Abbeyfield Society (The)

Downing House

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Downing House provides accommodation over two floors for up to 25 people with a range of care needs who require personal care. Accommodation on the ground floor comprises of a small extended lounge area and a separate dining area. The home is set in its own grounds near to shops and local amenities.

This was an unannounced inspection carried out on the 1 and 2 August 2017 and at the time of inspection there were 22 people using the service, one of whom was on respite at the home. The service was last inspected in May 2016 and was found to require improvement.

At the last inspection the registered manager had not been in post long. We saw at this inspection that they had recently left the service and a new registered manager had been appointed in June 2017. The new registered manager was not available at the time of this inspection so we dealt with the deputy manager, a senior care worker and the business manager.

The service had been without a registered manager for approximately one month. Prior to this inspection we checked whether the new registered manager had submitted the necessary application to CQC to register as a manager. We saw that they had and this process was ongoing. 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.

People living at Downing House told us they felt safe however we found occasions when their safety was compromised. People's safety was not protected. A poorly maintained piece of equipment was in use and regular checks to the home's fire protection system had not been undertaken.

The correct protocols were in place with regards to the receipt, storage and disposal of medicines, including controlled drugs. There were protocols in place for people who were prescribed a time specific medicine however protocols were not in place for all PRN medicines

Recruitment of staff was safe and appropriate checks had been made. Staff understood what action they should take if they were concerned that someone was at risk from harm. Staff were supported to keep people safe through appropriate training in areas such as safeguarding and moving and handling training. There were robust processes and systems in place when dealing with residents' finances and people were protected from possible financial abuse.

Applications had been made for DoLS as required and best interest decisions were documented. The service was acting in people's best interests and adhering to the principles of the MCA.

The kitchen area was clean and tidy and we saw the service had been awarded five stars out of a possible five during their most recent food hygiene inspection.

The cook was knowledgeable about how to prepare foods for those with swallowing problems and how to fortify food and fluids for those individuals who needed to gain weight.

The communal areas of the home were quite small and the lounge got very busy during the day. People using the service had varying needs but staff told us these needs were increasing and people were less independent. We brought the lack of space to the business manager's attention, particularly as the home was not full at the time of the inspection.

Feedback about the service and staff from other health professionals was complimentary. We saw that when necessary people had access to appropriate healthcare professionals however, we identified referrals to the falls clinic had not happened for two people who had experienced a number of falls.

A person's dignity was potentially compromised as health professionals administered an injection whilst they were sat in the communal area. It was not clear from notes made if the person receiving the injection and other residents in the lounge had consented to this.Staff did not offer the privacy of the person's bedroom or an alternative private space.

Staff recognised the importance of letting people be independent where possible and when safe for the individual.

An incident occurred in the dining room on the second day of our inspection. No harm was caused to the person who slipped from a wheelchair. Staff acted calmly and dealt with the incident professionally, treating the person with dignity and respect.

The service supported people with their end of life care and ensured their wishes were upheld whenever possible.

Care plans had not been reviewed in line with changes in need and not all care plans accurately reflected people's support needs.

The home had not managed to recruit an activities co ordinator. Improvement was needed to ensure all people had an opportunity to pursue hobbies and interests which were important to them.

There was a formal complaints procedure in place and any complaints received were acted on appropriately. We saw examples of compliments in the form of thank you cards displayed on the noticeboard.

The registered manager was new in post, however we were not confident that they had received the right support to provide them with a good oversight of the quality of the service. Systems to assess, monitor and improve the quality and safety of services provided to people at Downing House were not robust enough.

The service did not have an effective way of monitoring and analysing accidents and incidents that occurred to help ensure people who had experienced a fall were protected from further harm.

Staff meetings occurred every three months. Staff felt comfortable in these meetings and were able to make suggestions of how to improve the service for the benefit of residents. Supervision of staff had slipped and was sporadic.

Notifications were submitted to CQC as required. The new registered manager understood their

responsibilities with regards to this aspect.

We found three breaches in the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. These were in relation to safe care and treatment, person centred care and good governance. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People's safety was not protected. A poorly maintained piece of equipment was in use and regular checks to the home's fire protection system had not been undertaken.

The correct protocols were in place with regards to the receipt, storage and disposal of medicines, including controlled drugs. PRN protocols were not in place for all PRN medicines.

Recruitment of staff was safe and appropriate checks had been made. Staff understood what action they should take if they were concerned that someone was at risk from harm.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Applications had been made for DoLS as required and best interest decisions were documented. The service was acting in people's best interests and adhering to the principles of the MCA.

