Devonshire Manor Homes Limited

Devonshire Manor

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Devonshire Manor is a care home that provides accommodation for up to 15 people who need help with their personal care. At the time of the inspection 13 people lived in the home. Some of the people living in the home, lived with dementia.

People's experience of using this service:
At the last inspection, the provider was rated requires improvement. At this inspection, we found the service had deteriorated to inadequate.

There were no adequate or effective systems in place to monitor the quality and safety of the service. This resulted in people being exposed to ongoing risks.

Risks in relation to people's care were not properly managed and their care did not ensure their needs and preferences were met. This placed people at risk of receiving inappropriate and unsafe care.

People told us that the food and drink on offer was good. We found however that people did not always receive a diet suitable for their needs. Where people needed help from staff to eat their meals, the support provided was not well organised or person centred.

The Mental Capacity Act 2005 was not always followed to ensure people's legal right to consent to their care was respected. People's right to be independent and have control over their own care was not always promoted in the support they received.

People living in the home had little to occupy and interest them. Their social and recreational needs were not adequately supported and most people spent all day watching television.

On the days we inspected, staffing levels within the home were sufficient to meet people's needs. People told us they felt supported and that staff were kind. Staff recruitment however was not safe and some staff had not received the training and support they needed to do their job effectively.

Records showed that some people had raised concerns over staff conduct but there was little evidence that safeguarding procedures had been properly followed to ensure people were protected from potential abuse.

Fire safety arrangements were not robust. There was no formal fire evacuation procedure and practice fire drills had not been undertaken for some time. Staff members had not received training in how to use the home's fire evacuation equipment and fire alarm checks had also not been completed for over six weeks at the time of our inspection.

The atmosphere at the home was homely but the management of the service was not open, person centred or motivational. Neither the provider or manager had sufficient knowledge of people's care or their regulatory responsibilities. The service was not well-led and did not ensure people achieved good outcomes or had a good quality of life.

Rating at last inspection and update:
The last rating for this service was requires improvement (published 17 April 2019). After this inspection, the provider completed an action plan to show us what they would do and by when, to improve. At their recent inspection, the provider had not achieved the improvements identified in their action place. We found multiple breaches of the regulations and the provider's rating has declined to inadequate.

Why we inspected:
The date of the inspection was brought forward due to CQC receiving concerning information about the service and people's care.

Enforcement
We have identified breaches in relation to regulations 9 (person centred care), 11 (Need for consent), 12 (safe care and treatment), 13 (Safeguarding people from abuse and improper treatment), 14 (Meeting nutritional and hydration needs), 17 (Good governance) and 19 (Fit and proper persons employed.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our Effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led

Details are in our Well-Led findings below.

Inadequate

Devonshire Manor

Detailed findings

Background to this inspection

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

Inspection team
This inspection was undertaken by an inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

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

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

Notice of inspection:
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We assessed the information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the local authority to gain their feedback on the service. We used all this information to plan our inspection.

During the inspection
We spoke with five people who lived in home, three relatives and a friend of a person who lived in the home. We spoke with the manager, a senior care assistant and two care staff during the inspection. We also met and spoke briefly with the provider at the start of the inspection.

We reviewed a range of records. This included three people's care records and a sample of medication records. Three staff recruitment files, records relating to staff training and support and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

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

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

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

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

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

● Risks relating to people's care were not adequately assessed and staff lacked clear guidance on how to manage them. For example, people's moving and handling needs had not been assessed to see if they needed physical aids such as hoist or a stand aid to help them mobilise. In the absence of such assessments, staff had no way of knowing if the support they provided was safe and appropriate.
● People's accident and incident information was reviewed monthly but there was little evidence this information was used to prevent similar accidents/incidents occurring again.
● There was no written fire evacuation procedure for staff to refer to and no evidence that staff regularly practiced how to evacuate people in the event of an emergency. There was no evidence to show staff were trained to use evacuation equipment and fire alarm checks were also overdue.
● The home's laundry fire door was left open. This meant it would not be effective in the event of a fire. A laundry poses a significant fire risk as it contains heat emitting machinery such as washers and dryers as well as combustible items such as bed sheets. It also meant people living in the home had access to electrical machinery that could cause them harm.

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

Systems and processes to safeguard people from the risk of abuse
● Where people had raised concerns about possible abuse or, where potential incidents of abuse had occurred, safeguarding procedures had not always been followed.
● For example, a staff member reported one person's concerns to the manager. There was no evidence that the manager had investigated these concerns or reported them to the Local Authority or CQC.
● Another staff member had documented the concerns of one person in their care file. There was no evidence however that they had subsequently reported it to the manager or the provider for them to progress a safeguarding investigation.

The systems and processes in place to prevent abuse were not operated effectively. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The application forms completed by some staff did not give an accurate account of their employment history. There was no evidence that the manager had investigated these gaps or inaccuracies to ensure they had sufficient information on a staff member's suitability.
● Some previous employer references were not verified as being from a reliable and authorised source. The personal identity of some staff members had not been checked prior to employment.
● One staff member had started working at the home before the manager knew the outcome of the staff member's criminal conviction check.

