs toilet and bathroom.

Records relating to the management of the service, such as staff training records, were not fit for purpose. The provider was unable to provide updated information on the status of staff training. This lack of clear information meant that some staff did not appear to have been trained in key areas

Inadequate

Is the service well-led?

such as safeguarding or fire safety and that other training, including moving and handling, had been allowed to become overdue. Staff rotas did not demonstrate that the home had been staffed to a safe level at all times.

The provider did not have a system to seek and act on feedback regarding the service. Feedback surveys had last been sent in October 2013 and ad hoc comments were gathered and linked to the provider's website via an external service. While the provider was able to gather the views informally, there was no system in place to use the views of people and visitors to continually evaluate and improve the service.

The absence of an effective system to assess, monitor and improve the quality and safety of the service was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not displayed their rating received following our inspections in April and September 2015. From April 2015, providers are required to display performance assessments by law. This should be conspicuous and in a place accessible to people who use the service. It should also be displayed on the provider's website.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A manager had been in post since August 2015 and had applied to register with us. Staff spoke positively about the manager. One said, "She was sorting everything out. We could talk to her if we had any problems. She would explain things". Another told us, "She works nonstop, the hours she was doing". Staff told us that they felt listened to and that a staff meeting held in September 2015 had been useful for addressing issues and finding solutions to problems.

The manager was temporarily absent from the service when we visited for this inspection. In the interim, the provider explained that they would be providing leadership. The provider was, however, unaware of the documentation in use at the home. The provider said, "I'm no good with paperwork" and told us, "She (the manager) has lots to show you on the computer as I don't know anything". The provider did not appear to have sufficient understanding of the systems and processes required to lead and run the service safely. One staff member told us, "We keep drilling it to the girls, you need to write it down. (The provider) doesn't do paperwork". Another said, "People will be cared for, we've got a good team of staff, it's the paperwork that seems to suffer". In addition the provider demonstrated a lack of understanding of the requirements of the Regulations and how to achieve and sustain compliance.

At our last inspection we set a requirement relating to the notification of incidents. This was because the provider had failed to notify the Commission when DoLS were authorised or when the police had been called in relation to a person who had gone missing. The law requires that services notify the commission of these incidents without delay. Since our last inspection we sent guidance to the manager and provider requesting this information but just one notification of a police incident was received. We also found that incidents such as allegations of abuse and equipment failures had not been notified as required.

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

Following our visit, we received two notifications of DoLS that had been authorised. Notifications of other incidents remained outstanding.

People and visitors, with one exception, spoke positively about the home. One relative told us, "The culture is open". They spoke enthusiastically about the environment, the individual attention people received and the caring nature of staff. The friend of another person told us that they valued the homely feeling. In the absence of clear leadership, relatives told us that they found consistency in the senior care staff and that they had confidence in the care provided.