People's needs were increasing. People were sat in the lounge for long periods of time and space was limited as the communal lounge was small.

People had access to healthcare professionals and the vast majority of people were referred to healthcare professionals in a timely manner.

Is the service caring?

Requires Improvement

The service was not consistently caring.

A person's dignity was potentially compromised as health professionals administered an injection whilst they were sitting in the communal area. The privacy of others present in communal areas must also be taken into consideration.

Staff recognised the importance of letting people be independent where possible and when safe for the individual

The service supported people with their end of life care and ensured their wishes were upheld whenever possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans had not been reviewed in line with changes in need and not all care plans accurately reflected people's support needs.

The home had not managed to recruit an activities coordinator. Improvement was needed to ensure all people had an opportunity to pursue hobbies and interests which were important to them.

There was a formal complaints procedure in place and any complaints received were acted on appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems to assess, monitor and improve the quality and safety of services provided to people at Downing House were not robust enough.

Staff meetings occurred every three months. Staff felt comfortable in these meetings and were able to make suggestions of how to improve the service for the benefit of residents.

Notifications were submitted to CQC as required. The new registered manager understood their responsibilities with regards to this aspect.

Downing House

Detailed findings

Background to this inspection

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

This inspection took place on 1 and 2 August 2017 and was unannounced. The inspection team consisted of one inspector and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service, including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We contacted the local Healthwatch organisation and the local authority commissioning team to obtain their views about the provider. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We were alerted by a member of the local authority's Quality, Performance and Compliance team that a new registered manager was in post and checked that they had submitted the necessary application to register with the Care Quality Commission, and they had.

We spoke with ten people who lived at Downing House as well as two family members. We spoke with the business manager, the deputy manager, a senior care worker, five care staff, the cook and a domestic. We looked at records relating to the service including five care records, five staff recruitment files and daily record notes.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of those people who could not talk to us. We observed care and support at lunch time in the dining room and looked around the building and saw all areas of the home, including

some bedrooms, bathrooms, the kitchen, the laundry and other communal areas.

We looked at the systems and processes in place for monitoring and assessing the quality of the service provided by Downing House and reviewed a range of records relating to the management of the service; for example, medication administration records (MAR), maintenance records, audits on health and safety, accidents and incidents, policies and procedures, complaints and compliments.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe with the care and support they received from the staff at Downing House. People and relatives we spoke with were confident that there was no abuse, physical or mental, and no bullying happening at Downing House. One person told us, "I feel safe. So far I've no reason to complain." Another person we spoke with also confirmed they felt safe with staff. One person we spoke with did raise concerns about staffing levels during the night. Another told us they needed three members of staff to help them transfer and mobilise, although no specific concerns were raised by the individual. Staff we spoke with also told us, "We could always have more staff. Leave can cause problems. There could be a problem at night if the hoist was needed."

Some people were unable to fully express their views to us because they were living with dementia so we observed interactions between them and the staff. We saw that people were supported by staff who tried to reassure people and make them comfortable. However, during our inspection we observed that at times, people were not always kept safe.

We reviewed records to ascertain how the home managed accidents and incidents. We saw that accidents and incidents occurring within the home were logged and documented accordingly. However, we saw no evidence of body maps being completed following people having falls, as is good practice. We saw that two residents had had 13 falls between them during the three month period from 28 April to 28 July 2017, but as these had not been audited accurately or analysed no action had been taken to try to reduce the risk of further falls for these individuals. One plan of care had been reviewed on 10 April 2017 and again on 29 June 2017. Between these dates the person had experienced eight slips or falls however it was noted that the care plan was reviewed 'without any change'. Similarly the same person's falls prevention action plan, last formulated on 7 November 2016 was reviewed on 29 June 2017 and no changes were required to the action plan. There was no evidence of a referral to the falls clinic, despite the care plan stating this was to happen in the event of a fall. This did not constitute safe care and treatment for the individual.

On our second day of inspection we wanted to observe the lunch time meal and joined residents in the dining room. People were assisted into the dining room, either being helped to walk or were transferred in wheelchairs. We saw one person brought to the dining room in a wheelchair with only one footplate attached. The person was placed at the dining room table and the care worker left to assist other people. The person in the wheelchair managed to slip from the wheelchair and fell to the floor, banging their head. Whilst we did not witness the incident we saw the wheelchair travel into the room and concluded that the brakes had not been applied. We were initially informed that the person often took the brakes off the wheelchair, however when we looked at the person's care plan there was no risk assessment in place for this. Furthermore, given the person's condition, it was noted that they had 'poor movement' in all limbs, therefore it was highly improbable that they were able to reach the brakes and physically release them.