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

● On the day of our inspection, the number of staff on duty was sufficient however two relatives felt that on occasion there were not enough to meet people's needs.

Using medicines safely
● Some people's medication records had been handwritten by a member of staff without a second member of staff checking that the information was correct. This was not good practice and increased the risk of errors.
● The dose of one person's medication was dependent on the results of clinical checks undertaken by their GP. Despite this, there was no robust process in place to ensure that staff had the correct dose of medication recorded prior to administration. This placed them at risk of receiving too much or too little of their medication.
● There were no adequate 'as and when' required medication plans in place to advise staff when and how to administer these 'medications.
● The administration of medication designed to thicken fluids for people who may have swallowing difficulties was not recorded. This meant it was impossible to tell if they were given as prescribed.

Medication management was not adequate. This was a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medication was stored securely. We checked a sample of people's medicines and stock levels were correct.

Preventing and controlling infection
● The checks in place to prevent legionella bacteria developing in the home's water supply were not carried out properly by the provider. This meant these risks were not adequately prevented.
● The home was visibly clean. There was personal and protective equipment such as gloves, aprons and antibacterial gel for staff to use to prevent the spread of infection.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection, this key question was rated as requires improvement. At this inspection, this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to eat and drink enough to maintain a balanced diet

- Catering staff did not have a clear understanding of people's nutritional needs and risks.
- People's special dietary requirements were not always adhered to. For example, one person lived with swallowing difficulties. Records showed they were regularly given food types unsuitable for their needs which increased their risk of choking.
- We observed lunch. We saw that people who needed support to help them eat their meals where not given appropriate or consistent support.

This was a breach of Regulation 14 (Meeting nutrition and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's nutrition and hydration needs were not effectively met.

- People told us the food and drink on offer was satisfactory. Their comments included "It's OK, not exciting but I get enough and I've always got a drink"; "It's been very good but I'm not a big eater"; "It's lovely, I enjoy it" and "It's alright. I often have an alternative. I had egg and chips today as I don't like pasta".

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

- Where there were concerns about a person's capacity to consent to a particular decision, the MCA was not always followed. For example, some people had 'do not resuscitate' records in their care file with no evidence that the person had the capacity to consent to this.
- Some people were in receipt of covert medication. This meant that their medication was hidden in food or

drink without their knowledge. Legal consent for the use of covert medication must be gained by exploring the person's capacity using legal processes. There was no evidence the provider had done this.
● Some people had capacity to make their own decisions. We found that their liberty to do so was sometimes restricted. There was no evidence that the service had explored how to balance people's right to make their own decisions with their duty of care to keep them safe.

This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's consent was not always legally obtained in accordance with the MCA 2005.

Staff support: induction, training, skills and experience
● Gaps were evident in the training of some staff members. For example, none of the staff had completed suitable training in moving and handling. Some staff had also not completed training in safeguarding, food hygiene, infection control, mental capacity act or fire awareness.
● Some staff had not had regular supervision and an annual appraisal of the competency of staff members had not been completed in 2019.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as some staff had not received adequate training or support to do their job role.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

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

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

● People's needs and choices were not adequately assessed and their support was not was not always provided in accordance with standards or best practice guidance.
● People's nutritional support and the way their medicines were managed did not follow best practice guidelines specified by the National Institute for Health and Care Excellence (NICE) guidelines.
● People's capacity to consent to their care and treatment was not always assessed in accordance with MCA 2005.

The quality and safety of the service did not adhere to recognised standards. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were referred to some health and social care professionals in respect of their needs. For example, dieticians, speech and language therapy teams, district nurses and opticians.
● People told us they were able to see a doctor when the felt unwell. People's comments included, "Yes they wouldn't hesitate but, I haven't seen him [the doctor] recently"; "Yes I think they would get the doctor" and "Yes I saw the doctor about my leg and now the nurse comes in to dress it. It's getting better".

Adapting service, design, decoration to meet people's needs

● The home did not have a smoking shelter in the garden to protect people who smoked from the weather. At the time of the inspection, some people who lived in the home smoked.
● The home was well maintained. A new wet room was being installed and the provider was in the process of redecorating parts of the home.
● People's bedrooms were personalised with the things that were important to them including ornaments, furniture, photos and pictures.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has stayed the same. People's support did not always ensure their independence was promoted or, that they were well supported at all times.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

At the last inspection, people's care did not always ensure their needs and preferences were met. This was a breach of regulation 9 (Person centred care)) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, improvements had not been made and the provider remained in breach of regulation 9.

● Care plans did not show that people's equality and diversity was fully explored. Some of the information about people's needs was generic and not specifically about them.
● Some of the language used in people's care plans gave staff a negative impression of the people they cared for. This did not promote a caring culture that ensured people were well treated.
● When some people became distressed or upset, their daily records sometimes described them as 'abusive' or 'rude'. This was not indicative of a positive culture that strived to understand the reasons why people became upset, so staff could learn from and prevent these situations happening again.
● Staff routinely transported people around the home in wheelchairs as opposed to supporting them with their walking aids. This was not good practice and did not show staff supported people to remain independently mobile.
● Lunchtime on day one of the inspection was disorganised. One staff member was left to support three people who needed help to eat their meals whist other staff took their break. The support provided did not promote their dignity or independence.