The home was using a poorly maintained piece of equipment to transfer an individual, did not apply the brakes and did not use the lap strap to help secure the individual into the wheelchair. Accidents and incidents had not been analysed to try and stop the reoccurrence of falls. Risks of falls had not been

mitigated against. This meant care and treatment was not being provided in a safe way and this was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a maintenance man employed by the home at the time of our inspection, however this was only part of their role as they were also employed to undertake kitchen assisting duties. On our second day of inspection the staff member was undertaking maintenance duties around the home. They carried out checks on the home's internal systems in relation to fire protection, for example on the fire alarm, emergency lighting and call points checks. We checked records in relation to this and saw that there were gaps in these records. Fire bell checks should be undertaken weekly and we saw that this had last been activated on 31 May 2017, when the fire drill was last practised. Previous checks to this system had been carried out on 12 April, 19 April and 3 May 2017 and had not been done on a weekly basis to ensure people were protected from harm in the event of a fire.

The lack of regular checks on aspects of the home's fire protection system was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of our inspection we looked at whether medicines people required, were administered, stored and disposed of safely. On our arrival at the home we observed staff administering medicines to people and during the inspection we checked the medication administration records (MARs) for five people. The medicines trolley was stored in the deputy manager's office and was chained to the wall, as is good practice. We saw that senior staff dispended medicines from this office, as there were less distractions and therefore the likelihood of any errors was reduced. There was a monitored dosage system in place and we saw medicines for an individual were dispensed, the trolley was locked and the senior member of staff then entered the dining room and administered the medicines. On return to the office these were then initialled to indicate medicines had been taken.

We also checked to ensure medicines that required additional secure storage (controlled drugs) were being stored safely and appropriate and that checks were being carried out as required. At the time of our inspection one person living at Downing House was in receipt of controlled drugs. These were stored appropriately and had two staff signatures when administered, as is good practice. We checked the controlled drugs stock and this correlated with records held. We were satisfied that the correct protocols were in place and were being followed with regards to controlled drugs on site.

We saw there were protocols in place for people who were prescribed a particular medicine. It was outlined for all staff qualified to administer medicines to individuals when to do this as this was a time specific medicine. It also covered the side effects of the medicine and fluids to avoid taking the medicine with, as the effectiveness of the medicine might be altered. However we did not see protocols for 'as required' medicines (PRN). Good 'as required' (PRN) protocols help guide staff as to when they should administer these medicines, the maximum doses to be administered within specified timescales, for instance 24 hours, and certain foods to be avoided if relevant to the medicine.

We checked the medicines of a person who had recently been discharged from hospital. It was not clear from the discharge paperwork, or records maintained at the home, the timeline in relation to a loading dose of colecalciferol prescribed in hospital. We could not see an account of the medicines regime documented in the care plan or in the communication book, following the person's readmission to the home. Receipt of medicines brought from hospital were documented but all staff responsible for administering medicines should be made aware what the medicines regime should be following readmission to the home, particularly when there is a change from that administered prior to hospital admission .

We recommend the service follows guidance from the National Institue for Clinical Excellence (NICE) with regards to managing medicinies in care homes. In particular, that staff administering medicines are provided with all the relevant information with regards to people's medicines and that PRN protocols are put in place for all PRN medicines.

We checked the staff rota to ensure there were sufficient staff on duty, to meet the current needs of people living at Downing House. On the first day of inspection there was a senior care worker and three care staff on duty to meet the care needs of 22 people living in the home. Staff we spoke with did not feel rushed or under pressure, however they told us they did not always have the time to sit with people and have meaningful conversations.

We looked at five care files to see if they had risk assessments which met people's personal needs. The risk assessment document provided information about the risk to the individual person and actions staff could take in order to minimise the risk. Risk assessments had been completed for any areas that were considered to be of concern. We saw risk assessments for malnutrition, choking, skin integrity, medication, mobility and the risk of falls.

Records relating to the recruitment and selection of staff demonstrated that safe recruitment practices were in place. We looked at four recruitment files and found checks had been completed with regards to proof of indentity, two appropriate references and an application form. Staff recruited had the appropriate skills and experience to meet the needs of people living in the home. The service had carried out checks with the Disclosure and Baring Service (DBS). The DBS helps providers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support service. We saw the DBS checks were made on commencement of employment.