The above issues were a continued breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's care did not always meet their needs and preferences.

● People's care files were kept secure in a locked cupboard to maintain their privacy. A room upstairs however contained archived information about the service that was accessible to unauthorised persons.
● During our visit, the interactions between staff and the people they cared for were all positive. Staff supported people patiently and discreetly when they needed support with their personal care.
● People's comments included, "Staff are very good. I've had no problems from them and I'm satisfied with everything"; "I get up early and staff help me. They do my washing and it's lovely" and "The girls are really

nice, I have a laugh with them sometimes".

Supporting people to express their views and be involved in making decisions about their care
● Records showed that some people were not always involved in decisions about their care. For example, decisions relating to CPR (cardio-pulmonary resuscitation) or covert medication. This was not good practice.
● Resident's meetings took place to share information about the service with people who lived in the home. For example, people were given information about new staff, menus and activities.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and take part in activities that are socially and culturally relevant to them

At the last inspection, the provider had failed to ensure that people's needs and preferences were met. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, improvements had not been made and the provider remained in breach of regulation 9.

● There was an activities programme advertised but this was not always followed by staff. Activities for people to join in with were poor.
● On the day of our inspection, people were given colouring books and had their nails done but other than that there was little to occupy or interest them. People spent most of the day sat in the communal lounge with the TV on or in their own rooms.
● People we spoke with told us there was little to do. Their feedback included, "There isn't much to do in the day as I stay in my room because my legs are bad"; I just watch TV but it's mostly rubbish. I like sport especially football but I like other things like golf but I never know when it's on"; "I just watch TV" and "I sometimes do the activities like Bingo, but it's not on much".
● Relatives agreed with this. Their comments included "No, they just watch TV in the lounge"; "No, I used to help with the Bingo but not now. They sometimes do a quiz which they like";"They occasionally do a few activities in the lounge" and "No, not many (activities). They like music so I bought some 50's/60's CD's in but they don't play them much".

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support
● People's care plans did not always describe their specific needs. Some care plans were generic. and simply listed a series of symptoms or factors that could apply to anyone. This meant staff did not have sufficient guidance on how to provide personalised care so that people's needs and wishes were met.
● For example, there were no individual positive support plans to advise staff how to support people appropriately when they became distressed or upset. This placed people at risk of receiving support that did not meet their needs or support their well-being.
● People's choice or and control over their day to day life was not always respected. Some of the organisational practices in the home restricted people's ability to be independent and did not respect their wishes.
●For example, the service insisted one person returned to the home early evening if they wished to receive

their tea time medication. There was little evidence that the service had explored how to safely support the person safely to take their medication with them so that their day to day lifestyle was not restricted.
● End of life care planning was limited and required improvement to ensure people's wishes and preferences were respected. No-one at the home at the time of inspection was in receipt of end of life care.

The above issues were a continued breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's care did not ensure their needs and preferences were met.

Meeting people's communication needs
Since 2016 onwards, all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● There was some information about people's communication needs in their care plan. For example, how they communicated (verbal or non-verbal) and what aids they may require to communicate effectively such as glasses, hearing aids. This was good practice.
● Information about the service was primarily in written format. There were no alternative formats for example, large print or pictorial aids to share information such as the complaints procedure with people. This required improvement.

Improving care quality in response to complaints or concerns
● Although no complaints had been received by the manager since our last inspection, CQC had received information of concern relating to the service. This prompted this inspection to be brought forward and take place earlier than originally planned.
● Some of the concerns reported to CQC were substantiated during this inspection.

Inadequate

Is the service well-led?

Our findings

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

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

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

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

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

● The service was rated requires improvement in 2017 and 2018. At this inspection, the quality and safety of the service had declined further.
● The manager did not demonstrate sufficient knowledge of people's needs or the care they required. The management of the service was not effective, open or motivating.
● Neither the provider or manager had an adequate understanding of how to provide good care in accordance with their legal responsibilities under the Health and Social Care Act.
● The provider's governance of the service was poor. There was no evidence that they independently audited the service to check on its leadership or evaluated the governance arrangements in place to ensure they were effective.
●The systems in place to ensure the service achieved good outcomes for people were not robust. They failed to identify the concerns we found during the inspection. Where improvements had been identified, no adequate action had been taken to address them.
● During our inspection, we identified concerns with the risk assessment, management, planning and delivery of people's care; the implementation of the Mental Capacity Act; people's nutritional care; the action taken in response to possible incidents of abuse; staff recruitment, staff training and support. It was clear during our inspection that the service was not well-led.

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

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● Some statutory notifications had made by the manager in accordance with their legal duties but, others

had not. For example, the manager had failed to notify CQC and the Local Authority of three safeguarding incidents following the last inspection.

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

- The service made appropriate referrals to other health and social care professionals in support of people's needs.
- Relatives and visitors were made welcome and could visit at any time. They told us that staff kept them informed of any changes in their loved one's health and well-being.
- Staff meetings took place with staff to discuss the running of the service and people's care.