Staff we spoke with were able to describe how they kept people safe and what they would do if they suspected someone was at risk from abuse. Staff were supported to keep people safe through appropriate training in areas such as safeguarding and moving and handling training. The service also had up to date policies and procedures in place for staff to follow. We saw that these were made available to staff and discussed during supervision sessions. There were robust processes and systems in place when dealing with residents' finances. We were satisfied that people living at Downing House would be protected from financial abuse.

We looked at service certificates to check that the premises were being maintained in a safe condition. There were current maintenance certificates in place for the electrical installation, the passenger lift, bath hoists, gas equipment, water temperature checks and fire extinguishers. The environment was clean and tidy, but remedial work was required to a corridor on the ground floor due to water damage from a leak. There was a musty smell to one of the ground floor toilets, which may have been attributed to a broken extractor fan. During feedback at the end of our inspection, we brought this to the business manager's attention. We will check on progress with maintenance work at our next inspection.

We saw that staff had full access to protective equipment such as aprons and gloves and hand washing facilities. We saw the sluice area was fit for purpose and tidy, with colour coded mop buckets and mops correctly stored. Bedrooms were clean and tidy and the home had no odorous smells. We saw that a hoover had been left in one person's bedroom but we were unsure if it was stored there permanently when not in use. As the person was not mobile this did not constitute a hazard. However, if left around the home, this might pose a trip hazard to people who are able to mobilise independently. We brought this to a staff member's attention and we were told this was an error and the piece of equipment was removed from the bedroom. We reminded staff to make sure that items of equipment are stored appropriately when not in use

and do not impact on people's safety and personal space around the home.

Requires Improvement

Is the service effective?

Our findings

We observed people receiving care from staff who knew them well. Discussions with staff who worked at Downing House, showed they had a good understanding of people's care and individual support needs. Staff knew people's abilities and what they were and were not able to do.

As part of our inspection process, we looked at whether staff received essential training and support to ensure they have the required knowledge and skills to meet the needs of people living at Downing House. We looked at how staff were supported to develop their knowledge and skills, particulary in relation to the specific needs of people living at Downing House. We looked at the training records for five staff members, including two staff who had been recently recruited. We also looked at the staff training matrix and spoke to staff about their learning needs and also the recruitment process.

We spoke with four members of staff during the inspection who confirmed they had access to a range of induction, mandatory and other training relevant to their roles and responsibilities. Examination of training records confirmed staff had completed key training in subjects such as moving and handling; health and safety; fire safety; food hygiene; safeguarding; administering of medicines; emergency first aid; infection control and dementia. Training was predominantly in the form of E-learning, with added input and support from external training providers and some classroom based face to face training.

Staff confirmed they were receiving supervision sessions but we saw from the evidence we were supplied with, that supervision of staff had been sporadic for some time. Supervisions provide staff with the opportunity to raise concerns and to receive feedback on their performance. Supervisions give both management and staff the opportunity to discuss performance and raise any concerns they might have. Staff may feel valued or involved in the service.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We looked at care plans and other records with regards to the requirements of the Mental Capacity Act (MCA) 2005 and the associated DoLS. We discussed best interest decisions with the deputy manager and other staff. Through the examples given, staff demonstrated they had an understanding of the principles of the MCA and DoLS. We saw that if it was considered people were being deprived of their liberty, the correct

authorisations had been applied for.

We saw there were policies in place relating to the MCA and DoLS. Where people did not have the capacity to make decisions about their care, meetings had been held or relevant people were consulted., For example, relatives, health and social care professionals and legal representatives, to help ensure any decisions made were in the best interests of people using the service. We saw one person had a Lasting Power of Attorney (LPA) in place for health and welfare decisions. This is when a nominated representative can make decisions about an individual's daily routine once the individual is deemed not to have the capacity to make those specific decisions. Someone with an LPA can also ensure that the care a person receives, whether in their own home or in a residential care home, meets their wishes and expectations.

We saw a good practice example of a best interest decision in relation to a person's accommodation within the home. Senior staff judged it was in a person's best interests to move them from an upstairs bedroom to a vacant room downstairs. This would mean the person, who had a diagnosis of dementia, could be monitored and observed more frequently, especially during the night time when the person was more unsettled. The home had not taken the decision without consulting with the person's legal representative, who acted as a Deputy for the person, and we saw a valid copy of the Court of Protection order on the care plan. We saw emails had been sent to the legal representative outlining the person's care needs, the reasons why a room downstairs would be beneficial for the person and an invitation to see the room first before making the decision. It was only after they received an email agreeing to the move of room that the home took action and the person was moved. We were confident that the service was acting in people's best interests and adhering to the principles of the MCA.

We looked at whether people who live at Downing House had their nutritional and hydration needs met. We spoke with the catering staff about the meals they provided. We asked people what they thought of the food at Downing House and people told us, "The food is quite good" ; "No complaints about the food at all. I prefer savoury food and they give me my favourites"; "I ask for tomatoes on toast [for breakfast] and get it; I love my tomatoes on toast." One person told us they had come to the service 'almost a vegetarian' and said, "I was introduced to eating meat again here I'm pleased to say – it's so good." A fresh fruit platter was served with mid morning drinks which people told us they enjoyed. This was considered a healthy alternative to biscuits. We were told there was always choice and if items on the daily menu did not appeal then alternatives were made available.

On the second day of inspection we had lunch with the people living at the home to find out the quality of the food and to help us understand the meal time experience. The home had a policy of protected meal times, which meant that people's visitors are discouraged from visiting around the time meals were served. Protected mealtimes help promote and respect the dignity of people who require support to eat their meals. We found the meal to be hot and tasty and people looked to be enjoying it. By speaking with people and their relatives and through our own observations, we found that people were happy with the choice and quality of food served at the home.

We observed that the dining room appeared quite dark in décor and there were no tablecloths on the tables, although tables were nicely set for lunch. The home might want to explore ways in which to make the mealtime a more enjoyable experience for people.

We spoke with the cook about the dietary needs of the people living at Downing House and found they were aware of which people had specific needs, such as diabetes and had the relevant skills and qualifications for the role. The kitchen area was clean and tidy and we saw the service had been awarded five stars out of a possible five during their most recent food hygiene inspection.

The cook was knowledgeable about how to prepare foods for those with swallowing problems and how to fortify food and fluids for those individuals who needed to gain weight. The cook also knew the food preferences of each person, although there was no official notification given to the kitchen following a person's admission to the home, detailing their likes, dislikes preferences and choices.

We checked to see that the environment had been designed to promote people's well-being and ensure their safety. People living with dementia often spend long periods of time purposefully walking round their living space. We looked at whether the environment was suitable for people who were living with dementia. There was some large signage on toilet and bathroom doors to assist people with dementia and brightly coloured bathroom fixtures that contrasted to the plain sanitoryware. We saw a large clock being put up in the foyer during our inspection. Corridors to the ground floor were wide, light in décor and had been decorated to reflect themes., fFor example we saw an American theme with pictures of Elvis and Las Vegas. Some bedrooms, although not all, had large photograph frames attached to the wall next to their bedroom door. Each frame had the capacity to display up to five photographs and these had been tailored so that not every space held a picture. There was a photograph of the individual with their preferred name, their favourite colour and some information about them, such as what they liked to do. Having such distinctive indicators in place means that people with dementia might recognise their bedroom more easily, but this needs to be replicated on all bedrooms. We saw that people's bedrooms were personalised with family photographs, ornaments, cuddly toys and small items of furniture, such as a favourite chair. This meant that people with dementia might feel less anxious, by being surrounded with familiar objects.

We spoke to the business manager who recognised the need to improve the service for people living with dementia. They told us, and training records corroborated, that staff had attended training sessions and there were plans to extend knowledge about dementia even further by accessing online courses, with staff completing workbooks that would be verified by an external training company.

During the inspection we noted the small communal lounge got very busy during the day. People using the service had varying needs but staff told us these needs were increasing, especially as residents got older. Most people living at Downing House were either not mobile, could not mobilise independently or needed supervising when walking. This meant that people were sat in the lounge for long periods of time and space was limited. We saw one person come into the lounge and then turn around and leave. We asked them why they had done this and they told us it was because there was no room. They said, "I just go back to my room. It's not a problem." When asked if this happened on a regular basis they told us it did. We brought the lack of space to the business manager's attention, particularly as the home was not full at the time of the inspection.

During the inspection we spoke with a healthcare professionals visiting the home. We received positive comments about the staff who 'were brilliant' at referring into the community service. They told us care staff were always helpful and good at following care regimes and ordering equiment, such as for pressure care. We saw that pressure cushions were taken from bedrooms and placed in the lounge for people during the day.

People's care files, handover records and the communication book showed referrals had been made to other healthcare professionals and a record of apppointments was kept. The vast majority of people had access or were referred to healthcare professionals in a timely manner.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us they considered staff to be caring and compassionate although one person we spoke with told us, "Not everyone though." Another added that not all care staff were patient. During our lunch time observation we saw two people requiring assistance with eating were attended to by staff with tact, skill and empathy.

People's privacy was respected and they were able to spend time alone in their bedrooms if they wished to. We saw people receiving visitors in their bedrooms and some chose to take meals in the privacy of their own room too. People had been encouraged to personalise their rooms which gave bedrooms an individual, homely feel.

Staff told us how they ensured peoples privacy and dignity was maintained, by closing curtains when providing personal care. We observed staff knocking on people's bedroom doors and announcing who they were, as well as waiting for a response before entering a persons room. One person we spoke with told us he preferred for his bedroom door to be left open and said, "I don't like to be shut in. They [staff] still knock." A visiting relative to the home told us staff were always polite and courteous to them and to residents, and that people always appeared clean and well cared for.

We saw that district nursing staff came daily to administer an injection to a person. The person was sitting in the communal area referred to as the conservatory, with other people present. We checked notes made by the health professional after their visit and saw whereabouts on the body the person had been injected. Previous entries documented that consent had been sought from the person before administering the injection but the entry on this occasion did not reflect this. There was nothing in the person's care plan to indicate their consent to receive medical interventions in front of others and we judged that on this occasion the individual's dignity was potentially compromised. Staff should be mindful that the privacy and dignity of the person receiving the medical intervention is paramount, but the privacy of others present in the communal areas must also be taken into consideration. A private space, such as a bedroom, or privacy screens for example should be offered and made available for healthcare professionals visits.

During our inspection we observed caring interactions between staff and people who lived at Downing House. People were supported by caring staff and we observed and heard staff being kind, patient and caring with people. Throughout the day we saw situations where people were displaying signs of anxiety or distress, often due to their dementias. Staff were quick to offer support and reassurance people, often introducing topics of conversation the person could identify with to distract them.

Staff working at Downing House knew people well. Staff we spoke with were able to tell us people's likes and dislikes and the preferences people had. We saw recorded in one persons file their preferred choice of drink at meal times. Staff told us they still provided people with a choice of drink at lunchtime; they did not assume even though they were aware of individual preferences. One staff member told us, "People are entitled to have a change. It's their choice." Staff we spoke with recognised the need to offer choices to people and gave examples of when they might offer choices, for example what to wear; meal options or

what times they preferred to get up and go to bed. This meant that staff provided people with the opportunity to make choices about their care and daily routines.

During our inspection we saw that people were encouraged to retain as much of their independence as possible. Staff recognised the importance of letting people be independent where possible and when safe for the individual, but were on hand to help if needed. This was a good example of the service respecting and promoting people's independence to increase their sense of wellbeing and confidence.

The service recognised the need for confidentiality and we saw that this was practiced with the storage of people's care plans in a locked cupboard. Staff we spoke with were aware that they had access to sensitive information and the need for confidentiality was recognised. We were confident that staff took this seriously and would protect the interests of people living at Downing House and not divulge personal information.

The service supported people to remain in the home for end of life care rather than being admitted into hospital if this was their choice. This showed the service and staff were caring, compassionate and had the necessary skills to support people receiving end of life care at Downing House.

Requires Improvement

Is the service responsive?

Our findings

Staff knew people well and people we spoke with told us that staff were responsive to their needs. One person told us. "The girls are great; I need more help these days." A relative we spoke with told us they had no concerns and that their family member 'feels secure' living at Downing House. We judged that the service was not always responsive to people's changing needs.

During this inspection one person was accessing the service for respite, having done this previously on other occasions. Respite care is when a person receives care and support for a time limited period before returning home. Respite is often used to provide family carers with a break or when they wish to go on holiday. Through our observations we saw the person on respite care was fully mobile and they were walking between the communal areas of the home, looking for something to do. This person was of non-white heritage and their first language was not English. Due to cultural differences and the language barrier, we saw how this person was not able to integrate with other people in the home.

This person did not seem distressed or anxious, and they were smiling on the occasions we saw and interacted with them. However, when we asked staff about this person, they did not know the person's nationality and were not clear about the most effective and appropriate method of communication. This meant we were not assured this persons needs were being fully met. The service failed to demonstrate due consideration had been given to other methods of communication such as translation services, alternative language communication cards or pictorial prompt cards.

We checked to see if care plans were updated regularly to ensure that the information was accurate and a true reflection of the person's current needs. Care plans should provide clear guidance to staff about the person, and provide them with clear instructions on how to manage specific situations. We saw that updates to some care plans had slipped or had not been updated to reflect the person's current needs, for example following a fall.

Care provision was not always appropriate for people and care plans did not accurately reflect current needs of people. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked care workers how they knew what people's care needs were. One care worker said that they would find out by getting to know the person and following the care plan for that person. Another care worker said the manager or the deputy manager would inform the staff when needs changed and if people's care plans had been updated. In some rooms we saw 'Remember I'm Me' charts pinned on doors. These laminated charts indicated to staff a person's individual needs., For example, one chart we looked at told us the person preferred tea, used a wheelchair to mobilise and wore glasses. These were good reminders for staff, although these charts were not in every bedroom we entered, and we saw examples of care workers recognising people's needs and meeting these throughout the inspection.

We saw that, where possible, people had been involved in their care planning. People were aware of the care

plans in place and one person told us, "I haven't seen my care plan but I know I can." We found the service respected people's preferences and choices. Care plans we looked at contained some information about the person's life history, but this was not always complete. Documenting life histories can contribute towards more individualised support as staff are aware of people's past lives and what is important to them. We saw that people's preferences, their likes and dislikes and information about identified risks had been recorded.

We saw recorded in one care plan that a person's mobility was poor and their gait was not stable and staff should ensure their toe nails were 'trimmed regularly' to help with this. We saw that the person received foot care, which included having their toe nails cut, every three to four months. This meant that the service responded to the person's needs and continued to help them maximise their independence with walking.

At our last inspection we identified the service did not employ an activity coordinator. Since our last inspection the service had still not recruited to this role although the service could evidence that the recruitment process had been attempted, but so far had been unsuccessful. All staff were therefore expected to get people involved in activities, instigate discussions or provide entertainment for people living in the home, but we saw no evidence of this during our two day inspection.

We asked people living at Downing House if they felt there was enough to do in the home and most people thought there was, although the activities they focused on were based around finding ways to entertain themselves such as doing crosswords, puzzles or reading a book. One person told us, "I love reading; I'm never without a book." One relative, when asked about activities held in the home told us, "There's not a massive amount [going on]."

The lounge had been extended and at the bottom of the lounge was an area used for activities. We saw there were a number of books, board games, puzzles and arts and crafts made available for people, although we did not see these in use during the whole of our inspection.

At the last inspection we observed that the television in the lounge was on but muted, with music coming from a stereo. During this inspection we saw that this practice had not stopped. We observed subtitles displayed on a mute tv and music coming from a stereo in the same room. People sitting in the lounge area did not seem interested in either stimulus. However, people with dementia may feel over stimulated with both on at the same time.

National guidance and evidence based best practice around providing good dementia care is linked to appropriate activities as well as providing objects of interest to help stimulate people's minds. The home had made some attempt as we saw items such as hats, feather boas and beads were available for people if they wanted to play with these. They were displayed in the corridor near to the communal lounge but during our two day inspection we did not see any residents displaying an interest in these items and similarly, staff did not encourage the use of these as part of an activity. There was a local dementia café advertised on the noticeboard in the corridor of the home however, we did not see any trips organised to go there and people we spoke with did not tell us they had attended.

The home held an annual garden party, which had recently been enjoyed and celebrated special events during the year, for example St George's day and the Chinese New Year. There was a monthly church service held on the first day of inspection and we were told that volunteers from this church came to take one individual to a church service on a regular basis. A hairdresser visited the home on a weekly basis and 'Music For Health' provided armchair exercises for those residents wanting to participate. We found improvement was needed to ensure all people had an opportunity to pursue hobbies and interests which were important

to them. There was nothing recorded and evaluated in care plans with regards to participation in activities or entertainment and people were left to their own devices for the majority of the days of our inspection. We noted that during the handover staff were informed that one person was out swimming. People who could access activities independently were able to do so but there were people who needed assistance were limited in what they could do.

People were not provided with ample opportunities to engage in meaningful and stimulating conversations and activities. This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the service handled complaints. We found there to be a formal complaints procedure in place which was displayed on a notice board in the office. The service user guide also provided guidelines on how to make a complaint to the service and signposted people and their relatives to other organisations if they felt the complaint warranted escalating. Neither people we spoke with nor their visitors had any complaints but knew what to do if they had. They were confident they would be listened to and appropriate action would be taken.

There were meetings for people who lived at the home and their relatives and we saw copies of minutes from the last meeting displayed on a noticeboard in the corridor. The emphasis for the meetings was for people to share information and voice any concerns they might have, along with any suggestions for improvements. Records of minutes we were supplied with showed they were well attended.

We saw minutes from the last resident's meeting held in July 2017. Residents were informed about the planned changes to be made to the home and the improvements already made with the outside space and garden areas. The service planned to involve residents more with future recruitment of staff. One person had already taken part in this and there were plans to develop this aspect. Residents complained about the lack of things to do and we saw that suggestions had been made with regards to easy games and pastimes that could be adopted. We were confident that the service recognised the need for improvement in this aspect and was consulting with residents on how this could be achieved.

One person we spoke with had raised the fact that they could see a toilet from their seat in the dining room, as the dining room door was initially kept open during meal times. To resolve this it was agreed that the dining room door would be closed once everyone was seated at meal times and the person told us the door was now kept closed until people had finished eating and left the room. This showed us that the home was committed to ensuring people were involved in the running of the home, listening and acting upon feedback to improve the service. The person was satisfied with the action the home had taken in this matter and it had resulted in an improvement in their meal time experience.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection the registered manager had not been in post long. We saw at this inspection that they had recently left the service and a new registered manager had been appointed in June 2017. The new registered manager was not available at the time of this inspection so we dealt with the deputy manager, a senior care worker and the business manager. We noted that the report produced after the last inspection was available for people to read, with the rating clearly displayed as is the law.

The registered manager was new in post, having been promoted from the position of team leader in June 2017. The service had been without a registered manager for approximately one month. Prior to this inspection we checked whether the new registered manager had submitted the necessary application to CQC to register as a manager. We saw that they had and this process was on going. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We saw evidence of formal quality assurance systems in place at the service, undertaken by the registered manager and business manager, which were used to monitor standards and encourage on going improvements. Some audits however were overdue or had not been done, which impacted on the maintainance of people's safety and welfare.

We checked the accident record book and saw the numbers of accidents and incidents that had occurred since April 2017. Accident forms were completed in the event of a person having a fall, but we saw no further analyses of the accidents that had happened in the home. There was no log in place detailing who had had falls, when and where and what had been done as a result of the falls, for example review of medicines or referral to falls clinic. Themes and trends were not identified so that risks to people could be mitigated. This meant that the service did not have an effective way of monitoring and analysing accidents and incidents that occurred to help ensure people who had experienced a fall were protected from further harm.

Care plans had last been audited on 7 April 2017. This audit had identified a missing entry on one person's key worker log and the instruction had been to complete or remove the paperwork prior to the CQC inspection. We checked this care plan, saw the log was still in place but no entry had been made as a result of the audit, nor were there any further entries after 22 March 2017. The action was aimed at the keyworker of the person but It was not clear from the audit whether they had been informed and no follow up had been done so see if the action had been completed.

We saw audits on medicines had last been completed in February 2017. Three people were the focus of that audit and no issues had been identified. No more monthly audits had been undertaken since. Gaps in the testing of the fire alarm and emergency lighting had not been identified as no audits were being undertaken to check if these had been done.

We identified that systems to assess, monitor and improve the quality and safety of services provided to people at Downing House were not robust enough. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with said they felt comfortable approaching the registered manager if they had an issue. We saw examples of management supporting staff and the measures that had been put in place to assist staff. Staff who had had a period of absence due to sick leave were supported back to work in ways that assisted them, for example flexible working hours or the offer of a less demanding, alternative role in the home. The service was also quick to take disciplinary action if they felt a staff member's performance warranted this.

Staff we spoke with confirmed that staff meetings had occurred and were every three months. They told us they were able to make suggestions in these meetings if they felt it would improve the service or benefit the residents. The last staff meeting was held in May 2017 and covered aspects of care, rotas, staff behaviour, laundry and the possibility of a CQC inspection.

We had received a notification prior to this inspection from the new registered manager. This showed us that the registered manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration.

We asked for results from any surveys of residents, family and staff as these were not available in the home. We were told the service had distributed quality surveys to residents but had received no responses from people at Downing House. Survey results available related to the organisation as a whole and did not reflect how people felt about the service provision at Downing House. We received no feedback in relation to the staff survey.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care provision was not always appropriate for people and care plans did not accurately reflect the current needs of people. This was a breach of Regulation 9(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The home was using a poorly maintained piece of equipment to transfer an individual, did not apply the brakes and did not use the lap strap to help secure the individual into the wheelchair. Accidents and incidents had not been analysed to try and stop the reoccurrence of falls. Risks of falls had not been mitigated against. There was a lack of regular checks on aspects of the home's fire protection system. This was a breach of Regulation 12(2)(b)(d)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

Systems to assess, monitor and improve the quality and safety of services provided to people at Downing House were not robust enough.

This was a breach of Regulation 17(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.